REP. SCANLON (98TH): All right everybody. I would like to reconvene the Insurance and Real Estate Public Hearing, and I wanna apologize to the members of the public that are here and waiting. We did not certainly intend to start this about 50 minutes late, but we certainly appreciate your patience. As some of you that were in the room saw, we had a pretty large press conference going on, and we've wrapped that up. Now we will certainly get to the public hearing.

Before we go any further, I wanna welcome two of our new members Senator and Doctor Saud Anwar and Representative Anthony Nolan, who are both here for their first meetings on this committee. So, welcome guys. [Applause] I was told that Senator Bizzaro is also on this committee. So I don't see him in the room, but we'll certainly welcome him to the committee as well. And with that said, we will begin our public hearing, and our first witness to testify is Brenda Kupchick, though I don't see. Oh, yeah, there she is. All right. Representative Kupchick, long time no see.
REP. KUPCHICK (132ND): Good afternoon [laughing], Representative Scanlon, Senator Lesser, and Ranking Member Kelly and Ranking Member Pavalock-D'Amato. I'm here to testify on behalf of HB 7125, as we just discussed during a wonderful, hitting it out of the park press conference about this bill. I have been partnering over the last six years and working closely with the National Association of Mental Illness and other organizations as well, where I've learned a tremendous amount and it has fueled my passion for this issue, and I would like to turn this over to Steve Lichtman from Easton, who is a member of the National Association of Mental Illness and -- and who I have had a lot of opportunity to spend time with.

STEVE LICHTMAN: Thank you. We met previously at one of our NAMI forums. [Background talking] Thank you, Representatives, including my representative, Anne Hughes over there. I’m here to speak to you about -- well, in favor of House Bill 7125, regarding behavioral health parity. I wanna give my experience and observations.

My daughter developed two health problems during her high school years. In the first instance, she injured her knee as a high school junior playing lacrosse. She was bumped by another player and tore her ACL, MCL, and meniscus. We went to our local orthopedic practice in Fairfield, where she was diagnosed with MRIs, x-rays, etc., and treated. We paid our co-pays under our plan and pretty much had our choice of physicians, who all seemed to take our insurance. She also had extensive physical therapy that went on for months and was also covered.
In the second instance, one day we got a call from our daughter's guidance counselor that she had talked about possibly wanting to hurt herself and that -- they suggested that we take her for counseling -- not a call you really wanna get. Concerned, we talked to our pediatrician, who referred us to a psychiatrist, who we made an appointment with right away. Given the circumstances, we didn't question when it was time to pay $400 dollars per session and then later submitted our paperwork to find out that the psychiatrists, as are most psychiatrists I found in my experience in our area, are out-of-network, and we were reimbursed for roughly a quarter of what we had spent.

Also, it was determined that there was one recognized proven effective therapy -- I mean there are others, but this was the leading one -- for her condition, which is called dialectic behavioral therapy, and that's something that only certain centers provide and are properly trained on. And again, our experience in our area was that none of the providers would take -- take insurance, so again we were paying in this case $225 dollars a session, only to be reimbursed roughly about $65 dollars. And, you know, fortunately we were able to pay it because that's what parents do when your child is ill, but I'm sure there are a lot of other families who are precluded from adequate treatment when faced with these kinds of expenses.

Obviously, there was quite a bit of disparity between our two experiences there with my daughter's illnesses. So, I'm -- and as I mentioned before, I've spoken with many other families through support
groups and other places, from NAMI and with other family members of people with mental health issues, and they all pretty much express the same frustration -- that they're often barred or have a very difficult time getting adequate mental health care. So, in conclusion, I'm in favor of House Bill 7125 because it'll shine light on this practice that I have seen anecdotally and I've heard from many families exists, but we need some hard evidence to give you so that you can address this problem for Connecticut residents. Thank you.

REP. SCANLON (98TH): Thank you, and thank you Representative Kupchick. As I said during the press conference, you've been an incredible partner for me and others that have been working on this for a couple of years. And it's great to be working with you, and I think we will get this done this year, and it's great to have you here as well and sharing your story. Any questions from the committee? Seeing none. Thank you both very much.

REP. KUPCHICK (132ND): Thank you much for your time.

REP. SCANLON (98TH): Next up is the State Healthcare Advocate, Ted Doolittle.

TED DOOLITTLE: Good afternoon, Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato, and other honored members of the committee. Thank you for your time today. I know you've got a busy afternoon ahead. I'm gonna be very brief. My remarks today are directed toward Senate Bill 976, AN ACT ESTABLISHING
A TASK FORCE TO STUDY REIMBURSEMENT RATES PAID BY HEALTH CARRIERS TO HOSPITALS.

Before I get started, for those in the room who aren't familiar with the Office of the Healthcare Advocate, we provide services to the residents of Connecticut, especially those who are having trouble accessing health insurance. So, if you have a health insurance claim denial or something of that sort, we have a staff of nurses, paralegals, attorneys, and others that can help you in the fight with the insurance company. So please don't hesitate to reach out to us.

With respect to Act 976, excuse me, Senate Bill 976, as you all know by now from my testimony, I believe that healthcare costs are the main problem facing consumers. Important components of those costs include pharmaceutical costs but also hospital costs. That's what makes this type of study so important, and that is why I commend this bill to your attention, and I hope it does get approved.

There are certain models around the country who are having better control and knowledge of healthcare costs in hospitals. For instance, in Maryland, they have a rate-setting system, where their rates are set every year. So, everybody who goes for a knee replacement at Jones Memorial Hospital, whether you're coming in off the street, or you're Cigna, or you're Aetna, everybody pays the same price. That's something we're considering. Massachusetts also has a system where they examine the costs of the hospitals across the entire state, and they try to keep those hospital costs at a certain level of increase. So, those are some of the items that
perhaps this commission, if it's set up, or this task force, if it's set up, could -- could look to.

One modification I would consider -- an amendment to add my office to the task force. We have a special perspective on hospital costs given that many of our clients are experiencing exactly those types of issues. That does conclude my remarks. I am happy to take any questions.

SENATOR LESSER (9TH): Yes, thank you. Mr. Doolittle, it's good to see you, as always. Can you just expound in a little bit more detail about some of the models that are available around the country, and some that you think we should look at. I know you mentioned Maryland briefly.

TED DOOLITTLE: Yeah so, in Maryland, they have had in operation for several decades, I think probably about 25 years, a system that is similar to the system that was attempted to get off the ground in several other states, including Connecticut in the '90s. We actually had a similar system. But what they do is they have a commission. I'm not sure what the name of it is, but they appoint experts from a variety of industries. And as I understand -- as I understand it, the hospitals every year propose the rates that they're gonna charge for, you know, thousands and thousands of procedures and so forth, and that is then reviewed and debated by the expert commission and then those rates are either accepted or adjusted. As a result, Maryland has -- has been able to have a somewhat flatter cost trend curve, especially around the hospitals. They do have certain advantages in that state that might be
difficult to replicate in this state by which I'm referring specifically to a special subsidy that they get from Medicare CMS. I'm not sure that Connecticut would be able to duplicate that, but that it is a model worth -- worth taking on.

The Massachusetts model, as I mentioned, they have an office somewhat analogous to our new Office of Health Strategy, but they have a commission up there that is responsible for assessing the medical trend, the rate at which hospital prices are growing every year, and there is a cap, as I understand it, of how much the market, not any individual hospital but how much the market is to rise in any given year, and then they make some, you know, tough choices. All these options do involve -- involve hard choices. That's why it's very wise to do this in the form of a task force or a study to really have a very carefully thought out plan, but I do feel that this is the type of hard cost control decision that we just have to get to in this state in order to get our businesses to be economically competitive with overseas, where they're delivering the same type of healthcare for half the cost. We can do that -- I know we can -- in Connecticut, but this is the type of study we have to do.

SENATOR LESSER (9TH): Thank you very much, and thank you Mr. Chairman.

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): Thank you, Chairman, and thank you, Mr. Doolittle, for the good work of the Office of Healthcare Advocate. I'm so glad you brought that up. Can you speak a little bit to preventative
care. You've been talking very much about critical care, which is totally an issue that this bill can start to address with mental health parity, but I believe your office can probably speak to if people have more access to preventative mental health care -- the cost savings on the other end of that -- of it not becoming critical might be something really worth the commission's attention.

TED DOOLITTLE: It probably is. Now, Representative Hughes, I haven't done research on the exact question that you ask. I think that preventative health services in many instances, both medical and on the mental health side, can wind up with cost savings in the future. However, the question is quite complex, and there's actually been a lot of healthcare economic research on that very issue. And, to make it really simple -- for instance, if you prevent a death from lung cancer, that person survives, and grows to a ripe old age, and winds up costing the healthcare system money. So -- so there are certain -- it's not as cut and dried as we know that all preventative services over the long haul will always result in savings, but we do know that they will result in better health. And so that we, therefore, will always advocate for those preventative services, and then as a community it's our job to figure out how to pay for that better health. I do think there are savings possible there, but I just wanna caution that it's a more complicated question.

REP. HUGHES (135TH): Thank you for framing it that way.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you for your testimony. It's my sense that in the state of Connecticut, which is much smaller than some of the other states, there are just a few big players that are left now with respect to the healthcare systems, and because the smaller healthcare systems are being taken over by larger ones, and as a result of which, the prices have gone up. And this is going to help oversee and have a better understanding of comparing it too, but it would be worthwhile to know if there is comparison data from other states to be able to look at it. Because if there are three players, they will all be charging quite high, and they may be different from each other, but I think -- I don't know if there is a benchmark that would be -- we could look at somewhere else, which would help us control some of this excess charging, if you will. Do you know much about that -- if that data is available, or --?

TED DOOLITTLE: So, that data is really increasingly available. It's really going up exponentially -- the availability of that type of data. There is a -- a coalition of the five largest health insurance companies that have formed something called the Healthcare Cost Containment Institute, and they have all the data from all of their own plans. This is five -- we're talking Humana, Aetna, United Healthcare, all the big ones -- and that database now has something like 40 percent or thereabouts, maybe a third to 40 percent of the health claims in the U.S. There's also, rapidly coming online, other -- other databases, including our ongoing efforts here in this state to create what's called the All Payer Claims Database. So, those data are
increasing available and certainly looking to other states also important, as I think you were alluding to, to look to other states where there are more competitive markets or more consolidated markets to try to determine what element of the prices are driven by perhaps consolidation as opposed to true, more legitimate economic forces.

SENATOR ANWAR (3RD): Right. So, and I can recognize and respect the fact that the insurance companies would benefit if the healthcare systems started to charge less, but as consumers, we need to have some oversight of the insurance companies because let's look at what they're charging their consumers as well and then put that data together too at some level because this -- it would -- At the end of the day, if we are doing things to help the average community member or citizen for what they are charged, and so it's a whole spectrum, and while we are looking at one spectrum of that with the healthcare system, it's worthwhile to see what is happening to the charges the insurance companies are charging the community members. So, I don’t know how -- is there a way to look at that at some point? Do we need another task force? But, this would look at only a piece of the puzzle.

TED DOOLITTLE: You're absolutely right, Senator, but I would commend to you -- and I don't have the bill number at the top of my head -- but there is a bill that is actually goin' to be before this committee soon, and I forget the exact name of it, but it deals with the -- the rate review process, where the insurance companies every year file their rate requests. And this is a bill to consider adding consumer affordability to the list of things
that the insurance commissioner must take into account during that annual rate review process, so I'm sure you'll be interested in that bill when it does come before the committee.

SENATOR ANWAR (3RD): Yeah, good. Thank you, Mr. Chair. Thank you.

REP. SCANLON (98TH): Any --? Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Through you, good afternoon. So, you just mentioned the rate review process that insurance companies do. So, there's already a process in place for them to submit rate requests to the Department of Insurance, is that correct?

TED DOOLITTLE: The health insurance companies we're talking about?

REP. VAIL (52ND): Yes.

TED DOOLITTLE: Yes, sir.

REP. VAIL (52ND): And, do they just get to pick arbitrary numbers, or are those numbers usually based on claims paid out? What's your understanding?

TED DOOLITTLE: Given I'm not an actuary but an attorney by training, but my understanding is that the companies, with their actuarial teams and their medical teams, try to predict what the claims are likely to be in the next year, and they use that information in developing their rates.
REP. VAIL (52ND): And there are regulations already in place that say that they have to pay out a certain amount of claims based on the premiums they take in -- is that not correct?

TED DOOLITTLE: I think you're talkin' about the MLR, medical loss ratio rules, ["Yes" in background] where for certain types of plans there's -- under the ACA, they are required to spend either 80 percent or 85 percent of every premium dollar on medical claims. If that's what you're referring to, yes, that is in place.

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

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

TED DOOLITTLE: Thank you, sir.
REP. SCANLON (98TH): Next, I'd like to call Patrick Kennedy. ["Push the button" in background, then "Thank you"]

PATRICK KENNEDY: Thank you, Mr. Chairman. I wanted to take the opportunity today to highlight how Connecticut, tragically for the very people who live in this state, has the worst disparity in access to inpatient care when compared to other forms of care that would be accessible if you had another illness. And when you look at the disparities in how much behavioral health out-of-network coverage there is, Connecticut ranks demonstrably higher than neighboring New York and Rhode Island and Massachusetts -- 39 percent higher. That means that there is a much greater obstacle for people in this state when trying to access care. And this data is
from the Milliman Group, which is a nationally recognized kind of accounting and analytics firm, so it's -- it's not an advocate's portrayal. This is the real claims data that has been analyzed.

I appreciate the opportunity I have today to speak on your bill, but I can't ignore the fact that, just as you announced your bill today, there was a major United States Court of Northern District of California decision, the Wit decision, as it's known, against United Behavioral Health. And in it, the judge meticulously goes through how many ways that United Behavioral Health, you know, knowingly violated applying generally accepted medical criteria for those suffering from mental illness and addiction when determining who was able to get care and who wasn't. And just to tell you about what their decision was, the court found that although members in their health plan had this coverage guaranteed -- in other words, this is not just a violation of the Parity Law, this is a simple contract violation -- they thought they were buying one thing, and they got something entirely different. And, in addition to that, they developed, on their own, more restrictive medical necessity criteria with which they used this criteria to systematically deny outpatient, intensive outpatient, and residential treatment. Specifically, the federal court found that United Behavioral Health's internal guidelines limited coverage only to acute care in disregard of the highly prevalent chronic and co-occurring nature of these disorders.

And, my friends, this is what it's all about. Our healthcare system is a sick care system. If this
were cancer, you would not wait until it was a stage 4 illness before you covered it, but with mental illness and addiction, for some reason, and it's beyond my ability to understand, insurance companies are waiting till you get to death's door before they start taking care of you in terms of the reimbursement for your coverage. And, part of the reason we have such a scandal in terms of the indicators that you, Mr. Chairman, mentioned with respect to the lower lifetime expectancy for all Americans in this country because of suicide and overdose, it's inexplicable that we would have a healthcare system that does not treat these illnesses as the chronic illnesses that they are. In other words, they wait for you constantly to cycle in and out of crisis. And I can speak to this because I am someone in recovery and have spent a better part of my life going in and out of rehab.

As opposed to having my health plan reimbursed for a chronic disease management approach for my chronic illness of depression and addiction, instead my health plan waited for me to crash, and then because I was a congressman and could like make sure that they covered it, they covered it, and in and out, and in and out, and in and out. And, it made no sense to them, and it makes no sense to the people that are suffering from these illnesses. I will say parenthetically, it took me leaving public life and leaving politics to ultimately be able to find sobriety. It's not as if you can't find sobriety as an elected official [laughing] -- I have done my share of 12-step work with my colleagues in Congress, and they are representative, by the way, of our nation in every respect, including in the percentage of those of my colleagues in Congress who
suffer from these illnesses, and they suffer in silence.

Ironically, the greatest moment of my political career was the lowest moment of my political career, because when I got on the cover of every newspaper in this country because of my accident driving my car under the influence, I became such a well known addict and alcoholic that every other addict and alcoholic in Congress knew who to call on. In other words, they had no idea who the other addicts and alcoholics were, but they knew I was, and that meant every time I went to the floor of the House of Representatives or committee meeting or out to political event, I had my colleagues taking my back. And we all know that peer support is an essential part of recovery and that that wrap-around approach is essential, and that's what insurance companies should be paying for. [Applause]

I know, Mr. Chairman, I'm probably way over my time right now, but let me just say -- highlight some other things about this decision. It said that United Behavioral Health was not credible. That's pretty incredible to have a federal court judge call out the number one insurer in this country for not being credible. In fact, they said, United's experts had, "serious credibility problems," and this is like scathing, and that is why I see this decision as such a landmark decision. That's not to say United's alone. We all know Aetna -- you could see the sign not far from here -- had a terrible decision in Pennsylvania no more than two or three months ago, where the insurance commissioner there really had a scathing review of their violation of the Parity Law. And we know neighboring New York
Attorney General cited both Blue Cross and Cigna for pretty dramatic violations. And, in California, Kaiser Permanente has been cited many times.

My point is that this is a systemic problem throughout the insurance industry, and the reason I've highlighted this United case is that it should give you added motivation to pass this legislation, which will help end and finally enforce this kind of law that will end the discrimination for those who are suffering from these illnesses. These illnesses know no boundaries, and I'm just so grateful that both Democrats and Republicans have come out so strongly in favor of this. And I'm excited by the opportunity to see the Governor, later on, express our strong support for this, and I'm very confident that he will sign legislation that's sent to him, and I would not hold back on being as proactive as you can in terms of putting the onus on these insurance companies to disclose this data and really holding them accountable through ongoing market conduct exams, which in the parlance of those who know this space means that you constantly monitor whether they are getting it right or whether they are needing to be brought back into the main.

And so, with that, I thank you, Mr. Chairman, for the opportunity to speak today. Matt, you as well, and I’m happy for any questions if you might have any.

REP. SCANLON (98TH): Thank you very much, and I wanna just echo what I said earlier, which is that to have you here means a lot, not to me but I think to everyone on this committee in attendance here today because you have certainly blazed a trail that
few other people, I think, have blazed in terms of standing up for people whose voices are not necessarily the ones most often championed by members of Congress and members of state legislatures. And my father was an alcoholic and died in 2007, and I know how hard it is to attain and maintain that sobriety, and it's a constant struggle. It's a disease that never goes away. 

"That's right" in background] And I think about it every day, and it informs the reason why I work on this stuff, and I know it's the same for you, so I wanna thank you for that. ["Thank you" in background] I want to ask you something. The Milliman report obviously is something that I first became aware of because of your brother, who, as you know, I campaigned with and was the senator for my district, and when he decided not to run again for this office, he made me promise that we would go back to this bill. So, I hope you tell him we're fulfilling that promise today.

PATRICK KENNEDY: I'm already texting him. Senator Kelly made sure of that.

REP. SCANLON (98TH): But what -- what I guess I can't wrap my head around is that in the wealthiest state in the nation, in a state that has so much going for it, that we could be worst in this regard. And I think the only answer to as to why that was -- somebody asked me earlier -- is because the folks that are left behind here are the ones that we don't talk about, and it's the ones that you spent your life talkin' about. And I wonder if you could just share, given the fact that you've traveled across this entire country and the entire world, what this means to people who are every day, and their loved
ones, who are struggling to find services, that are payin' out-of-pocket costs that are exorbitant that they don't pay for physical health, that they can't find providers who can help them -- why this is so important to the people that you are fighting for and that we are fighting for.

PATRICK KENNEDY: Well, thank you, Mr. Chairman. People just want dignity, and when you're looking for healthcare and someone's looking back at you and saying your life isn't worth it, and we're not gonna give you lifesaving care, [announcement in background] there's nothing more insulting to a person than when someone says that you're not worth it. And that's the message that people with these illnesses get routinely because we as a society still do not understand the biochemical nature of these illnesses.

And I just stopped for a second 'cause you mentioned your father, and my mother suffered from alcoholism and depression as well, my dad post-traumatic stress, having seen his brothers murdered, and the point is -- is that you're already feeling and made to feel "less than" because this is apparently your fault that you're feeling this way -- just all you need to do is snap out of it -- but come back for a second and think about how many people would willing get up every day and do their best to piss off everyone around them, okay, risk their livelihood and their employment, risk getting arrested -- I mean, seriously, there's no person. They're human beings. We all wanna be loved, respected, be part of society. This is a sign that you're not yourself and you need treatment. So, for someone to say that this is a voluntary thing -- that you're
voluntarily trying to become a pariah in society just doesn't wash with me.

So, what's so sad is that insurance industry has never moved even though the medical community has, and I think the reason is that there's no political pressure brought to there. Because, guess what, the stigma of these illnesses keeps people silent, but if this were another illness, God, you'd have people around the corner waiting to come in here, when you consider the fact this affects one in four people. I mean, this oughta be -- you oughta be needing to get a whole new committee room to accommodate everybody who's affected by these illnesses, and yet people do not wanna come forward. And it's because we're all acculturated into thinking that we're not worthy if we have these illnesses, and the reason is -- is because we don't think we're gonna get better.

But to this case with United, if they're waiting to only cover stage 4 addiction, what do they expect to be the results. If you waited for stage 4 cancer and then all of a sudden people dying and dying and getting really sick, and guess what, the chemotherapy is not taking hold, and the illness metastasized -- you're like, oh my God, treatment doesn't work. We don't say it that way. We say let's get in in stage 1 and 2 because then we have a chance to reverse the illness. And if we did that in our country, guess what, we wouldn't have this concept that somehow people don't recover because I think these illnesses are entirely treatable if treated like diabetes or treated like other chronic illnesses, and I think we could save so many more lives than we can imagine.
I think we could dramatically cut the number of suicides in this country that are skyrocketing -- twice the rate of homicide are the number of people taking their own lives. That is often not even discussed because we're so overwhelmed by the opioid crisis, but the suicide crisis is equally disturbing. And just to put these in perspective, during the HIV/AIDS crisis, we were spending 50 -- we were losing 53,000 people to HIV/AIDS every year, and we were spending $24 billion dollars on that crisis. Now, we're losing over 72,000 lives, over a third more in lives, and we're spending one-fifth the amount of what we spent on HIV/AIDS, and Congress is doing jumping jacks thinking they've done so much to help the opioid crisis because they've spent $5 billion. By the way, that money just came out a year ago. Before that, three years ago, we were only spending $500 million dollars. So, we were spending more than -- in New Jersey for the opioid crisis than we were spending nationally for the opioid crisis. I mean, you can't make this stuff up -- in this day and age, and I will tell you, in ten years and hopefully sooner, we'll look back and think how in the world could we have let this go on so long when we knew how to intervene and make a difference. And the reason we never did it is because the advocacy wasn't there like other advocacy movements in the past.

REP. SCANLON (98TH): Thank you. I’m gonna open it up for questions from Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman, and thank you, Patrick, for your testimony. You have been an extraordinary voice, both in this building but across the country, and I think we all
appreciate what you've done on this issue. I just have a really basic question. In -- 23 years ago -- 23 years ago, Congress passed I think the first law on mental health parity back in 1996, and since then Congress has passed a whole bunch of laws on this. The state of Connecticut has passed a whole bunch of laws on this. Why is it that we are still having a hearing on mental health and substance abuse parity in 2019? Why have we not solved this issue? Why have those laws been insufficient?

PATRICK KENNEDY: So, each law tries to close another gap in terms of enforcement. So, the initial laws focused primarily on the quantitative treatment limits, the higher co-pays for people with mental illness and addiction, the higher deductibles, the higher premiums, and even most importantly the lower lifetime caps because these illnesses affect young people, and they blow through their lifetime limit pretty quickly, which then leaves them with no coverage at all. That was the situation just 11 years ago. So, that all got fixed.

Then, with our law, we covered the non-quantitative treatment limits. That's really where the prize is. That's going into how medical necessity determinations are arrived at and how they're applied, and whether they're applied equally in mental health and addiction as they are applied in medical and surgical care -- and I might add, for the people who don't know about this, whether they're inpatient in-network or outpatient in-network, or inpatient out-of-network or outpatient out-of-network, or they need pharmacy or emergency room benefits. I say all that because I want people
to know that across the spectrum of treatment, across the spectrum of insurance, insurance companies are supposed to cover these illnesses in the same ways they would diabetes, cardiovascular disease, cancer and the like. And, as I said, there's just never been the advocacy.

So, I'd like to say that I can take credit for the passage of the Mental Health Parity Law, but really the credit goes to Senator Chris Dodd. And the reason it goes to your senator, Chris Dodd -- your former senator -- is because he was Chairman of the Banking Committee in 2008 during the worst financial crisis since the Great Depression, and I had asked Chris Dodd to help me pass my bill, HR 1424, which was on the desk in the Senate, and Chris said to me, I'll look into it. And then the stock market crashed. The banks started going belly up. And Chris Dodd called me back, and he said, Patrick, I've got a solution for you. He said how 'bout I write the whole Toxic Asset Relief Program into your bill, HR 1424, THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT. He said the one catch with that Patrick is that's gonna make you the sponsor of the largest federal bailout in our nation's history. [Laughing] And I said to Chris, I said, "Can you do that?" And Chris said, "I'm Chairman of the Banking Committee," and that's how we got parity passed -- because of Chris Dodd. It wasn't because we had the great marches on the Mall, and the Congress responded to the people's will. It was because I called my dad, and my dad called Chris Dodd.

So, I mean, and you all know as legislators how that works, but it's a sad commentary on the fact that the reason we haven't made progress is that there
isn't that sustained effort. Now, the reason today, I've already spoken to Congressman Jim Ramstad, my Republican co-sponsor, we are doing letters to all the big employers, and frankly not just to United, to Aetna, to Cigna, Blue Cross -- we want all the big employers to be on notice that they have a fiduciary responsibility, a legal obligation under the Parity Law to be responsible for its adherence, just like the third-party administrators they have covering their benefits. It is because this is about an opportunity to put pressure on the insurance industry finally to do something. And United might get a court-appointed monitor. That's a big deal. I don't know if they're gonna end up getting that or not, but if they do, that means the federal court's gonna put some, you know, federal intervention in the largest insurer in this country and saying you better follow this law -- not only today, or tomorrow, but in the future. We got a consent decree, which is the equivalent of ongoing monitoring by the state AG in New York. And as I said, Aetna got cited by the insurance commissioner of Pennsylvania recently, and California cited Kaiser Permanente.

My point is -- is that we need to keep pressure, and I think that times are changing and these insurance companies can't find ways to wiggle out of this. They have to come up here and give us solutions. And frankly, as a consumer of mental health and addiction care, I'm not satisfied with how they have addressed this epidemic from the vantage point that we know what care works, and we're not applying what we know works. It's simply put that cognitive behavioral therapy, very valuable therapy, can be adjusted to address particular types of diagnoses,
and we know how to measure outcomes in terms of the reduction of symptoms, reduction of hospitalizations, and other co-occurring physical disorders. I mean, this can be done -- we're living in 2019 -- and it's cheaper for them. So -- and they have to come up if they say, oh well, you know, we only have them for a year, and we can't afford to invest in, you know, preventive medicine. That's not true. They can come up with their own insurance industry plan, like we did in Rhode Island when we wanted to insure all kids in our state. We assessed every insurer in the state a tax on them based upon their market share. So, there was no insurer that had to shoulder this. They were all assessed equal to their percentage of the market for a prevention fund, and guess what, they all loved it because, you know why, they knew all those kids were gonna grow up and be on their health plans and that if they paid for the early intervention, it was gonna reduce the risk of them having to pay for, you know, acute care later on. That's the kinda attitude we need from the insurance industry as opposed to us having to lawyer up and having to come after them in terms of these regulations, and I hope they use this opportunity to come forward with a whole new approach to them covering this, and I think passage of this bill will help wake them up as well.

SENATOR LESSER (9TH): Thank you very much, and thank you for that. And I also appreciated one of the things you really pointed out in the press conference we held earlier is that this is part of a national effort, that this bill lines up with similar legislation that's being heard in other states and has already passed a number of states, and so that is -- it's helpful to make sure that
we're providing a consistent framework to try to make sure that that law that you passed -- and I'm feeling better about knocking doors for Chris Dodd in the throes of New Hampshire already -- but that bill that you passed really does have the effect that we're hoping it has, and that we don't have to keep passing additional mental health parity laws. We wanna get this issue resolved once and for all.

PATRICK KENNEDY: So, finally, let me just say that, again, I thought I was done with my political career when I came back from rehab. People had all called on me to resign, and I went out and campaigned all over my district. And, for the first time in my whole political life, finally people started coming up to me and telling me their own stories and why this was so important to them. And, amazingly, a year after my DWI, I got the largest plurality of my whole congressional career.

All I can say to you is I remember, as we're all paused, standing in front of a polling place in Warren, Rhode Island, at 10:30 in the morning, and a man who I knew hated me -- 'cause, you know, Rhode Island's small, we all know who everybody is, just like you guys in Connecticut -- and he'd been on the radio talk shows going after me, and he goes, "Kennedy, I hate everything you stand for." I said, I know -- and I'm tryin' to find someone else to talk to -- I'm like, and where's Sean when I need him -- and no one was there, so I had to talk to this guy, and he said, "But this election, I'm gonna vote for you," he said, "because my family suffers from this, and I thought enough about it, and I thought you're out there publicly and I know you're
gonna do what you've always done and keep fighting for this."

And so, what boggles my mind, is even with all those entrants into the current bid for the White House, none of 'em have made this a signature issue for them, which is, you know, for my mind, just shocking.

REP. SCANLON (98TH): It's not too late to declare your candidacy. [Laughing]

PATRICK KENNEDY: Well, you know what, Mr. Chairman, I used to think I had a lot of baggage [laughing], but next to the guy in Washington now, I'm starting to look pretty good. [Applause/laughing]

REP. SCANLON (98TH): Patrick, I just wanna -- some of the members of the committee might have some questions if you're willing to take some? [Background talking/laughing] I will also just make a blanket statement that statements or expressions of approval or disapproval are supposedly prohibited in this room, so please, even if you love what's being said, keep your applause to yourself. Any questions? Representative Hughes.

REP. HUGHES (135TH): Thank you, Chairman, and thank you so much, Representative Kupchick, for your advocacy, for your public service. And you mentioned something about kind of the revival of public determination around this issue ["Yeah" in background], and I just wanna tell you that when my parents got engaged, they were aged 30 and they were so excited that they called the White House to tell their president, your uncle, that they got engaged. And they actually got the White House, you know,
operation, and they said President Kennedy was not available, but would they like to talk to Mrs. Kennedy. And they said, well, yes we would -- because they were so old then at 30 that this was like, you know, a big deal that they were actually engaged, especially for my mother, and they actually spoke to Mrs. Kennedy's social secretary to give her the good news. But, the reason I tell you that is because that was an era when our government was accessible to the people, and that truly they felt like it was representative and that their public servants were truly answerable to the public -- to any public. And they went on to become public school teachers, and I'm the proud daughter of those public school teachers. And, as a social worker in the field, I have seen firsthand the effects of really a non-engaged public around this, and like what you describe, the suffering -- the silent suffering -- and the ability to make profit off of that suffering, and that really, I think the profiting, has led to a -- a crisis. And now, I think we're seeing a revival of that public determination -- that's why I ran, and that's why, I think, I won -- but to reengage the public in our care and our basic rights to this kind of parity.

And I will also say that my uncle, Father Richard McSorley, was a good friend of your uncle, Robert, and was with your -- would it be your cousin -- when he was gunned down by gun violence and was called on by the family to tell the children. So, I think that -- that a little bit of that public engagement died with those deaths and murders and gun violence, both -- both of your uncles and Martin Luther King Jr., and I hope we are seeing a revival with all the young people that I see here today that I hope is
gonna speak about peer support and the parity for that and also the -- you know, the reengagement of young people. This is their future, and we all have a right to hear from the people most centered at the -- at the center of the epidemic. So, thank you for your advocacy and testimony.

PATRICK KENNEDY: Thank you so much.

REP. SCANLON (98TH): Any further questions from the committee? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Chairman. So, I'm an intensivist, a critical care doctor and a lung doctor, so I manage patients in the intensive care units. If you look at this specifically even from a financial and from the insurance company's point-of-view, they will save far more money. ["Right" in the background] Because, in the acute care, well, the human loss and the challenges are different -- we can look at that, as such -- they may not necessarily look it -- but if they look at it from the cost of care that they are providing in an immediate critical situation, it's far more than prevention. ["That's right" in background] And they have not been smart enough to look at it from a prevention point-of-view and a strategy management point-of-view. So, this is a win-win strategy. It's not like the insurance companies are gonna lose at this. This is actually -- everybody will win if we support and do the right thing. So, I just wanna make that comment with respect to the cost and then the management perspective.

PATRICK KENNEDY: Well, as you know, Doctor, the real cost is on the other physical side ["Yes" in
background] because all of us, if you don't treat addiction and mental illness, we run up a big tab on the rest of our physical health. And, if you evaluate the total cost of care for the whole person, you'd actually see that if you bump up the care for mental health and addiction, you'd actually see a reduction in a lot of the comorbidities. As an intensivist, you're witnessing through your own practice, and so I think that you're making a fantastic point.

REP. SCANLON (98TH): Thank you, Senator. Any further questions from the committee? Seeing none. I just wanna thank you again for being here today, for lending your expertise and for your -- lending your voice, and on behalf of the committee, we really appreciate you being here.

PATRICK KENNEDY: Thank you, Sean.

REP. SCANLON (98TH): Thank you, Patrick. All right, we are well past the time that we -- nobody heeds my warnings -- we're well past the time where we have to move on to alternate between the public and the elected officials. So, with that, I'll call Dr. Mark Spellman from CPA. [Announcement in background]

DR. MARK SPELLMAN: Senator Lesser, Congressman Scanlon, honored members of the committee, it's so good to be here with you. For a little context, the epidemiological study, The Midtown Study, showed that 80 percent of Americans will suffer from a condition that needs mental health treatment in the course of their lifetime. This is really about all of us, and I'm really glad this is a bipartisan
issue because it is a win-win and it is about all of us.

I'm Dr. Spellman. I'm here representing the Connecticut Psychological Association. We share something in common with insurance companies. We respect data. We're experts in data. They know what we know, and apparently what many of you know, and that is people who get good quality mental health care have lower lifetime health costs and better health outcomes. And so, to your point about this is win-win, why are we still having to advocate for mental health coverage like this. And this answer is because -- you know, it's game theory -- if I'm an insurance company and I invest in prevention, but you're another insurance company and you don't, you benefit from my investment because I'm probably not going to keep my customers long term. So, insurance companies don't see how it's a win for them to invest in lowering another insurance company's costs long term. But, with mental health parity, if everybody plays by the same rules, then there is no incentive to win and someone else's expense, and we all win.

We recently surveyed our membership in Connecticut psychologists, and we submitted our findings as testimony. One of the themes you'll see in our research is that many of us feel an obligation to take in-network reimbursement, which is a half, perhaps a third, of our standard fee in our commitment to the community. But there does come a point when in-network reimbursement drops to 60 percent of what HUSKY pays, where you start to feel a little taken advantage of for your commitment to serving the community. And, you know, one insurance
company, in particular, we are leaving in great numbers because their reimbursement is so low. This bill would fix that.

I would also like to speak up for what Mr. Perez talked about earlier about the cost of HUSKY care and protecting HUSKY investments in our citizens. So, I see people and my colleagues see people on HUSKY, and you know mental health problems are the main reason why people who might work can't. And folks I see, folks my colleagues see get on their feet, they get a job, and they lose HUSKY, and then they lose their psychologist right when they most need our support. So, speaking on behalf of the Connecticut Psychological Association, I really hope you'll support the Parity Bill. Thank you.

REP. SCANLON (98TH): Thank you, Doctor. I appreciate you being here today and for all your work on this issue. Any questions from the committee? Seeing none. Thank you very much.

DR. MARK SPELLMAN: Thank you.

REP. SCANLON (98TH): Dita Bhargava, and she'll be followed by Tim Clement.

DITA BHARGAVA: Thank you, Senators and Representatives, for allowing me to testify, and I apologize in advance if I'm repetitive from the press conference earlier, but I did want my support for Bill 7125 to be recorded publicly.

My name is Dita Bhargava. I'm an ambassador for a national organization called Shatterproof and founder of Combat Addiction Network. On July 13,
2018, my family suffered a devastating loss when we lost our son, Alexander Pelletier, on his 26th birthday to an accidental overdose in Canaan, Connecticut. Alec was a loving, sensitive, intelligent, handsome young man. He was incredibly athletic and shined as a AAA hockey player in his youth, and Alec had a contagious smile and sense of humor -- it would light up this room.

Alec suffered from depression as a teenager and was diagnosed with a bipolar condition. He started self-medicating with marijuana in high school and was found unconscious and unresponsive on his grandmother's couch in his senior year of high school with a bottle of OxyContin on the end table. That marked the beginning of a seven-year struggle with opioid addiction. In the end, he was fully committed and engaged in his recovery. He looked forward to a spiritual, fulfilling life of sobriety, empowered by the love of God, his family, and his friends.

As parents, this was a sad and painful journey. We often felt alone and helpless. Our son was suffering from an insidious disease, and the healthcare protocols we could turn to were severely inadequate. Alec completed several rounds of treatment in various recovery centers. Every relapse was faced with the same challenge of obtaining approval from health insurance companies for treatment, and treatment was always only partially covered. We've spent hundreds of thousands of dollars of our personal -- well over $100,000 dollars of our personal money on his disease, and I can't imagine for those who can't
afford to do that what type of treatment, if any, that they are getting.

Once in treatment, there was no standard of care that the recovery centers operated on, which meant we were relying on hope as opposed to evidence-based methods. Upon leaving treatment, there was no transitional plan for Alec or support system that would help him battle this disease in the real world, and hence the relapse.

Connecticut, as you know, has been especially hard hit by the opioid epidemic. Opioid-related overdose deaths in Connecticut climbed 400 percent from 2012 to 2017. Our state has suffered over 1,000 deaths for the last two years in a row. The number of deaths in Connecticut related to fentanyl increased 4,400 percent from 15 deaths in 2012 to 675 deaths in 2017, and it was up another 12 percent last year. And fentanyl-related deaths now account for over 70 percent of overdoses.

For the first time in decades, life expectancy in the U.S. has fallen consecutively for two years due to this crisis. We have an aging demographic, and our young are dying in large numbers. Drug overdose is now the number one killer in our country for people under the age of 55. This is an extremely dangerous trend that must stop immediately, and this bill is the first step to provide access to those suffering from the disease, so that they can be cured.

House Bill 7125 will introduce critical legislation that will help identify barriers to much needed treatment for patients suffering from addiction.
disease. During one of the last conversations I had with my son, Alec, I was running for statewide office, and I asked him how I should address his disease if the questions were ever asked while I was campaigning. Alec told me that I should be honest, and that everyone should know about the struggles he has had to endure from a disease that had taken the lives of so many of his young friends, a disease he wanted our leaders and health advocates to pay attention to and help with the same intensity that they would if he was battling cancer.

One of the greatest moments of solace during this time for our family happened when many of Alec's peers came forward and across the country and told us how much he helped them in their recoveries, and it was very comforting to know that in his short life, Alec made such a meaningful difference to others and that the world was left a better place because of him. There's so much work to do, and while Alec is no longer here to go on saving lives, we can do it for him. And so, I thank you all for being here, and I hope that you support this bill and help support this much needed step to solving this crisis. Thank you.

REP. SCANLON (98TH): Thank you, Dita, and I just wanna say, I know your son is proud of what you're doing today and what you've been doing, and you and I have talked about this at length and we will continue working on this together, and it's not in vain that we -- we fight this fight every day for folks that we love and we've lost. So, thank you for being here.

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

SENATOR LESSER (9TH): No, thank you, Mr. Chairman, and like you, I was moved beyond words when you were telling your story and Alec's story, both here and in the press conference earlier. I can't imagine the courage and strength it must take for you to take this moment of incredible pain and try to turn it into something good for all of the other young people out across this state and this country who are suffering from addiction and substance abuse. And, you know, this bill doesn't solve all of those problems, and it doesn't intend to. I know that there are a lot -- a lot of other issues that you're hoping that we'll address soon, but my hope is that your advocacy here and your presence here today makes a small difference, and I'm just incredibly appreciative of your work and wish you well as you -- as you move forward with this new project. So, thank you for being here for today and for sharing your story and hope that this bill that we're considering now is a good first step. Thank you.

DITA BHARGAVA: I appreciate that, Senator Lesser, and I will just add to that that I think the reason why, like Congressman Kennedy had mentioned earlier -- why this is the number one killer in our country, far beyond anything else including car accidents and gun violence and any other crisis that we are saving, yet only $5 billion dollars nationally is being attributed to solving this crisis -- I think the reason for that is stigma. And -- and so, when Alec passed away, and I'm thankful -- I'm very thankful that I had that conversation with him when
I was campaigning because we may have second-guessed whether or not he would've wanted us to come out and talk about this disease that he had because he knew there was a lot of stigma, and he pleaded that people look at it as a disease, like he -- those were his words, like cancer.

And so, I know that this is a crusade that -- that he is guiding me through, but I think the first thing that we need to do in this state and our country is remove the stigma and treat it like the disease that it is because otherwise our country is in trouble. Because our young are dying off, and we have an aging demographic, and if we don’t treat this like it's like a disease it will become a crisis that, you know, could be irreversible in terms of the long-term effects that it has on our state and country.

REP. SCANLON (98TH): Thank you. Any further questions from the committee? Seeing none. Thank you so much for joining us today.

DITA BHARGAVA: Thank you. Thank you.

REP. SCANLON (98TH): Next up is Tim Clement, followed by Suzi Craig.

TIM CLEMENT: Hello. Thank you for allowing me to testify, and I'll be brief because I know that time is short. My name is Tim Clement. I'm speaking on behalf of the American Psychiatric Association. We are strongly in support of this legislation. And just to summarize something I said earlier at the press conference, this is -- this language in this legislation is based on a national model that I created when I worked for Congressman Kennedy in The
Kennedy Forum and perfected American psychiatric physicians and signed into law in four states. It's being introduced in at least a dozen others. It's also very closely in line with federal guidance that was issued last year. And really, without this information, there's no way to know if there's compliance with the law, that's why you need this -- this information that's in the reports. It's a complicated law, and that's why it's taking so long.

And one thing, also, I've done a lot of work with state regulators throughout the country and federal regulators. I've actually done direct enforcement work myself, and I can tell you, there's a lot of ground to cover. And I can -- I can guarantee you, when you get these reports, you're gonna find some issues, and this is gonna be a years-long process. So, anyway, I know we're gonna be short on time and I'll stop there, and thank you for allowing me to speak and testify.

REP. SCANLON (98TH): Thank you, Tim. I wanna thank you. We've had some conversations as well, and I know you'll help us make this bill as strong as it possibly can be. So, I wanna thank you in advance for all your help in the next couple of months to get this thing done.

TIM CLEMENT: Yes, absolutely.

REP. SCANLON (98TH): Any questions for --?
Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you. I was wondering what is being done -- and I'm sure this is probably one of the issues that you were just
referring to -- but for people who either don't want to admit to themselves or family members try to help and they don't want to cooperate or don't want to go seek the help that they need. What's being done on that front?

TIM CLEMENT: Well, I think there's a lot of, as just mentioned, you know, the stigma is a huge issue. There's a lot of prejudice that people with mental illness and substance use disorders encounter, and I think there's a lot of -- I know Mental Health Connecticut is doing -- they have a great stigma reduction program that they're doing. I think when people feel that they won't endanger themselves by seeking -- seeking help, then they will seek help, and I think that right now our country still has a long ways to go before we're there. But I know there's a lot of good work going on by the entire behavioral health advocacy community to reduce that stigma and make people feel comfortable in coming forward and getting treatment. Because, as Patrick mentioned, such a small percentage of people do seek treatment, and then even when they do, then they have these insurance problems. So, I think that there are a lot of efforts around the country to help people feel more comfortable and reduce some of that stigma and make them feel comfortable seeking treatment.

REP. PAVALOCK-D'AMATO (77TH): Thank you.
REP. SCANLON (98TH): Any further questions? If not, thank you.

TIM CLEMENT: All right. Thank you.
REP. SCANLON (98TH): Did Suzi step out? If so -- no Suzi -- she's back. It's a bumpin' ringtone, but we just don't know who owns it, I guess. [Laughing] Yeah, it's okay.

SUZI CRAIG: Rep. Scanlon, Senator Lesser, Ranking Members, and honorary members of the committee, I just wanna thank you so much for your leadership and for shepherding HB 7125. We've talked a lot about it. [Laughing] So, you have my testimony. I don’t think I’m gonna read from that.

I just wanna make two points. And, Rep. Scanlon, you mentioned this during the press conference, that the Connecticut Parity Coalition, of which I'm honored to help lead, is comprised of 25 organizations from across the state, and these folks are -- it's a unity of addiction and mental health professionals, advocacy and support groups, suicide prevention and addiction advocacy experts, therapists, professional associations, church leaders, lawyers, social workers, regional mental health boards, and nurses, doctors, and individuals who have been personally affected. I hope I didn't leave anybody out in those categories. But I think that, you know, that really says something -- all walks of life, all nooks and crannies of folks from across the state coming together. Clearly, you know, we may not agree on other issues and other situations, but we agree on this. So, I think that really drives home the point that it's time to pass this bill.

And when we pass this bill, I just wanna make one other point, which is -- and I unfortunately missed Tim's testimony, but -- so I don't need to, I think,
reiterate certain language that needs to be put back into the current draft -- but please make sure that the language includes the specifically laid out necessary language that follows the national model. So, making sure that we have that specific language will help just achieve clarity and parity, which is my new mantra -- clarity and parity for the insurance companies so they know exactly what to report out on and so we can see how they're designing their plans and what -- you know, what is actually happening in coverage areas.

So, and with a little bit of time, I do wanna show support for HB 5270, the Peer Support Bill. Mental Health Connecticut employs peer specialists. We are in full support of taking peer support to the next level. You know, there's an interesting gap between -- I'll wrap up real quick -- there's an interesting gap between the fact that folks like Advocacy Unlimited and CCAR and others have trained peer support specialists, and yet they don't have jobs, right -- 'cause the only way that you can have access to those services is if you're in the state system, but folks out of the system do not have access to this care. So, please consider that bill as well, and I'll -- I'll stick around for any questions that you have.

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

REP. VAIL (52ND): Thank you. Good afternoon. I -- just for clarity -- I didn't get your name and who you represent.

REP. VAIL (52ND): Thank you.

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

SUZI CRAIG: Thank you.

REP. SCANLON (98TH): Ben Shaiken.

BEN SHAIKEN: Hi, good afternoon, Representative Scanlon, Senator Lesser, Representative Pavalock-D'Amato, and members of the Insurance and Real Estate Committee. My name is Ben Shaiken. I'm the Manager of Advocacy and Public Policy at the Connecticut Community Nonprofit Alliance. We are the statewide advocacy organization representing nonprofits with a membership of more than 300 nonprofit organizations and associations.

As you all know, nonprofits deliver essential services to more than half-a-million people each year, and they employ almost 14 percent of Connecticut's workforce. We're part of the Connecticut Parity Coalition, and we're part of it because a lot of our members provide behavioral health and substance abuse services and treatment to people across Connecticut. We support House Bill 7125, and I will just echo -- echo Suzi's comments and Tim's and ask the committee to pass it with the substitute language that's attached to my written testimony, Suzi's written testimony, and others.
I won't read my testimony, which you have. I just wanna highlight the why for us. It's not always clear that the parity regulations are being followed, and as you heard from Congressman Kennedy and as you heard at the press conference, a study from 2017, a Milliman study, said that Connecticut is the state with the highest disparity between physical and behavioral healthcare. And our members, providers of mental health and substance use treatment, report to us exactly that. By their missions and also their contracts with the state, frankly, nonprofit providers in Connecticut serve all clients and provide them the care that they need regardless of their ability to pay. And that means that when a commercial insurer denies a claim, the nonprofit is gonna deliver the service anyway, without being paid or without being paid what they should for that claim.

After years of state budget cuts, nonprofit providers are already under pressure and underfunded, and they can't afford to continue subsidizing private insurance plans that will not pay for medically necessary care. And that's why we think the state should -- should do a better job enforcing its parity laws that are on the books, and this is step one to doing that.

I'll also just note some impacts on the state budget that that has. One is in my testimony, which is that the Departments of Mental Health and Addiction Services and the DCF, they both provide limited grant funding, which has actually been cut significantly in recent years. That covers the cost of care for people who are uninsured and underinsured, and that includes people whose
commercial insurance plans are not adequately paying for behavioral health, substance abuse, and mental health treatment. That funding -- part of the justification over the last five or six years for those cuts is that under the Affordable Care Act more people have gotten health insurance, which is true. The problem is that without parity being adequately -- adequately enforced, those people are still not being able to get their behavioral health, mental health, substance abuse treatment paid for. So, I will wrap up there and not take up more of your time. I, again, urge the committee to pass this as law, as detailed in my testimony, and I welcome any -- any questions. Thank you.

REP. SCANLON (98TH): Thank you. Any questions from the committee. Seeing none. Thank you very much.

BEN SHAIKEN: Thank you.


SUSAN KELLEY: Good afternoon, Representative Scanlon, Senator Lesser, and members of the Insurance and Real Estate Committee. My name is Susan Kelley, and I'm the Director of Advocacy and Policy for NAMI Connecticut, the National Alliance on Mental Illness. I'm also part of the Parity Coalition that Suzi Craig spoke about. We strongly support House Bill 7125, and you've heard a lot today about it. I just wanna make a few points that the substitute language that the advocates have put forth is something that we understand you will be taking a look at. We urge you to do so because it follows the current language of the bill but adds necessary provisions regarding non-quantitative
treatment limitations, which I won't get into the weeds about unless you wanna hear about it. I do have examples attached to my testimony as well as a copy of the substituted bill.

But I would like to mention two important parts of the bill that are custom to Connecticut, and that is the annual report that's to be submitted in order for the insurers to demonstrate compliance and also that there's going -- requiring the holding of an annual public hearing on the report. And I think these requirements are essential to really obtaining the kind of enforcement that we're looking for in this bill, and public input is particularly necessary because of the substantial numbers of insured people in this state who have been negatively impacted as a result of ongoing disparities in accessing affordable mental health treatment. And these individuals and families and the public should be and must be included as an integral part of the state's efforts to ensure parity.

I'd also like to -- I'm here to testify on Senate bill, I mean -- I'm sorry, House Bill 5270, regarding peer support. Peer support is an evidenced-based mental health practice. Its research shows that experience as a peer support specialist can be an -- are an important part of an effective treatment for mental health and substance use conditions. And to be sustainable, we need to have insurance reimbursement for these services, and currently there are some services being provided by DMHAS but through grants. However, Medicaid doesn't cover reimbursement for services, though I believe they're working on it, and there appears to be some
insurers who are now starting to try to cover peer supports, but this is happening slowly. And states like Connecticut that are having financial difficulties, and given the increase in need for mental health services and addiction related to the opioid crisis, coverage needs to happen now, not later. So, thank you very much. I have other issues covered in my testimony, but I'd be happy to answer any questions.


SUSAN KELLEY: Thank you.

REP. SCANLON (98TH): Next up is Ewelina Chrzan. I'm sorry if I just did a really horrible job pronouncing that.

EWELINA CHRZAN: Good afternoon. My name is Ewelina. I'm also a member of the Parity Coalition. I am 33. My diagnosis is bipolar with psychotic features, and I am also a recovering alcoholic. I am on Medicaid. I will focus my testimony on the challenges of living in the system of dependence on the state, my efforts to leave the system, and what I believe to be systemic barriers to transitioning into a life on private insurance while living with a mental illness.

I currently have a psychiatrist, a psychologist as well as a home care nurse who sees me each morning. I also have had multiple hospitalizations and have undergone close to 50 electroconvulsive shock therapy treatments. I do not pay anything for my
treatment out-of-pocket. My care isn't perfect. After a hospitalization in November, my next appointment with a psychiatrist was scheduled 10 weeks out. I was not adjusting to my meds well. I made numerous phone calls to my resident. It took some pressing for them to be returned. The residents at the UConn outpatient clinic only see patients for half a workday a week. Time is thus a scarce commodity for them. Despite such limitations, however, my care is adequate, and I believe I have made significant progress.

The biggest challenge to my quality of life, however, is my lack of a full-time job. I do not mean in the material sense. I live with my parents, and I do not pay for rent, food, or bills, but that is precisely the problem. My dependency threatens my dignity and exacerbates the depressive side of my illness, including suicidal thoughts. Despite mental health challenges about five percent of the time, I am fully functioning the rest of the time. I desperately want to work. I desperately want to be a contributing member of society.

I have a degree from the University of Chicago and a law degree from Cornell. I'm a barred attorney in good standing in Connecticut. I have been actively seeing law employment for over a year to no available -- no avail. I have hired a career counselor who has helped me perfect my resume and cover letter. I've only had one interview. The problem is that I have major gaps in my resume. When I was getting electric shocks, I was bedridden for most of the week. I could not have possibly worked. I now understand the concept of the glass ceiling. Work seems within my reach, yet it never
seems to materialize. I did get a job at Nordstrom and also some political campaigns. None of these were enough to pull me out of the Medicaid bracket, however. I often wonder who is even able to pull them out of Medicaid, and when they do, would their care even improve? Would it be affordable?

It seems as if we live in a system where the benefits of staying in low-paid work and on Medicaid outweighs the incentives of higher-income work and private health insurance, which is replete with inadequacies in the area of healthcare. If and when I transition to private health insurance, I wonder things like whether I will still be able to afford -- - I'm sorry --

REP. SCANLON (98TH): No, please finish -- finish.

EWELINA CHRZAN: -- a home care nurse. As a recovering alcoholic, she ensures I take medication that makes me very sick if I drink. The medication only works if I take it, and I do not trust myself with that task. That is the nature of addiction. We need to protect ourselves from our own wayward thoughts. The medication has kept me away from alcohol for over 18 months, and my life is better for it. A home care nurse is an example of a non-quantifiable treatment metric -- the type of care element parity legislation will help ensure becomes available and affordable to private health insurance companies. Thank you for your time.

REP. SCANLON (98TH): Well, I wanna thank you, Ewelina, for having the courage to come forward and share this story with us. I really, truly mean that, and I -- I'm blown away by your testimony, and
I just have a couple of questions for you. Do you feel like, if you were on private insurance -- do you feel like you would have the same extent of the help that you're getting right now?

EWELINA CHRZAN: I don't. I was on private insurance prior to Medicaid, and I was paying the $200 dollars for my psychiatrist appointments. I -- just given that I was living with my parents and -- and I did have savings from working as a lawyer before, I never -- I never thought I would be eligible for Medicaid. That is something that the hospital at UConn put me on, and things became a lot more affordable after I transitioned to Medicaid. So, the incentive to stay on Medicaid is definitely there.

REP. SCANLON (98TH): Thank you, and I again wanna thank you very much for being here today. Any questions from other members of the committee? Representative Hughes.

REP. HUGHES (135TH): Thank you so much for your testimony. On Medicaid, is any kind of social work services provided as part of your like sort of maintenance treatment? Is that covered, or no?

EWELINA CHRZAN: Not that I know of. I know that while I'm hospitalized there is a psychiatrist -- I mean, a social worker that is part of the team, and that does help with -- with procuring certain benefits.

REP. HUGHES (135TH): 'Cause I know -- some of the testifiers before talked about not having that discharge planning coverage out of -- you know, once
you leave the hospital, and that that's a key, key component of just basic maintenance treatment, and that's not covered by private insurance currently. And I -- I was curious as to whether it was covered by Medicaid, but it sounds like it's not as part of discharge planning. Just I commend you for your bravery. Thank you for speaking up about your own truth, and it's our job to make good policy in response to the public need. So, thank you.

EWELINA CHRZAN: Thank you.

REP. SCANLON (98TH): Any further questions? Thank you very much. Next up, Dr. Shaukat Khan, followed by Dr. Falisha Gilman.

DR. SHAUKAT KHAN: Mr. Chairman, Representative Scanlon, respected senators and representatives, good afternoon. My name is Shaukat Khan. I am a psychiatrist and the President of the Connecticut Psychiatric Society, an organization for 800 psychiatrists in the state.

Psychiatrists are medical doctors specializing in the treatment of mental illnesses and substance use disorders. And you have already known many people testified as patients. The -- as a psychiatrist, I work at the VA Hospital, West Haven, and also Yale Behavioral Health Services in Hamden. Information that I provide here today will be from my own experiences and experiences of my colleagues. So, there will be a lot of information, so just bear with me.

We support Bill 7125 with substitute language, and in my recent testimony, I have made many points why we support that. As many speakers will tell, a
major difficulty with implementing parity law is the benefits that are non-quantifiable. Those are differences in care that cannot be easily identified except through comparing statistics across large populations. Regular disclosure by the insurance plans is needed for having statistics, which is largely lacking now. This bill, if passed, will help us in that way.

From the psychiatrist's perspective, I see several problems with the current situation. Some of those have already been discussed, like referrals. You heard that one of our patients, they are admitted in the hospital in acute situation as a danger to themselves, suicidal, homicidal. Acute treatment -- when the acute treatment is taken care of, they need proper referral and proper care, but under current circumstances that's not possible, you heard, already.

Moreover, sometimes there are limitations in terms of days, how many days they will be -- they can be admitted in the inpatient setting, and then how many ways they can be -- how many times they can have visits after the discharge. These are unfortunately arbitrarily decided by the insurance company. It is not -- it's not decided by the doctors.

Failed treatment -- I know that my time is over, but I just want to give some points -- failed treatment is an issue. You need to have -- have cheaper medication tried, and you have to have a failed treatment. Just imagine that if you need to try somebody who's in a medical -- a serious medical condition cheaper medication before you go for the proper treatment. That's happening in psychiatry.
Network inadequacy -- many times the patients will not find a treater in their network. In fact, one study suggests nearly 35 percent of the patients had difficulties in finding a therapist in the network. The effect -- not having these -- enough treaters is kind of not getting the proper treatment and despite the fact that they are paying their share of cost. Maybe the most common reason for lack of practitioners in the network is inadequate reimbursement by the insurance companies for their services.

Prior authorization is another issue. I just had that experience yesterday. Simple medication -- patient is on this medication for quite a long time at a very good regular dose, and I had to make a prior authorization for this medication just yesterday, which took 45 minutes of my time. So -- so, there are many other issues. Like recently, as you might be aware, that there is a trend of using interventional treatment methods in psychiatry, like transcranial magnetic stimulation, like vagus nerve stimulation. These are expensive procedures, and these need comparable coverage by the insurance companies when it comes for the -- for the really the parity, in terms of parity.

REP. SCANLON (98TH): Dr. Khan, if you don’t mind just summarizing the rest of your testimony. I certainly appreciate that.

DR. SHAUKAT KHAN: I will. Sorry. There are some psychiatric services coming up for improving access, like collaborative care and telepsychiatry. Those need to be practically -- have parity in terms of
coverage, because if you think of the collaborative care, it entails a psychiatrist having the same location with a primary care doctor. Just imagine that the primary care doctor -- there's no priority with the psychiatrist in terms of payment.

And, as I mentioned that I work at a veterans' hospital, this is a disturbing fact -- I'm just bringing up just from presenting my -- supporting my -- my testimony. There are 20 million veterans in America. Five million of them, about 25 percent, suffer from mental illness. And in a study -- a study in 2015, 1.6 million veterans went to veterans' hospitals. So, there are a large number of veterans, a lot of whom -- of them -- are not getting care, or their getting care from the private sectors. The problem that is affecting our other -- the rest of the population, also is affecting our veterans. So, they deserve parity.

So, in summary, the mental illnesses are major causes of death and suffering. The National Institute of Mental Health estimated in 2016, 44.7 million, approximately one in five American adults have mental illness, and nearly 50 percent of us will suffer from a mental illness in our lifetime. CDC reported 41,000 deaths in 2013. That's more death from cancer of prostate. So, mental illness, thus --

SENATOR LESSER (9TH): Dr. Khan, could you please summarize?

DR. SHAUKAT KHAN: -- needs equal priority, if not more, as the other services. We support this bill wholeheartedly. I would point out that we have
submitted written testimony on HB 7261. I'll be here -- we also support that bill, and I'll be here to answer your questions, if needed.

SENATOR LESHER (9TH): Thank you, Dr. Khan, and thank you for the Association's support as well. It's always good to see you here before the legislature, and we really appreciate your testimony. Are there questions from members of the committee? If not, thank you very much for your testimony. Appreciate your time.

DR. SHAUKAT KHAN: Thank you.

SENATOR LESHER (9TH): Next up, we'll have Dr. Falisha Gilman, followed by Tom Burr. Good afternoon.

DR. FALISHA GILMAN: Good afternoon, Chairman Lesser, distinguished members of the Insurance and Real Estate Committee. My name is Dr. Falisha Gilman, and I'm a psychiatrist training at Yale School of Medicine, and I'm here to testify in support of HB 7125.

As a physician, I treat patients with psychiatric illness and substance use disorders, and I have the true privilege of witnessing patients get well with the help of evidence-based interventions. Like other chronic diseases, such as diabetes or heart disease, psychiatric illnesses and substance use disorders have effective treatments. Recovery is possible, but only if treatment is accessible and affordable.
I submitted written testimony that outlines points, so I wanna take this opportunity to actually share some experiences that I've had working on the inpatient and outpatient settings providing psychiatric care. When I was -- so, in psychiatric training, we spend a full year doing a combination of internal medicine and neurology before we start doing or practicing psychiatry, and I wanna talk about the anecdotal evidence I have based on my experiences working on both of those services.

So, when I was doing a rotation in psychiatry, I had a patient who presented and he was catatonic, which means -- catatonia is a neuropsychiatric disorder in which patients are unable to really respond to their environment, so it affects both behavior as well as motor skills, and it has an incredibly high mortality rate. The standard treatment is either benzodiazepine as a medication or electroconvulsive therapy. ECT as a standard treatment is very effective, and this patient had a history of responding well to it. And so, when I came onto the case, he had already received about two weeks of treatment, and it often will take about one to three weeks for it to be completely effective. And I was asked to do what is called a doc-to-doc, which is when you as the physician on the treatment team speaks to the physician for the insurance company because the service has been denied and is no longer covered. And so, there I was, spending hours for the next several weeks trying to explain to another physician, who had never even laid eyes on this patient, why this person needed this life-saving treatment. And in my year of being on a neurology service or a medical service, never once as a
resident, or did I ever see an attending, have to do this.

Another example is we had -- we had a suicidal adolescent who was admitted to our unit, and the coverage stopped because she had reached her day limit. So -- and I can't imagine what that would be like for her or her family -- and we weren't comfortable discharging her because she was still suicidal.

So, in summary, as I said, the specific points regarding language is outlined in my written testimony, but I wanted to make sure that you all had the opportunity to hear the patient experiences that are happening right now in the units that we all work on. Thank you to Chairman Lesser and to Chairman Scanlon for really being champions of mental health parity. Thank you, and I would answer any questions.

SENATOR LESSER (9TH): Thank you, Dr. Gilman, and thank you for sharing that story. It's distressing that we still haven't found a way to solve that problem and that you're still having to have conversations like that. I'm hopeful that your patient got the care that -- that he needed.

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

DR. FALISHA GILMAN: Good afternoon.

REP. VAIL (52ND): What form of treatment did you say worked for it? Was it medication that worked for the catatonic patient?
DR. FALISHA GILMAN: So, the way that we treat catatonia first is we use a benzodiazepine, which is a medication. ["Okay" in background] That is only effective in about 70 to 80 percent of patients with catatonia. So, the -- in the patients who do not respond to benzodiazepines, which use ECT. It is the most effective. It is more effective, and it is effective in treating catatonia when benzodiazepines have not worked.

REP. VAIL (52ND): And ECT again -- I'm sorry.

DR. FALISHA GILMAN: Electroconvulsive therapy.

DR. FALISHA GILMAN: He had a -- so, he had a history of schizophrenia, and catatonia can co-occur with schizophrenia as well as with mood disorders, like depression. It's actually much more common to occur with depression than with a psychotic illness, and he had a history of previous episodes of catatonia and was known to have a resistance -- not -- but the catatonia would not respond to benzodiazepines but would respond to electroconvulsive therapy. And that was clearly documented in his medical chart, which the insurance company had access to to review.

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

DR. FALISHA GILMAN: You're welcome.
SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? Yes, Senator Anwar for the first time.

SENATOR ANWAR (3RD): Thank you. Dr. Gilman, thank you so much for advocating on behalf of your patients, and many of the times, because of the time limitations, the physicians just wait for hours and then they just hang up, and then they have more staff to sit down and make those phone calls. ["Um-hm" in background] Some of these entities that are out there, the financial benefits in their minds are when the clinicians give up, and so thank you for not giving up and thank you for all the physicians who don't give up. We have to keep doing this, but I think it's time for some laws to be there to protect the people, especially in psychiatry, when it's not visible. It's very easy for somebody to say, but people die, and unfortunately far more die than they should with the lack of appropriate treatment. So, thank you for coming up and speaking.

DR. FALISHA GILMAN: Thank you.

SENATOR LESSER (9TH): Thank you, Senator. Any other questions from members of the committee? If not, thank you, Doctor, for your testimony.

DR. FALISHA GILMAN: Thank you.

SENATOR LESSER (9TH): And I think my co-chair, Representative Scanlon, did acknowledge we've been joined by a couple of new senators earlier -- representatives earlier -- and acknowledged Representative Nolan and Senator Anwar. We've also
been joined by a third new member of this committee, and I wanna acknowledge Senator Bizzaro, who's also been appointed to the committee. Welcome, Senator, and welcome to the Insurance and Real Estate Committee. You came on a busy day, but good to see you.

Next up, we have Tom Burr, followed by Diane Frost.

TOM BURR: Good afternoon, Senator Lesser, and the esteemed members of the Real Estate and Insurance Committee. My name is Thomas Burr from Glastonbury, Connecticut. I am the Community Affiliate Relations Manager and part of the public policy staff at the Connecticut Chapter of the National Alliance on Mental Illness, NAMI Connecticut. I am also the parent of an adult child who is in recovery from bipolar disorder after eight years' worth of repeated psychosis, suicide attempts, hospitalizations, incarcerations, and homelessness. Currently, however, he is living on his own. He is in recovery, working full time, and doing very well. In fact, he has been clean and sober and working for the past 11 straight years. Note, some of the best care he ever received was right here in Hartford at the Capitol Region's Mental Health Center.

I am here today in support of HB 7125, the Mental Health Parity Law or Bill with the substitute language, as well as HB 5270 concerning the Peer Support Specialists Bills. My colleague, Susan Kelley, who you heard from a few minutes ago -- she's our Director of Public Policy and Advocacy at NAMI Connecticut -- has already given her testimony. I would encourage you to read through it all because it had some really great information in there. I'm
just gonna kind of reiterate a couple of things or just kind of expand on a couple of things, but we really believe both of those bills are worthy of your consideration and passage into law. I'm gonna add some personal perspective on them.

Regarding mental health parity itself, I was frankly amazed when my son was no longer able to be on what I considered at the time to be my wonderful health insurance that I had that was provided by my employer at the time, who was a Fortune 50 company. When he went onto Medicaid and had to be hospitalized, I was beyond apprehensive and I feared the worst; however, it was the best care he ever got. What private insurance promises, the state system actually delivers. As someone who still volunteers as a NAMI family and caregiver support group facilitator, I hear this sort of story regularly from our members.

In regards to the peer support specialists, as someone who has been in the world of mental health for the past 20-some-odd years, I can tell you that these individuals provide something that most clinical staff cannot -- real world experience and most importantly perspective. One of the truly devastating effects of having a mental health condition is the inability to see your way out of the darkness when you're in crisis and into recovery. I saw this play out with my son, who was extremely despondent and thinking his life was over, and I hear this on a regular basis from others that are working on their recovery. Having a peer support specialist available and who has made their way through the process of recovery is simply just a
critical requirement for someone battling these types of illnesses.

So, just to wrap it up, in summary, I support both the Mental Health Parity Bill with the substitute language and the Peer Support Services Bill, and just a final thought -- prevention works. Treatment is effective, and people do recover. My son is just one of countless examples I could cite of people who have recovered who are now leading meaningful lives, working and paying taxes. I will now answer any questions you might have.

SENATOR LESSER (9TH): Thank you for that inspiring testimony. Also, I think you might have given us a shout out for a public hearing we're having in a couple of days on a public option for health insurance, but stay tuned for that. But thank you for your testimony. Are there other questions from members of the committee? If not, thank you so much for your testimony. Really appreciate it. Thank you for sharing your story. ["You're welcome" in background]

Next up, we have Diane Frost, followed by, I think, it's Valerie English Cooper. My apologies for mangling anyone's name. Good afternoon.

DIANE FROST: Hello. Good afternoon, Senator Lesser, Representative Scanlon, and members of the committee. Thank you for this opportunity to talk with you. My name is Diane Frost. I reside and work in Connecticut. Your commitment to making my home state as good as it can be is why I'm here.
When I was born, I was a little off, as my parents would've described. They found a psychiatrist who first diagnosed me at 15. My mother paid for care for lack of insurance coverage. My medication made me drowsy, and the lithium gave me tremors, and my peers noticed in a really bad way. My mom ran out of money, stopping much of my treatment. In college, student insurance covered physical but not mental health care. Thank goodness, my father found an insurance program covering preexisting conditions. My dad found another psychiatrist too. I graduated, and both insurance policies stopped. I needed a psychiatrist in Connecticut. Dad found one nearby (hooray Dad). On my first appointment, I was up before interviewing him as for the job. I liked his manner. My mother was proud of my proactivity.

In his care, my tremor went away after a medication switch, and he told me I could resume drinking caffeinated beverages to stop falling asleep in the middle of a conversation. I faced the world with new confidence. Since being his patient, one thing's been amiss. He doesn't accept insurance. He says the care we provide is treated as a second-class citizen -- it's as if we are not important in what we do. That's the first time I equated medicine with money.

This financial puzzle influenced my choice to be a master's level social worker. I'm supposed to be able to support myself modestly. That's still problematic. My doctor still doesn't accept my employer's insurance, and my medication has never been cheap. We have a parity law that says mental and physical health is equal. Is not the brain the origin of function connecting to the body that
carries the whole person. As this is new law, I can't say parity has been practiced. Documentation of how insurance pays the bills should demonstrate accountability and responsiveness to care.

In the interim, I pay out-of-pocket. I cannot afford all my doctor visits and prescriptions on one paycheck. So, I look at my pay schedule. I've opted to separate my doctors fees and my medication from my rent, electric, and grocery bills. This is unfortunate. I see, know, and feel for every person in Connecticut who requires treatment as well as basic living needs. Please see this healthcare issue the way it is. My mind's as necessary to living well as is my body. Support this bill. Change the lives of so many in need -- just like me.

And, if I could add on the Peer Support Bill, I am a peer support specialist, and I can't tell you how much it changes treatment when someone looks into your eyes and says, "You should be here. You should be functioning. You should believe in yourself, and that's not BS." Thank you.

REP. SCANLON (98TH): Thank you so much for being here today. Any questions from the committee? Representative Dathan.

REP. DATHAN (142ND): Thank you so much for being here, and thank you so much for your testimony. I really appreciate that you point out peer support services. I have talked to so many people and say that that has been an essential part of their road to recovery, and I just wanted to comment to say I'd love to see insurance and any sort of plans cover
these services because I think the true road to recovery is multifaceted.

DIANE FROST: It is.

REP. DATHAN (142ND): And, if you have anything to add, please add it now, but thank you.

DIANE FROST: Okay. I'll add that it's work. Not only is recovery work, but being ill and faking it before a world that's not going to support you and all of your talents, it hurts. And it's a lot of hard work to still wake up in the morning and say there's gonna be purpose to this day, but I'm part of it. It took me 20 years to say to myself and believe it that I earned being here. I don't have to pass a test. All I need to do is talk to someone who has that same question, and I feel validated in my experience when they believe it as much as I do.

REP. DATHAN (142ND): Thank you.

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): As a fellow social worker, I just wanted to say I'm very, very proud that I am in your ranks. Thank you for testifying and showing up.

DIANE FROST: Thank you.


SENATOR ANWAR (3RD): Thank you. Just a comment. The peer support system that's there, it's a -- what
I've experienced in the community when I have somebody who needs help -- it's a secret network almost because there's no organized system, and there's no payment system that's in there. And people help each other, and it's just fascinating how helpful it has been for a lot of people. You just make a phone call, and then everybody who's been through this, they want to help out and they have had their trainings and have been ready. And it's just neighbors, community members helping each other. Now what -- at times, for the patients who do not have any support system, we actually have somebody who is a peer sign the HIPAA forms and then -- and become a peer supporter just for -- as gratis to the community, and they're helping people out. But, if it becomes formal, and they're a support system, it would really be of benefit for a lot of people.

DIANE FROST: I believe you're correct, and if I can just respond without taking too long -- 'cause I've got a lot to say on peer support. If you were to put us into a similar crowd, all of us, in this working world, if you were to ask who takes pride in their gifts, has worked hard to make them as good as they can be and as effective, we would all stand up -- peers and otherwise. Thank you.

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

DIANE FROST: Thank you.

REP. SCANLON (98TH): Valerie English Cooper, followed by Kathy Flaherty.
VALERIE ENGLISH COOPER: Hello, Representative Scanlon, Senator Lesser, members of the committee. Thank you so much for providing the opportunity to give testimony on this important legislation. My name is Valerie English Cooper, I'm a mental health first-aid instructor and a registered voter in Washington, Connecticut. I'm here in something of an unusual capacity because I have the benefit of bringing over 2,000 voices with me today as a mental health first-aid instructor responsible for execution -- field execution of SAMHSA's Project Aware Community Grant from September 2015 to October 2018.

I trained over 2,000 residents of the state of Connecticut in mental health first-aid -- community members, all walks of life. Two bus drivers, probably close to 70 years of age, in the public transit system, one Saturday morning drove up from Bridgeport, Connecticut, to get to Waterbury, Connecticut, to sit for eight hours of instruction, they said, to support their colleagues with substance use problems. They walked out the door saying we're never gonna look at the people who walk into our bus the same way again. Powerful training. But, I'm here representing people in the training who by far have, generally speaking, private insurance. It's a population we haven't talked about too much today.

But, in Connecticut, access to care is one of the greatest impediments to recovery. Mental health treatment is not covered by private insurance. You thing it is, but it isn't. Why? Because 40 percent of people don't even get care in any given year. That's adults and adolescents together. Among the
most vulnerable population, transitional youth, age 16 to 24, only 20 percent of people get care in any given year. Four out of five kids are walking around -- four out of five kids with a mental health disorder are walking around not getting care. Why? Because they can't afford it. They can't afford it.

Co-pays -- mental health professionals, the master's and PhD level professionals that do week-to-week evidence-based, as Patrick Kennedy said, cognitive behavior therapy and all of the other evidence-based treatments out there, who do it week-to-week-to-week, they are considered specialists. Therefore, there is, generally speaking, about a $40 dollar co-pay. So, if you talk $40 dollars times four, that's $160 dollars per month. Most people cannot afford to pay that. [Background noise] That's just out of the box for them. If there's no co-pay but a high deductible, they're paying $100 dollar plus per week times four -- $400 plus a month until their deductible is met. So please know that insurance is not paying for mental health treatment in the state of Connecticut. We need to address that.

And just one more quick to summary -- it's not just access to care, it's stigma, and the way to reduce stigma is to change the minds of people throughout this state, neighbors, friends. And just wanna say that we also need parity in preventive care, parity in -- between public health trainings for physical illness, being CPR/first-aid, and parity between public health trainings for mental health problems, and that's mental health first-aid. And we don't have parity at all, but that would help get people. People aren't seeking help, but studies show that they would be more willing to seek help for their
problems if someone they know and trust encourages them to do so. And who is that? That's all of us. That's friends, family members, neighbors, colleagues helping encourage.

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

VALERIE ENGLISH COOPER: Thank you so much.

REP. SCANLON (98TH): Appreciate your testimony today. Any questions from the committee? Seeing none. Thank you so much. All right. Lastly, on this bill, is Kathy Flaherty.

KATHY FLAHERTY: Good afternoon, Senator Lesser, Representative Scanlon, and members of the Insurance and Real Estate Committee. My name is Kathy Flaherty. I'm the Executive Director of Connecticut Legal Rights Project, a co-chair of the Keep the Promise Coalition, and a member of the steering committee of the Cross Disability Lifespan Alliance, but the most important role that I really play here today is a person living in recovery from a mental health diagnosis, and for that reason, I can speak both personally and professionally to the importance of supporting both 7125 and 5270.

You've heard a lot of testimony today about why mental health parity is important. One of the most frustrating things for me as an attorney is the fact that it exists in federal and state law, but the promise of it is not being kept in reality on the ground, and I think this bill could be a good step in addressing some of those things. A couple of years ago, the legislature started a behavioral health working group, which actually Diane and I
were both part of, and sitting in meeting after meeting, knowing the experiences of our friends and our colleagues, where they just weren't getting the care, and frankly the insurance department fighting us every step of the way to require the insurance companies of this state to report data that will show that they're not following the law. I can understand why they don't want to report the data that shows they're not following the law, but that's exactly why we need to require them to do it.

I can tell you that, as a person living in recovery, the thing that has been most helpful to me besides the support of my family is the support of my peers. I have always participated in teaching one of the sessions of the certification class for the peer support specialists through Advocacy Unlimited, and it is amazing for me to see the transformation between the people who come in at the beginning of the class, which is usually when my session is, and where they're at at graduation. Because they're all people who have taken negative experiences from their lives and wanna turn that around to help other people.

I've facilitated peer support groups. I don't have the time to do that now, but I definitely see the difference it makes in people's lives. I know that there are some insurance companies who have on their websites that they make this available. I have yet to find anybody I know with private insurance who's been able to access peer support services. So, I think we might wanna consider adding to the bill that the same way you put up your network of your -- your psychiatrists or your social workers, that you also put on your website who are the peer support
specialists that you pay for who are in your network. I'm happy at this point to end and just answer any questions members of the committee might have.

REP. SCANLON (98TH): Thank you, Kathy, and thank you for being a resource for this committee and working on this issue with us. Appreciate that.

KATHY FLAHERTY: You're very welcome.

REP. SCANLON (98TH): Dr. Anwar.

SENATOR ANWAR (3RD): Thank you so much. Thank you for your testimony. Would you be able to say what are the other places and formal systems for peer support [background coughing] -- peer support specialist training.

KATHY FLAHERTY: Yeah, there are other people who will be testifying after me specifically on the Peer Support Bill, but I know that CCAR, the Connecticut Coalition for Addiction Recovery offers a recovery coach certification course. Advocacy Unlimited offers a recovery university peer support specialist training. And my understanding is Mental Health America has a national certification that's a partner, and I know Mental Health Connecticut, I believe, has piloted that here in Connecticut.

SENATOR ANWAR (3RD): Okay, and --

KATHY FLAHERTY: Those are the ones I'm aware of. I don't know that that's all of 'em.
SENATOR ANWAR (3RD): I think we'll talk about that probably later, so thank you so much. ["Okay" in background]

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

KATHY FLAHERTY: Thanks.

REP. SCANLON (98TH): All right. There are some students who have been waiting here for quite some time to testify on a bill, and they have to go back to doing what students do. So, I'm gonna do a little privilege and ask them to come up here on 5627. First up is Alyssa Pettridge. Not here? How about Jermaine Clarke?

JERMAINE CLARKE: Good afternoon, Honorable Senator Lesser, Honorable Representative Scanlon, and members of the Insurance and Real Estate Committee. My name is Jermaine Clarke. I'm a registered voter in Hartford, Connecticut. I am here today in my role as a dental hygiene student from Tunxis Community College's dental hygiene program. I am here to testify in support of HB 5627, THIS ACT EXTENDS THE PERIOD A CHILD, STEPCHILD, OR OTHER DEPENDENT CHILD MAY RETAIN INSURANCE COVERAGE UNDER A PARENT'S HEALTH INSURANCE POLICY.

I am sure the testimonies presented today and submitted as well will bring light to how many have lost dental coverage in their time of need. I, too, am one of these people. Rather than speaking about how I'm personally affected by losing dental coverage, I find my time better dedicated to elucidating the connection between oral health and
overall health. By the end of this testimony, I hope everyone listening will realize that oral health and overall health are synonymous, and that our policies need to reflect this relationship as well.

Losing dental coverage but retaining healthcare coverage is equivalent to playing football without a helmet. What good is protecting the rest of your body while leaving your head completely exposed? It seems that many of us are unaware of how a dental disease can manifest into diseases that can affect other bodily systems and organs. For example, something as simple as an infected tooth, which could be drained by the dentist, can become extremely dangerous if left unchecked. The bacteria from an infected tooth can spread to the lungs. In order to treat this, you'd have to call a pulmonologist. The bacteria from an infected tooth can also spread to the heart, which would need to be treated by a cardiologist. The bacteria from an infected tooth can even spread to the brain, which would require a neurosurgeon to resolve the situation.

I think every one of these medical specialists mentioned would be severely disappointed in a healthcare system that allowed a tooth infection to progress to that nature. It's a waste of resources, especially for something preventable. It could potentially cost insurance companies more money in the long run. This is due to the fact that they will be paying more money for complex medical procedures caused by dental disease rather than paying for routine dental visits that could prevent severe disease.
Keep in mind that the examples depicted to you today highlight the synergistic relationship between oral health and overall health. These are just a few of the many instances where lack of dental coverage can progress into severe disease. I encourage you to extend dental coverage on family plans to young people up to age 26. Thank you for your time and for supporting young people in Connecticut.

REP. SCANLON (98TH): Jermaine, thank you for your testimony today. Appreciate that. I think after your testimony I was pretty convinced by the way, just so you know. [Laughing] Quick question for you. So, right now, under the Affordable Care Act, folks can stay on their parents' insurance till they're 26 years old. ["Yeah" in background] In your testimony, you said pretty often and at length that there was really no difference between dental and physical health care. Do you think that that's the case?

JERMAINE CLARKE: I do think that's the case because there are many diseases that manifest orally -- oral cancer, you know. It's just something that needs to be looked at over time rather than coming in once in a while. The longer you see someone's mouth, the better prognosis you have for those type of diseases. There's just so many things, like when it comes to the wisdom, the third molars, the average age cited by the ADA is between 17 and 21. So, they come in even later at times, and why be forced to take out your teeth because you're about to lose dental insurance. ["Sure" in background] And why undergo unnecessary surgery -- although it's minor and common surgery, anything could go wrong.

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

JERMAINE CLARKE: Hello.

REP. VAIL (52ND): So, when you do your -- your examinations, do you do some cancer screening.

JERMAINE CLARKE: Yes, all the time.

REP. VAIL (52ND): In the mouth -- do you check the glands?

JERMAINE CLARKE: Yes, we do a head and neck exam all the time.

REP. VAIL (52ND): Okay. All right, thank you.


SENATOR LESSER (9TH): No, I just wanted to thank you for coming up and testifying. I'm still trying to figure out why they -- why they carved off dental health from all other kinds of healthcare when they passed the Affordable Care Act, and I certainly see them as linked and wanna thank you for testifying. I think you're gonna be a great dental hygienist when you graduate. It sounds like you know your stuff. So, thank you for coming up here today.

JERMAINE CLARKE: Thank you.
REP. SCANLON (98TH): Representative Dathan. Jermaine, hang on, you've gotta sell some more people here.

REP. DATHAN (142ND): Actually, Senator Lesser stole my thunder. Thanks. Thank you, Mr. Chair.

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): Thank you, Jermaine, and I am so curious as to why you went into your profession. What drew you -- since it's obviously not the payment because there's not parity yet?

JERMAINE CLARKE: There's a lot of things. I like to work with my hands, but probably the biggest thing for me was participating in Connecticut's Mission of Mercy, the free dental clinic. I can't quote to you what year it was exactly -- it's a little fuzzy -- but I did participate in the downtown location one, and just seeing how happy everyone was. There was a guy who wanted dental care -- he said because he had a chipped tooth he was afraid to go into an interview, so it's just like how people feel about their image. Something like that -- who knows what else it, you know, kept him from doing, you know.

REP. HUGHES (135TH): Would you say it's a basic health need?

JERMAINE CLARKE: A health need and also the fact that you can help people feel good about themselves and smile genuinely, rather than we tend to focus on the aesthetics of a smile rather than a smile that
comes from, you know, the bottom of your heart. I know it sounds -- [laughing].

REP. HUGHES (135TH): Not at all. I love this stuff. No, thank you. [Laughing] Thank you for your testimony, and thank you for devoting yourself to this profession and advocacy.

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

REP. PAVALOCK-D'AMATO (77TH): I just wanna thank you for taking time from your day and your studies to come over here. My -- a woman who's like my second mother, Mrs. Benzavingo [phonetic], was the former director of the program, so I will definitely report back to her and tell her that she should be very proud that the program is doing very well and the students are, you know, taking time again to come up here and advocate for something so important. So, thank you again.

REP. SCANLON (98TH): Thank you, Jermaine. Next up is Brianna Munoz from UConn.

DR. BRIANNA MUNOZ: Good afternoon, Senator Lesser, Representative Scanlon, and committee members. My name is Brianna Munoz, and I'm here today as a dentist to testify in support of House Bill 5627, AN EXPANDING UPON THE PERIOD IN WHICH CHILDREN CAN RETAIN DENTAL INSURANCE UNDER THEIR PARENTS' POLICIES. Since children can stay on their parents' medical insurance policy, many Connecticut families make the assumption that this also applies to dental medicine, but unfortunately, at the current time, it does not. So, as our Connecticut youth are
embarking upon their college experience, they're turning 19 years old and are unexpectedly losing their dental insurance coverage. Increasing the number of 19 to 26 year olds with dental insurance would have a profound impact on society. Not only would passing this bill increase the utilization of preventive and routine care services, but it would also decrease emergency room visits as well as subsequently decreasing the overall cost to the healthcare system in the long term.

While I was in residency, I rotated through the emergency department at Connecticut Children's Medical Center, and within this 11-week timeframe, I treated 78 dental emergencies after hours within the emergency room. So, this is a significant issue that we all must consider. But, the question that I wanted to pose today is what would happen in an urgent care center or an emergency room without employing dental staff or a dental facility?

[Announcement in background]

When patients present with acute dental pain, physicians are limited to prescribing either antibiotics or pain medication, such as opioids. Neither of which would treat the underlying cause of the dental infection. We are in the midst of an opioid epidemic at the moment, and I think that we all have to do all that we can to decrease the number of emergency room visits as well as dental-related opioid prescriptions. The mouth is certainly the gateway to the rest of the body. It is not separate from it. So, I believe that it is time that health insurance policy reflect this inexorable link between medicine and dentistry by
extending the dental insurance coverage to the age of 26. Thank you.

REP. SCANLON (98TH): Thank you, Brianna, for being here today and sharing your testimony. Any questions from the committee? Representative Dathan.

REP. DATHAN (142ND): Thank you, Doctor. I appreciate your testimony. In those cases that you talked about in the emergency room, what percentage would you guesstimate that they would've been preventable in your experience?

DR. BRIANNA MUNOZ: So, the statistics nationwide estimate 80 percent of dental emergency visits treated within the emergency room setting to be completely preventive. From my personal experience, it would be similar to that as well. Either I was being paged for a dental infection or dental trauma, but the majority were due to dental infection. But, no matter what the cause, I think having a dental home was of prime importance and knowing the proper steps to manage the dental emergency.

REP. DATHAN (142ND): So, from a cost perspective, the preventative treatment for those that would've been preventable was probably less expensive than the actual cost that was actually incurred by the insurance companies as a result of the treatment that these folks had to have in the emergency room?

DR. BRIANNA MUNOZ: Absolutely, yes. So, there would be overall cost savings. So, across the country in regard to dental-related emergencies, $1.6 billion dollars are currently being spent in
the emergency room setting, and there would be a significant cost-saving impact of having dental insurance and increasing accessibility to care within the dental home.

REP. DATHAN (142ND): Great. Thank you so much. Thank you, Mr. Chair.

DR. BRIANNA MUNOZ: Thank you.

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): Thank you, Chair, and thank you, Doctor, for your testimony. Would you say that through your experience that if -- from the insurance perspective this is a fairly young and healthy population -- if they were to, you know, cover them till 26 that that risk pool is significantly different than say the over 65 population?

DR. BRIANNA MUNOZ: Um-hm. That's a great question. Thank you. So, when we're considering just the age range of 19 to 26, the reason for presentation to the emergency room, when we're considering all those different case presentations, dental pain is the third most common reason for this specific age range. So, it definitely is relevant. And when we consider dental development, our wisdom teeth, our third molars, develop between the ages of 17 and 21. So, this overlaps that timeframe when patients may present with pericoronitis, an inflammation of the gums surrounding our third molars, and they may need their wisdom teeth extracted, which is extremely costly, and that's not considering sedation services on top of that.
REP. SCANLON (98TH): Thank you, Representative. Any further questions. If not -- Doctor, thank you so much. Next up is Pareesa Goodwin.

PAREESA CHARMCHI GOODWIN: Good afternoon, honorable members of the Insurance and Real Estate Committee. My name is Pareesa Charmchi Goodwin (is my mic on? -- yes, it is) -- my name is Pareesa Charmchi Goodwin. I'm the Executive Director of the Connecticut Oral Health Initiative, a nonprofit organization that advocates for oral healthcare for Connecticut residents. We strongly support House Bill 5627, WHICH WILL EXTEND THE PERIOD DURING WHICH CHILDREN MAY RETAIN DENTAL INSURANCE COVERAGE UNDER THEIR PARENTS' POLICIES TO THE AGE OF 26.

The bill will provide continuity of care for young adults until they're able to assume individual coverage on their own. Continuous care is crucial for managing chronic health conditions, like tooth decay and its effect on other health conditions that the other two speakers have already addressed, such as the connections to heart and lung disease, diabetes, and adverse birth outcomes, such as low birth weight.

Over 80 percent of U.S. adults in their 20s and early 30s have tooth decay. Preventing and treating this decay early is not only good for health, it's more cost effective, as the associated illnesses and infections are much more costly to treat and can also threaten one's life. In 2008, so actually before the Affordable Care Act, Connecticut legislators passed a bill to allow children to remain on their parents' health plan until the age
of 26. Dental coverage was not included in this legislation, leaving many young people and their families so surprised and confused to learn that they may not have their dental coverage when they turn 19.

Allowing children to remain on their parents' dental plan till the age of 26 will establish parity with health insurance, and it'll also make it more likely that young people will keep up with their preventative cleanings and oral hygiene. Young adults ages 19 to 34 are the least likely to have private dental benefits with over a third forgoing dental care altogether.

These years are a time of transition for many, including college or graduate school, just starting your career or wanted to start your family. But dental services are expensive, and young people often have financial barriers that lead them to ignore regular cleanings or not prioritize their oral hygiene, and sometimes this means that they unknowingly let decay fester and then resort to the emergency room from a resulting pain and infection. Toothache strong enough to interfere with ability to sleep, ability to eat, and ability to work are a common reason for young people to visit the emergency room. You heard Dr. Munoz say it's actually the third most common reason for young adults to go to the ER, and these are people that are otherwise healthy. These visits are costly to the individual and to our healthcare system. As we all know, the ER -- I call those the expensive doors -- you don't wanna go through them. It's not good for your own personal pocket, and it's really not
good for our healthcare system. It's costly for everyone.

Tooth decay is preventable, and we shouldn't be seeing advanced cases in a wealthy state that has a high number of dental providers. Good oral health is essential to staying healthy. House Bill 5627 recognizes that oral health is a part of an individual's overall well-being and should be provided alongside existing health coverage. We realize healthcare coverage is needed for this age group. We need to give dental coverage the same consideration. Our neighbors in Massachusetts have already extended dental coverage to age 26, and this is a measure that supports our young people, makes it easier for them to get the care they need. It decreases their out-of-pocket costs, reduces emergency room visits, and ultimately has healthcare savings. I urge you to support this bill. Thank you so much for this time and opportunity to testify.

SENATOR LESSER (9TH): Thank you so much for your testimony, and thank you for all of the work that COHI does in advocacy. Are there questions from the committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much. I know you mentioned -- thank you, Mr. Chair -- you mentioned Massachusetts as being one of our neighbors that actually have already done this. Are you aware of any other states that have done this, and if so, how many?

PAREEesa CHARMCHI GOODWIN: I'm not aware of other states that have actually done this. Dental
coverage seems to be often overlooked because it's traditionally been a carve out, which I think is part of the problem with why culturally we don't always recognize that oral health is actually important to our overall health. And as Jermaine mentioned earlier, there's a lot of things that present in the mouth before they present in the body, such as oral cancer that's usually -- the dentist is the first person to catch that -- the dentist or the hygienist. So, I don't know if other states have. I have put up the Bat-Signal to see my friends in other states have info on this, but Massachusetts has already done it. I believe that they actually did it at the same time because it was an administrative burden to separate them. And I do know that, right now, municipal employees in the state of Connecticut, so not state employees at this time but municipal employees, already have done this. And because it was an administrative burden, that actually was more costly to exclude the dental coverage, which is a funny little thing. I think in a lot of ways it's an oversight.

REP. DATHAN (142ND): That makes sense. If you do find out any other states that do have this, will you please let us know?

PAREESA CHARMCHI GOODWIN: Absolutely.

REP. DATHAN (142ND): Thank you very much for your testimony. Thank you, Mr. Chairman.

PAREESA CHARMCHI GOODWIN: Thank you so much.
SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? Yes, Senator Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman, and good afternoon. And I think you just answered my question. ["Okay" in background] I was gonna ask if you thought it was an oversight and maybe not done on purpose, but just people didn't think about it when we made the change. Do you think that's a possibility?

PAREEESA CHARMCHI GOODWIN: I think that's completely possible.

REP. VAIL (52ND): Then it's time we catch up.

PAREEESA CHARMCHI GOODWIN: Yeah, I think so. The mouth is part of the body. [Laughing]

REP. VAIL (52ND): Okay. All right, thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions? If not, thank you very much for your testimony.

PAREEESA CHARMCHI GOODWIN: Thank you so much.

SENATOR LESSER (9TH): Next up, we have Mary Boudreau, followed by Claudine Fox. Good afternoon.

MARY BOUDREAU: Good afternoon, Senator Lesser, and distinguished members of the Insurance Committee. I'm Mary Boudreau, and I am a registered dental hygienist, and I recently retired as the Executive Director from the Connecticut Oral Health
Initiative. I have been working on this bill with Representative Cook for over four years. I worked with Representative Scanlon two years ago when this bill was up. We really need to move this bill forward for all the reasons you've been hearing from the people before me.

I wanna say that as a dental hygienist, I noticed back when I first graduated, back in the '70s, that we oftentimes did not see patients between the age of 18 to 26 years old -- 27-28 years old is when they'd start coming back in. Probably the number one reason that most will say they didn't go is because their parents stopped pestering them to go to see the dentist twice a year, but really, the most common reason, the reason they didn't go, is because of their income is limited at that age. They're either in school, or they are working at a first job, and they don't have dental insurance. Besides going into all those issues that everyone has spoken to, I do wanna talk about the cost of this bill because that was a big issue two years ago. I don't know what's gonna come out as a fiscal note this year on the -- on this bill, but two years ago it came out, and the amount included what those premiums would be if the 22,000 state employees who have children of that age decided to have their services, you know, the dental coverage continue. But it is the parents who would be paying that part of the bill, so yes, the premiums need to be paid, but it's not from the taxpayer's money as a whole -- it is from those parents who choose to do it would be paying for it. The comptroller at that point told us that it would actually cost about a penny to two pennies to the state to have these people covered because that's approximately what it would
cost in order to cover the cost of entering them in the system, or letting them stay in the system and taking out the ones whose parents don't opt to cover the 18 to 26 year olds.

But there's a much larger cost to not covering the young adults at this age, and that is when they do come back in to the dental office at that 26, 27, 28, 29 years old -- is that instead of just going in and having their teeth cleaned, they haven't had their teeth cleaned in all those years, so they now oftentimes will need four quadrant scaling and root cleaning under Novocain. It's not a fun service. It's also oftentimes four treatments at a much higher cost. Instead of having a simple filling done, they need to have that root canal done. They need to have that tooth extracted. They have that tooth extracted, they're gonna need an implant to replace it. They're gonna need a, you know, bridge work, or they're gonna need dentures if there's multiple teeth involved. The cost is much higher in dollars, but the cost is much higher to them just in the pain and discomfort that they have to go through in order to get healthy besides then all those ramifications it can have on their health.

So, in final -- just to finalize what I'm saying. I'm looking forward to this bill getting onto the House floor for a vote, and I am still available as a resource even though I'm retired. In my testimony, you have my personal contact information.

REP. SCANLON (98TH): Any questions from the committee? Representative Vail.
REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. You brought up cost, so I'm gonna -- I wanna talk about that. So, this bill would allow for people to keep their children on their insurance. It doesn't mandate them to -- is that your understanding?

MARY BOUDREAU: That's my understanding.

REP. VAIL (52ND): And -- and so that cost would then be borne by the parent whose insurance rates would increase.

MARY BOUDREAU: Right, and right now, as a legislator and if you decided to leave your children on there, who are 19 to 26 years old, I've been told that it's $50 dollars a child per month. So, it's $600 dollars a year in premium that you would be paying, not the taxpayers.

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

MARY BOUDREAU: Thank you.

REP. SCANLON (98TH): Claudine Fox. [Background talking] That's okay. We'll still be here probably. Michelle Haines from Tunxis.

MICHELLE HAINES: Good afternoon, Senator Lesser and Representative Scanlon, and members of the Insurance and Real Estate Committee. My name is Michelle Haines, and I'm a registered voter in Suffield, Connecticut, and I'm here today in my role of a
dental hygienist -- dental hygiene student and a mother.

I'm here to testify in strong support of HB 5627. I care about this issue because when I was 25 years old I had to have all four of my wisdom teeth extracted due to pain, and if it wasn't for being on my parents' dental insurance, I would not have had the funds to pay for that. Dental -- between the ages of 19 and 26 are stressful enough with college and figuring out your life. So, the possibility of losing your dental insurance or not being able to afford a needed treatment should not add to that stress. Dental care is important to me because your mouth connects to your entire body, and not being able to afford and receive a needed dental treatment can also lead to further health issues, as you've heard. I urge you to expand all coverage on family plans to young people up to 26. It helped me immensely when I needed it most, and I want that option for future children, including my own. Thank you for your time and support.

REP. SCANLON (98TH): Thank you for your testimony and for being here today. Any questions? Thank you so much.

MICHELLE HAINES: Thanks.

REP. SCANLON (98TH): Deb Polun, followed by Olivia Sagan.

DEB POLUN: Good afternoon, members of the committee. For the record, my name is Deb Polun, and I work for the Community Health Center
Association of Connecticut, and I'm here today to support House Bill 5627.

As you may know, the community health centers across the state provide care to all people, regardless of ability to pay, including medical, behavioral health, and dental care. Just as an example, in 2016, health centers across the state provided over 264,000 dental visits, and that's people with Medicaid, people with commercial insurance, and people with no insurance at all.

We support this bill, as we have done for the last several years, because it's a common sense initiative that improves access to healthcare for people and costs essentially nothing to the state. This is a really consumer-friendly idea that just helps improve health outcomes. It improves people's lives. It improves their health. It helps keep healthy young adults in the health insurance system, which is also a plus, and it provides peace of mind for parents looking to keep their children healthy, and it makes it easier and more cost effective to serve the health needs of thousands of young adults in our state.

So, I would just ask that this committee move this bill forward this year. There's really nobody who's testified in opposition to this bill over the last couple of years when it's come up, and I think this is the year. This is the year to get this done, and you know all the health reasons, and there's -- I don't see any barriers to getting this done this year, so I ask for your support.

REP. TURCO (27TH): Thank you, Mr. Chairman. Deb, you just mentioned that past years it's been brought up, it hasn't passed. You don't see barriers this year. Just curious -- what were the barriers previous years?

DEB POLUN: I honestly don't know the barriers. I think the first year it came up, my understanding is that CBIA originally thought that the businesses might bear the cost of this insurance, and so that put a little bit of a wrinkle in the bill's passage that year. When it was then explained, oh no, the businesses can pass the cost along to their employees, and the employees can either choose to keep their kids on or not, that opposition disappeared, so.

REP. TURCO (27TH): That's a -- that's a good point. So, the employer can choose to decide not to pick up any of that premium for the dependents, have the employee decide if they want to. Would there be any kind of administrative costs or anything on the insurance companies or on the business, if they did that model where they passed off that premium?

DEB POLUN: As far as I can tell, no, but it might be a good idea to ask the insurance companies that. This is the same thing that we currently do -- right now, a lot of dental insurance and medical insurance allow employees to keep their kids on if they're full-time college students. So, there's some
administrative burden there to prove that they are in college full time and not just the right age. And so, that would remove that, and it would just need to go based on age at this point. So, it might actually streamline things.

REP. TURCO (27TH): Okay. Thank you very much.

DEB POLUN: Thank you.

REP. SCANLON (98TH): Any other committee members with questions? All right. Thank you so much.

DEB POLUN: Thank you.

REP. SCANLON (98TH): And last on this bill, Olivia Sagan from Tunxis. [Background talking] Okay. That's a good place for her to be, so that's all right.

All right. So, we will go back to 5270. Margaret Watt.

MARGARET WATT: Good afternoon, Rep. Scanlon, Senator Lesser, and members of the Insurance Committee. My name is Margaret Watt. I'm the Co-Director of The Hub, which is the Regional Behavioral Health Action Organization for Southwest Connecticut. And I am here -- actually I've submitted written testimony on three bills before you today. I'm in support of the Parity Bill, the Peer Support Services Bill, which is what I'll talk about, and also the Psychotropic Drugs Bill, which is coming up later. So, I'll refer you to those written comments.
In terms of peer support, first I wanna thank you, Rep. Scanlon and Senator Lesser for drafting the bill. So, for those who don't know background on this, what is peer support? Peer support is what you heard from Senator -- Congressman Kennedy today. It's when someone who has the same lived experience that you're having, we're talking about mental illness or addiction, [ringing] is able to make that connection, provide that emotional support, and it's a non-clinical support service that can greatly increase access to care, help people stabilize in times of crisis.

A certified peer supporter is someone who has the lived experience but also has training. So, they have the knowledge of techniques and resources, and they can help someone access the help they need. We heard Congressman Kennedy. We heard Diane Frost, Tom Burr, Kathy Flaherty -- we've already heard a lot of people talking about the value of this. Connecticut does have two types of certified peer supporters. We have what are called recovery support specialists, RSSs, trained by Advocacy Unlimited, and we have what are called recovery coaches, trained by CCAR.

The bill before you today -- the original bill came up a couple of years ago, introduced by Rep. McCarthy Vahey. It came out of work in our region in Southwest because we have a lot of certified peer support specialists who -- very few of whom can get jobs because you really have to -- there -- there's no insurance funding. It's not a billable services, and therefore employers who might want to incorporate peers into their treatment team aren't really able to do it. And we also have a lot of
people in our region who have experienced peer support or have wanted to experience it and have not been able to access it. Because if you're in that 80 percent of state residents that has commercial or private insurance, you're really not gonna find the peer support.

So, I summarized some of the research on the benefits of peer support in my written testimony, but there is ample evidence it improves quality of life. It improves skills, symptom management, saves a ton of money because you can reduce the number of hospitalizations. You can reduce re-hospitalization. You can reduce length of hospital stay. And when you think about hospitalizations for psychiatric or addiction purposes costing anywhere from a thousand to $5,000 dollars a day, every day that someone stays out of the hospital and is helped to -- helped to remain stable, it's a huge cost saving.

In my written testimony, since I know my time is up, I've made some comments on the actual committee bill that you raised around DPH regulation. I think a couple of key points will be that this is an opportunity to do a crosswalk between the two existing certification and training programs for peers. I don't think it should take a lot of time. I think there -- we know of people who have done both training programs. I think it's a useful opportunity because one thing to be aware of is the current training programs and certifications, one of them, the RSS program, is more focused on mental health care support; the other recovery coaches are focused more on addiction care support. And what happens in the real world is people have both --
they have mental health and substance use -- and you wanna make sure that whoever the treater is or the peer support specialist or whoever is knowledgeable about both. They may be more expert in one than the other, but the co-occurrence is critical. So, I'd be happy to answer any questions.

REP. SCANLON (98TH): Thank you for -- for being here today, and I'm not sure when you were in the room earlier when Patrick and I were talking, but my father was an alcoholic before passed and he did --

MARGARET WATT: Thank you for sharing that.

REP. SCANLON (98TH): He was sober for the time since I was born until he passed away in 2007, and he was often a sponsor for a lot of different people and helped them find and attain that sobriety. "Yeah" in background] And I remember, growing up, him interacting with so many men, specifically, to try to help them, and the phone would ring at 3 o'clock in the morning in our house, and he would get on the phone and try to talk some -- you know, somebody off of havin' a drink -- and that's difficult thing.

MARGARET WATT: It's a -- that honesty brings people to the table.

REP. SCANLON (98TH): Yeah, sure. So -- but tell me a little bit about why maybe having somebody with lived experience can help somebody find that moment of clarity -- specifically, you mention in your testimony recovery coaches, and a lot of them are in our hospitals across the state, on the frontlines of this opioid addiction. Somebody comes in, they've
been Narcanned, they're, you know, sittin' in an emergency room, and some man or woman walks in and says, "I've been sitting where you are, and there is a possibility for you to find recovery, and I can show you how." Tell me why that's different and why that's as valuable as a nurse or a doctor walking in there and having that conversation.

MARGARET WATT: And maybe more valuable at that moment in time. I think you already almost highlighted it right there. So, the recovery coaches -- Connecticut has been placing recovery coaches in or making them on-call to emergency departments in the last couple of years related to the opioid crisis. So, someone comes in after an overdose, and a call goes out, and an on-call peer recovery coach comes in, and you know, a lot of times you're talking about people who may have been in active addiction for a long time. They may have cycled in and out of trying to stay sober and clean. Maybe it's, you know, the third overdose attempt. And at some point, when you've gone through all that, you're not really believing that any kind of clinical intervention is gonna help anymore.

And I've talked to a recovery coach, and I heard a story about this. It was young man, and he said he went into the room, and the person was hiding under the sheets and wouldn't come out. And he just said -- they're trained to do a two-minute spiel on their own history -- and he just said, you know, a year ago, I was actually in this hospital, and I was under those sheets, and I was sure I was gonna die and I didn't think anyone would help me, and I'm here today. And it's that message of hope, and it turned out it was another young man who pulled the
sheet down and started that process, and again, it's the here -- I'm here to listen, it's not about me. I'm connected to you, I'm listening, I'm validating, but message of hope and knowledge of resources.

I think an example from the recovery support specialist side on the mental health thing -- I have three board members, in the last year -- people who have had, you know, chronic mental illness their whole life, have had multiple psychiatric hospitalizations -- they've had all the therapy in the world. They know all their DBT skills. They're on the meds that they need to be on, and if you have treatment-resistant depression or whatever, it can come back. So, I have literally three members of my board in the last year who have been re-hospitalized for suicidality, only to keep them in a safe place for a few days. They didn't have med changes. They didn't get any real therapy. They didn't need any of that. They just needed a place to be. Well, if they were in Massachusetts, they could've gone to Afiya, which is a peer-run respite, and you go there and you stay there, and peer support specialists work with you. It's so much cheaper. It's so much more valuable. It has an impact on your life, and it's not the trauma of lying in a hospital bed and feeling like you're a failure.

REP. SCANLON (98TH): And do any states currently allow this right now? Are there any states?

MARGARET WATT: So, virtually every state has some kind of peer support specialist training.

REP. SCANLON (98TH): But coverage for it, I'm sorry.
MARGARET WATT: But coverage -- so, a lot of states have Medicaid coverage. We have -- we basically -- the grants that fund peer supporters -- peer supporters in this state -- are actually one form of a Medicaid plan. I think the reason we see it as really valuable to have this be under insurance is -- oh and Kathy Flaherty mentioned earlier -- she's gone -- oh, you're there -- that it does appear that some insurance companies are starting to say we're going to cover this a bit, but we don't think it should be some. We think it should be all because it's a really valuable piece of the workforce, and we've got a workforce shortage in mental health in general.

And I was thinking about what Patrick Kennedy said before -- stage 1. Stage 1 -- why are we waiting for everybody to be in a crisis and be hospitalized. Stage 1 is if you have your peer support, you know, before you get there, that's way more valuable. Even like the recovery coaches from CCAR -- you go to the hospital first, so you incur the hospital costs, and then you get your recovery coach. We should be looking at peer supporters in sobering centers, in living rooms, which is another model, in peer-run respites, ways to keep people healthier, out of crisis, in the community, and do that stage 1 intervention.

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

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

REP. VAIL (52ND): This bill would require the Department of Public Health to provide certification. You mentioned certified peer support specialists now. Who's making that certification now?

MARGARET WATT: The certification currently is through Advocacy Unlimited, which is a nonprofit here in the state of Connecticut, and/or -- there's two -- you can also go to the Connecticut Certification Board, CCB. So, I actually do think having it regulated through DPH makes a lot of sense. There is, as someone mentioned earlier -- there's now a new national certification program for peer specialists that was developed by Mental Health America. One of the things that I think is valuable about that is it kind of provides a career path. So, you could do your in-state certification, and then maybe if you wanted to go for that career path and work in the private sector under private insurance, you could do that extra level. And it was developed -- their certification program was developed with feedback from peers in all 50 states and from employers, from healthcare and hospital employers, on what they needed from this model.

REP. VAIL (52ND): Of those two certifications that you mentioned, does the state recognize those certifications?

MARGARET WATT: Yeah, they do.

REP. VAIL (52ND): Is there a fee?
MARGARET WATT: It's relatively minor, but yeah.

REP. VAIL (52ND): But there is a fee?

MARGARET WATT: Yes.

REP. VAIL (52ND): And so, they also provide the training?

MARGARET WATT: The training is provided -- CCB is just a certification thing -- Advocacy Unlimited provides the training on the mental health side. CCAR provides it on the addiction side. CCAR is the Connecticut Coalition for Addiction Recovery.

REP. VAIL (52ND): And, how much -- so, they're looking to have this covered by insurance. How much would they expect to get paid for that type of service?

MARGARET WATT: Right now, peers in the state generally make somewhere in the range of $17 to $25 dollars an hour. Jeff Santo, who is going to be speaking later on this bill, has done a nice little analysis of how many hours of peer support you could get for the price of a single day of hospitalization.

REP. VAIL (52ND): Okay, so -- so if someone were to get the services now, they'd have to pay out-of-pocket or they'd have to be receiving it on a voluntary basis -- is that correct?

MARGARET WATT: Well, so you would actually -- if you're in the DMHAS system, so if you're eligible for the Department of Mental Health and Addiction
Services care, which means you're Medicaid eligible, you know, you're poor and you have a severe mental illness -- you would get peer support as part of your treatment plan. It would just be part and parcel of some of the services that you're offered. If you're in the private sector, you would have to go find someone -- you wouldn't know it existed number one. You would have to find someone who is trained, and you'd have to negotiate a fee with them, and really that just doesn't happen. We have talked to employers -- hospitals and so forth -- who are aware of the model and are interested in involving peers on their team but, by and large, just don't see a way to hiring someone, even though it's really low cost for them compared to a social worker or a type of clinician, but they don't see their way to doing it 'cause it's not billable.

REP. VAIL (52ND): All right. So someone can't volunteer this type of service.

MARGARET WATT: They can volunteer it, and you know, like when Rep. Scanlon talked about his dad. I mean, if you're in AA, there are peer support models out there that are, you know, 12-step models and support groups and things like that, but what we really see as valuable is integrating peer support into the treatment system. So maybe you go here first, divert people from the hospital when they need it, so that someone can accompany you for a while. Because, if it's a volunteer model, you know, your volunteer is at work, and they have their own job, and they have their own family. Whereas maybe you're in a crisis and you really need to be in a place and sit with someone for 48 hours. Maybe you need someone to accompany you a couple of hours
a day for a couple of weeks after you do get out of the hospital, so that you aren't re-hospitalized really quickly. The re-hospitalization rates are pretty tremendous. I'm sorry, I can't remember the statistic. But you look at the cost of the hospitalization and how many people go back in within 30 days, and you realize that something didn't work the first time around. But when peers accompany someone after they come out of the hospital -- there was a pilot in Connecticut a few years ago, they had a 48 percent reduction in re-hospitalizations.

REP. VAIL (52ND): Would all this be based upon a hospitalization, or if I was feeling I needed some type of peer support and I was in my home, would I -- is your idea that I would be able to access that peer support at home as well?

MARGARET WATT: So, peers generally are mobile. They can go where the person is. They can go to the home. They can meet them in the community.

REP. VAIL (52ND): You mentioned the peer-run respite in Massachusetts. Is that currently -- do they take insurance payments on that in Massachusetts?

MARGARET WATT: They -- no, they do not.

REP. VAIL (52ND): Okay, thank you.

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Margaret, for your testimony. Thank you, Mr. Chair. We
touched a little bit about kinda hourly billing rates, and I'd love to get that information to see, you know, what a peer support specialist might charge per hour compared to a full-on psychologist, what they may charge in a -- especially in a crisis situation. Is there any sort of data showing the kind of results that maybe something like CCAR's or Turning Point might have? Because I was very impressed with their testimony the other night over in Appropriations, and I see it as a really cross benefit to prevent re-hospitalization, and I would love to get some understanding of maybe what cost savings we could potentially have -- not just within Medicaid but also saving insurance companies money for re-hospitalization and better patient outcomes as well.

MARGARET WATT: And right exactly, the better outcomes as well. So, my written testimony has some data from different states and different places where they've shown cost savings like $5,000 dollars a person over a year, $2 million in a county in reductions in homelessness, hospital care, jail diversion. Those are a couple of statistics I remember because my laptop just turned off, so -- but I have some of that in there. CCAR, I know, has done research on the -- the savings from the recovery coach model, so I will get that data to you and I'll send it maybe to Rep. Scanlon to share with the committee.

And one thing I will say in terms of the per-hour cost -- so, you know, just because the peers who are being employed are working for $17 to $25 dollars an hour doesn't necessarily mean that that's even fair because I know there is a peer supporter -- she's a
recovery coach, she works for Norwalk Hospital on the community care team -- it's not the CCAR ER model, she does mobile outreach -- she's tremendous. She has gone out in the community and connected with people who have not been -- you know, the most recent case was where a church group approached me and said we have a parishioner who we have been just like floating from house-to-house for a year. We've taken her to every service in town. She needs treatment. She's hearing voices. She has this, that, and the other symptom. She's couch-surfing everywhere. No one could help her. I go, let me call Nicole. Within two days, she's set. She's set because Nicole went to her and said I've been there, I know what you're dealin' with -- made it happen. Nicole, however, is a single mom and is working for a hospital as a peer support specialist who everyone in the region thinks is tremendous, and she can't quite make ends meet on her, you know -- so, the $20 an hour that I'm saying, they should make more. It's still cheaper than any clinician, way cheaper than a psychologist, but I'll get you data.

REP. DATHAN (142ND): Great, thank you so much. Thank you, Rep --

REP. SCANLON (98TH): Just one final question from me, which is that the Department, as you might have seen, testified against the bill and said that they don't have the resources to -- to license this and suggested that we sort of just go with the latter half of the bill, which is to require the insurers to cover it but not have them license it. Is that something that you think would be a second-best option here or --?
MARGARET WATT: I do because we do have these certification programs in place. I mean, I think it's worth looking at -- you know, I still think it'd be valuable to do this kinda crosswalk of the two, and maybe look at that national program. But, you know, the people who are working in these programs have training, have been demonstrated to do a good job. You know, you still are hiring folks. Like when you hire someone, you make sure they're the right person for the job, but you know, you do know what the job -- what the credential means. We know what that means, and we've seen people be really successful. I think, you know, generally speaking, we're talking about a really low-cost intervention that fills a gap in the workforce, that we know is effective. We know it costs less than any of the alternatives. And it's also -- you know, we're talking about the Parity Bill so much today -- this is a different form of parity. This is parity between poor people being able to access this service, and 80 percent of the state that doesn't get DMHAS services not having access to this.

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

MARGARET WATT: Thanks, Representative Scanlon.

REP. SCANLON (98TH): Sue Buchsbaum -- Buchsbaum [mispronounced].

SUE BUCHSBAUM: Excuse me, I take a lot of psychiatric medication, and it makes my mouth very dry. So my name -- Senator Lesser, Representative Scanlon, and distinguished members of the Insurance and Real Estate Committee. My name is Susan
Buchsbaum, and I'm a registered voter in the city of Stamford, Connecticut. I am a certified recovery support specialist, have lived experience of both mental illness and addiction, I have treatment-resistant depression and PTSD, and I'm in recovery from opioid addiction. I am testifying as a private citizen and as an interim board member of The HUB, the Regional Behavioral Health Action Organization of Southwestern Connecticut, and as a member of Keep the Promise Coalition.

Margaret covered a lot of what I was going to cover, so I'm just going to speak from -- at you -- to you, and tell you of my experiences. So, I've had a diagnosed mental illness since 1981, and I worked for DMHAS for 10 years, first at Fairfield Hills State Hospital, then at Norwich, Cedarcrest, Greater Bridgeport Mental Health, and the F.S. Dubois Center. I can tell you from my experience -- I will give you one example -- why peer support works.

When I first started at Fairfield Hills Hospital, I would do groups on each of the units of the one building that was left still open, Canaan House. And I would do group on Canaan 1A, which was the most ill people there. There were approximately between about 250 patients remaining at that time, in 1994. Every single patient came to my group, and I gave that group once a week for one hour. So, if you wanna know if peer support works, I can tell you it works. The staff would stand in the nurses' station and point at us and laugh as we were in the TV room. People were just yearning to have someone listen and not ridicule them, not judge them. The power of it was just so immense. I really can't tell you. And when the young woman who was in the
gray coat who testified over there, it really got to me. I started crying. I was sitting over there. Why? Because I tried to go back to get an MSW last year, and because of my treatment-resistant depression, I was unable to finish the program. So, her saying that she went to social work school really affected me.

I just, if you would allow me to just briefly --

REP. SCANLON (98TH): Sure, if you wanna summarize, that'd be great.

SUE BUCHSBAUM: -- summarize. Margaret was saying -- you know, I was hospitalized at Silver Hill Hospital last year in June, and I didn't have a medication change. It was basically because I was suicidal and needed to be in a safe place. I have been hospitalized more times than I can count. It's a waste of money. And I currently am a client at the Dubois Center. And in the push program there, there are two recovery support specialists that run that program. And when I have had an increase in symptoms, they have been there for me to meet me in the community for coffee, anything, and it means all the difference in the world. So, I know I'm over time, and I'd be happy to answer any questions that any of you may have. Thank you.

REP. SCANLON (98TH): Well, thank you. I wanna thank you for coming and sharing your story today. I now Stamford's a long way away, so I appreciate you --

SUE BUCHSBAUM: I was here Friday night too.
REP. SCANLON (98TH): Yeah, I appreciate you making it up here and sharing your perspective, which I think is valuable because you've sorta seen both sides of it and you see how the value is there on both sides. So, thank you. Any questions?

Representative Hughes.

REP. HUGHES (135TH): Thank you so much, and I wanna encourage you, as a fellow social worker, you're obviously already more than halfway there, so don't give up. But, so where exactly do you stand on the Parity Bill -- can you just --?

SUE BUCHSBAUM: Oh, I am in full support of the Parity Bill. In fact, for the record, I'm in full support of all three bills that have come -- 5270, the parity between physical and mental health, and the psychotropic medication bill too. I'm in support of all three.

REP. HUGHES (135TH): And would you describe it as a basic right to -- to functioning in terms of your potential as to -- to have access to these basic services, mental health services including peer services -- for you?

SUE BUCHSBAUM: Oh, absolutely. And I'm lucky that I'm -- I mean, it's been a tough road, but I am lucky because I'm a client of the state. I've been on Medicare for many years. I'm on SSDI, that's what -- I live on an income of slightly more than $1,400 dollars a month. I'm currently not working. So, yes -- peer support -- I love giving peer support, and I do it anyway to colleagues, friends, but receiving it is also just as important. And it's just when someone comes to you and shares their
lived experience, there's something incredibly powerful about that.

REP. HUGHES (135TH): Yeah, the power of mutuality.

SUE BUCHSBAUM: Yes.

REP. HUGHES (135TH): Thank you. Thank you for your testimony.

SUE BUCHSBAUM: Thank you.

REP. SCANLON (98TH): Thank you so much, Sue. Appreciate you being here today.

SUE BUCHSBAUM: I'd just like to, very quickly, I just wanna correct Margaret in one aspect. I just wanna say that I've been looking for an RSS job, and since I live in Stamford I look in Westchester County too, and I recently saw an RSS job posted and they were only offering $14.25 dollars an hour. So, I think that Margaret's number of $17 dollars on up may be a little bit high, and certainly in the $20 dollar range that would be state employees. Thank you for allowing me to be up here a few moments.

REP. SCANLON (98TH): Thank you. Jeffrey Santo, followed by Michaela Fissel.

JEFFREY SANTO: Good evening. First I'd like to thank you all for giving us the opportunity to speak today. I did submit my written testimony, and I am going to vary from that a little bit. I wanna talk to you a little bit about being a recovery support specialist. It's not something I woke up one morning and said that's what I wanna be -- because I never woke up and said I hope I get diagnosed with
depression today -- I hope I wake up in an ER after attempting to take my own life, but that's what happened. When I was growing up, if you asked me what I wanted to be, I woulda told ya I wanted to be a chef and follow in my grandfather's footsteps.

In December of 2017, I was doing a presentation at the Valley Social Club, and the presentation was called Power of the Peer, and it talked about how people with lived experience can help others, and in a community clubhouse environment it was really important because they are all peers. And when you can build a foundation of trust among the population there, they tend to rely on one another, confide in one another, and actually lean one another when they need to. After the presentation was over, a woman approached me. She was a guardian for a young man with autism, and she told me that she thought her daughter might be suicidal, and she asked me if I would reach out to her and talk to her, and I did. I ended up calling her that night, and she said I know why you're callin', my mother told me about it, I'm not into this. And I said, all right, let me tell you my story, it's the same story I told your mother, and when I'm done, if you don't wanna talk about it, I'll hang up the phone, no questions asked.

That conversation led to a three hour and 45-minute phone call. Come to find out, she was an ER technician. The very first person she lost in the ER was her cousin, and she started living with depression. Two weeks later, she -- she lived through a trauma that I can't even imagine. They brought in somebody who was in a car accident off of Route 8. They brought him through the door, and she
immediately recognized who this man was. After six-and-a-half of her team working on him, they saved his life. And she immediately became depressed and she had thoughts of suicide, and she told me it was because she started blaming God for what had happened. And she couldn't understand why God wouldn't let her save her cousin but allowed her to save -- allowed her to save the life of the man who raped her when she was 17 years old -- that's where she recognized him from.

When I went back to the Valley Social Club later on in January, her mother walked up to me, threw her arms around me, and told me that I was the only reason she had her daughter for Christmas. That is when I made the determination to become a recovery support specialist, and I never knew that sharing my story would be that powerful to someone else, but it is a very effective tool that we have as specialists, where we can share our stories, because most professional treatment providers will never tell a client that they've heard voices, or experienced depression, or have PTSD. And, to answer your question, the training for becoming a recovery support specialist through Advocate Unlimited -- Advocacy Unlimited -- was $250 dollars, and they offer free supplemental trainings all of the time. In fact, March 8 and March 11, I'm going to be taking a two-day class that talks about how to deal with people who are veterans. Thank you.

REP. SCANLON (98TH): Thank you, Jeffrey. I appreciate you sharing that perspective with us. Any questions from the committee? Representative Dathan.
REP. DATHAN (142ND): (Oh, sorry -- thank you.)
Thank you for your testimony. I really appreciate it. Are you from Norwalk?

JEFFREY SANTO: Yes.

REP. DATHAN (142ND): You look very familiar. I think we've spoken on the phone during the campaign, hopefully.

JEFFREY SANTO: And I met you outside West Rocks.

REP. DATHAN (142ND): That's it. That's it. Thank you so much for coming up today. I know it's a long journey, and I really appreciate you -- hearing your story. I would love to connect with you later on and figure out a way that we can, you know, support some of these issues that you find important to you. So, thank you for coming up. I appreciate it.

JEFFREY SANTO: The reference that Margaret had made about the cost analysis, I believe it was the Connecticut Mirror reported that for every patient we have at Connecticut Valley Hospital, it's roughly $567,000 dollars a year. If you were to take that and split it between 12 full-time recovery support specialists, you'd be able to have them on for 40 hours a week at $22 dollars an hour.


MELISSA THOMAS: Hi, Mr. Chairman and members of the Insurance and Real Estate Committee. My name is Melissa Thomas, and I am a certified recovery support specialist employed by Pathways, which is a
private nonprofit mental health agency in Greenwich, Connecticut. So, I came here today, and I brought actually one of my clients who I work with closely.

I'm here to testify in support of Bill 5270 because -- for a lot of reasons -- requiring health insurance coverage for outpatient peer support services -- because I have to acknowledge what everyone has said before me, so much has been said, but we can't afford to wait until people are in crisis to provide them with access to treatment. And recently, I've seen too many people die because they're suicidal and they don't have access to treatment that they can afford, or someone else is making the decision about how many days they have left in the hospital, and they don't have anyone to sit with and talk to. Too many people have died recently. And the other thing is, there aren't enough people who talk openly about their stories.

My written testimony shares a lot of my story. It took me a long time to find out that recovery support specialist was a job and a job that I could have. In my work as a peer support specialist, I've been very fortunate to see firsthand the effects of it, and to be able to share my story, which involves many hospitalizations and 30 rounds of ECT and multiple suicide attempts, my parents re-mortgaging their home to pay for all of this because our insurance said they would cover it and then didn't. I've been suicidal for as long as I can remember. I got genetic testing done that showed that I am medication resistant. There's not a psych med you could give me that would make me better, but I was prescribed psych meds for years. They made me sicker. But peer support offers a different way.
It offers connection. It offers knowing that someone else has been through it and lived to tell the tale, and it is a very powerful tool for sustaining mental health, not just in crises but having people around you who you can connect with and be honest with. I've seen it reignite the hope when I've shared my story and the fact that I'm still here in spite of everything I've been through. When I share it with my clients, some of whom have been in residential treatment for more than 30 years, hope becomes alive again. A lot of people who are in treatment for that long become complacent. They're okay. They don't -- there's a reason to keep fighting, and having peers can inspire them.

Unfortunately, through all the very expensive treatment I received, I never had a peer. I had a lot of very expensive doctors, and a lot of very expensive social workers, and a lot of very expensive people who I just couldn't relate to. I'm college educated, I can do research, but they were treating me like I was no one. And my humanity was largely stripped from me, and orders were given from on high.

In my work, I find that -- I'm trying to remember -- in my work I find that even clients who don't necessarily want to work with their clinicians initially, maybe a conversation with me will convince them that it's worth trying something different, or trying something new, or trying again, or keeping trying because there are solutions, but it's easy to lose hope. And -- I'll sum up pretty quickly -- for me, when I was going through treatment, I did not know a single human being on
the face of this planet who admitted to being mentally ill openly, and I certainly did not know anyone who had a career path that I admired who admitted to being mentally ill openly. So, when I got my first diagnosis, probably at age 15 -- I'm 34 now -- I didn't know that it was possible to have a career at all. Recovery -- being a recovery support specialist has brought that to me, but it's still very underpaid for the amount of work I do. It's constant. So, thank you for listening, and I'm here to answer any questions.

REP. SCANLON (98TH): Thank you, Melissa. We appreciate you being here today and for sharing your story and your perspective and what you do as an RSS. So, thank you so much. Any questions? Representative Hughes.

REP. HUGHES (135TH): Thank you for your testimony. Thank you for your advocacy, and would you -- would you, in your experience, characterize the way you've been treated as sort of a civil rights issue in terms of --?

MELISSA THOMAS: Yes, in addition to my mental health, I have a large array of very well-documented physical health problems, including endometriosis that I've needed four surgeries for, a lesion growing on my pituitary gland that I'm looking at an upcoming brain surgery for -- things that you can see that are wrong with me. But most of the time that I go to a doctor and they see my history, which includes my mental history of being in hospitals, and I'm an dismissed easily as being hysterical or a hypochondriac, or having psychosomatic symptoms and not worth their time, or -- oh, you should really go
see your psychiatrist about this. I've had an endocrinologist send me out of his office and email my psychiatrist saying I think she's going off her rocker. My rights are violated all of the time in terms of access to care because I admit to being mentally ill.

REP. HUGHES (135TH): So, would you classify that, the way you're being treated, is as a second-class citizen because of your mental health diagnosis.

MELISSA THOMAS: Um, probably. I -- it took me a long time, but I am unashamed of anything I've been through, and I'm willing to talk to anyone and everyone about it. I post the pictures of me getting ECT on Instagram, and I talk to people all around the world about it, but a lot of people are ashamed. A lot of people don't wanna talk about it. I have no idea if any of my colleagues were in treatment. I'm the only one on my staff that admits to be in treatment. And probably being so open about it doesn't help me, but I think that as part of a member of society who wants us to continue to get better as a society, I will continue to tell my truth to anyone who will listen, to tell it loudly, to fight for what I believe are my rights to be taken seriously.

REP. HUGHES (135TH): Well, I would say -- I would commend you. You are a survivor. Every day, you are a survivor. And I am deeply concerned that it sounds like you've been discriminated against, especially by the medical community, not just the insurance community but the medical community.
MELISSA THOMAS: Oh, yeah. [Background talking] I've sent a lot of angry letters to everyone. I follow up. I -- if I have been discriminated against by a doctor, they get an angry letter documenting exactly what happened. One time at Stamford Hospital, I was there, and my colon had adhered above my appendix due to adhesions from endometriosis, and the doctor saw that I was on a psychiatric medication and said there's nothing wrong with you, you have to go home and poop, and didn't take any further testing. I needed emergency surgery to remove the adhesion within two weeks.

REP. HUGHES (135TH): I'm sorry that you were treated that way.

MELISSA THOMAS: I'm not the only one.

REP. HUGHES (135TH): Thank you for your advocacy, and hopefully we're turning a new era of unafraid and unashamed, and I hope to support that movement that you're helping head up here.

MELISSA THOMAS: Thank you.

REP. SCANLON (98TH): Thank you, Melissa. Appreciate you being here today. Matthew Reilly, followed by Tom Burr.

MATTHEW REILLY: (It looks bigger.) Good evening. My name is Matt Reilly. I was born in Greenwich, grew up in Darien, and now I'm back living in a mental health group home in Greenwich, Connecticut. I've been in various kinds of treatment for as long as I can remember. The first time I was sent to a mental health professional, I was probably about
eight years old. I'm 29 now. I am in favor of passing this House Bill 5270, AN ACT CONCERNING PEER SUPPORT SPECIALISTS AND REQUIRING HEALTH INSURANCE COVERAGE FOR OUTPATIENT PEER SUPPORT SERVICES PROVIDED BY PEER SUPPORT SPECIALISTS. As someone who is currently benefiting from peer support interventions provided by a certified peer support specialist, I urge you to pass this bill, not just for my sake but for the sake of many other Connecticut residents who have experienced mental health problems and could benefit from peer support themselves. Requiring health insurance to cover the services provided by qualified peers will increase access to relevant services.

Now, I'm a client of Pathways, in Greenwich, living in their transitional housing program, a place I landed in after a manic episode. The group home I live in is highly structured due to insurance requirements and is staffed 24 hours a day. There are many groups and interventions that I have access to. I have a very confident and engaging social worker, and a good local psychiatrist. Insurance covers all of this without question. Yet, until recently, at times, I still did not feel connected to my recovery. These treatments and groups and meetings with professionals felt like things that were happening to me, rather than choices I was making in my life to become a healthy, independent adult.

This is not a compliant or negative reflection of anyone -- complaint, excuse me -- negative reflection of anyone I work with. This is my way of saying that sometimes traditional care is not enough to feel connected. Being in treatment off and on
for so long has been hard. I recognize that I have a tendency to run into trouble I can't get myself out of sometimes, and that I need help figuring out what sustainable recovery looks like for me. I've had periods of doing well and living independently. In my mid-20s, it seems like I had things figured out, until I drove my car into a telephone pole and wrecked it. The car wreck and subsequent 18-month-long hospitalization sent me back into needing more comprehensive treatment, living in my current group home. Pathways has a peer support specialist, Melissa, that I've been able to begin working with in the past few months. I've been able to connect with her differently than I've been able to connect with other staff. She is not my only resource, but she is one I rely on and trust with things that I would not share with other staff. Working with her in individual sessions as well as peer support groups, she has helped me gain perspective, refocus my goals, and reorient my disposition, which had previously been bleak.

When she asks me to -- shut up Bill -- when she asks me to challenge my thinking patterns or consider approaching things differently, I enjoy improvising and collaborating with her for the expressed and explicit reason that she does understand in an empathetic and nonclinical way in addition to all the other reasons. When I was asked to accompany her to advocate for this bill, I jumped at the chance. I do believe in this bill. Any questions?

REP. SCANLON (98TH): Matt, thank you for being here today and sharing your perspective. We appreciate that. Any questions from the committee? Thank you so much. ["Aw" laughing] Tom Burr.
TOM BURR: Good afternoon again, Representative Scanlon and members of the committee. I didn't expect to actually take two bites of the apple bill, but since you invited me up, I will.

I just wanna reiterate everything you've heard today from some of the peers as well as people like Margaret Watt talking about peer specialists. As someone who's worked for NAMI Connecticut for eight years, one of the things I get to do for the organization is a thing called mental health in the media. And what that requires me to do is read everything that's being published out in the world around mental health, and everything I've ever read about peer specialists has been really on point with what we've heard today. It's very cost effective, and it works.

Now, one of the things that I think you should all be aware of is something that I heard from my son. I mentioned in my earlier testimony that he was a train wreck for eight years, but he's currently been sober for over 11 years and doing fantastic. People can and do recover. We were actually, just this morning, did a presentation down at an event at Sacred Heart University in Fairfield that was sponsored by Optima -- Optima's Health Care, and Margaret was there in the audience watching. You can ask her how we did. I thought, you know, my son especially did fantastic telling his story. But, one of the points that he said is germane to this conversation we're having. It was a question, I think, that you, Representative, may have asked, or one of the other members, but it was about, you know, what is it about peer support that makes it so
different compared to just getting care from a medical professional.

And, for people with a mental health concern, it's very common to have an experience like my son did, where he was either misdiagnosed, given medications that actually the side effects are really severe, or in his case, at times, he was treated forcefully because of the nature of his illness, and as such, developed quite a negative impression of the medical community, not to mention what the previous testifier, Melissa, spoke about as being condescended to or dismissed by the medical profession. My son has experienced all of that, and so, it makes them very distrustful in a lot of cases of the medical community, whereas a peer is someone who's been down this road. Again, it's the perspective that's invaluable, you know. And talking just from my own perspective, even though I was trained by NAMI back when I as a volunteer through our family-to-family class and learned all I could learn about mental health, and medications and what they do, and coping skills, and advocacy, and all this stuff -- I didn't understand what it was like to have a serious mental illness. It took me years to really appreciate that people who are involved with these illnesses are really suffering. No one chooses this path, trust me. It took me a long time to understand that, and I think there are definitely medical professionals out there who don't understand that, and that's why the peers are so important -- that perspective of someone who has been down that road and has seen their way out of the forest.
That was the other thing, when he was really sick, he couldn't see his way to recovery. It just looked like an impossible task. But, the help he got, primarily through AA 'cause he was dual diagnosis, helped him see out of that forest into recovery, and he's in a tremendous place, really a good place for 11 years, because of that. I'll answer any questions you may have. Thank you.

REP. SCANLON (98TH): Thanks, Tom. Appreciate it.
Representative Hughes.

REP. HUGHES (135TH): Thank you so much for your testimony on both accounts. It just occurred to me as you were describing your son's experience that the peer supports very much act as translators to several different systems, and because we do make it a -- kind of a mandate to provide translators to, you know, non-English-speaking language people when they come through the emergency room or they encounter the -- we try -- even the court systems, but a lot of our major, you know, points of service -- that maybe we should require providing such translators to the larger systems that -- and really reclassify peer support, not just as essential -- as essential tools in the mental health service treatment but also as essential translators.

TOM BURR: Yeah, I agree, and in fact, you bring up an interesting point. And I think a lot of people, again, if you've never been down this road, you don't understand it. One of the exercises we teach in one of our classes at NAMI is an exercise in what it's like to be hearing voices, and it's an exercise that brings that whole experience home. If you've never experienced that, someone who's in crisis who
presents themselves to the emergency room will have a really hard time understanding what a medical professional is trying to say to them because of the cognitive issues involved in that. So having, again, someone who's been down that road, has dealt with psychosis, has dealt with hearing voices, can really relate and have the patience and understanding to work with someone, whereas a medical professional who doesn't have that training, doesn't have that experience would not really be able to do that, would lose patience with the person, thinking they're not paying attention or they're just not with it. You know, it's just -- it's really helpful to have them.

REP. HUGHES (135TH): It's a specific kind of competency that we -- we should require.
TOM BURR: Yes.

REP. HUGHES (135TH): Just like we do as cultural competency.

TOM BURR: Without a doubt.

REP. HUGHES (135TH): Thank you.

TOM BURR: You're welcome.

REP. SCANLON (98TH): Thank you, Tom. Appreciate it. [Question in background] Melissa, if you wanna come back up real quick 'cause we've just got a couple of other bills to get through today.

MELISSA THOMAS: To the point that you were -- to the question that you were asking about interpreters, I think I could speak to you very
well. I am not on the clinical staff at my job, but I work with a large clinical staff, and largely -- and I'm not a diagnostician, I don't have a master's degree, my undergrad degree is in creative writing -- I've spent a lot of time in psych wards, and a lot of time in the RSS training, which I think is like eight-weeks long and very intensive. But anyway, frequently I am the first person to make contact with a client that notices when symptoms are starting to get worse, when they need more attention, when they need more intervention. The other staff -- I'm not disparaging them at all, they are very good, but they don't see some of the smaller tells. They don't have the lived experience. They don't speak that language, so to speak, and so I do spend a lot of time translating and advocating for people who are afraid to admit -- to speak up and say, hey I might be slipping. But, I notice, and I can approach them and have that conversation and advocate for them to seek a higher -- seek more treatment again.

REP. SCANLON (98TH): Thank you very much, Melissa. Appreciate you sharing that.

All right, Amir Abdur-Rahman. [Crosstalk] Appreciate your patience, sir.

AMIR ABDUR-RAHMAN: [Background talking, "It's good, it's worth it."] Good afternoon. My name is Amir Abdur-Rahman. I'm here to support the House Bill 5270, on peer support and peer specialists, and the -- what is it -- the recovery coach, also, a little bit I wanna mention about 7125.
Everything that Martha Watt here has said, I support. Myself, I have been working as a peer support, a coach, mentor, a life coach for many years, over 20 years or so, unprofessionally. So, I work as a human service worker. On the entry level, I was unable to provide a job for my family, a working wage. I'm a little nervous because I have eaten all day, and my sugar is kinda low. I should've grabbed something to eat. Anyhow, so I have a bachelor's degree. On an entry level, I cannot make enough money to provide for my family, so I went into technology. I was injured last year. That kept me out of work for the whole year. So, this summer, I figured I can start now with human services. I work with Street Safe Bridgeport in Bridgeport. It's a non-law enforcement -- are you familiar with the group? Yeah, so one of the things that I notice is that that demographic, the inner city people, do not have access to many of the services that we're talkin' about today. Not only that, many of them need -- they have -- they suffer from PS -- post-traumatic stress syndrome from gang violence, from drug use. A lot of them need to be talked down from suicidal tendencies -- the type that are lethal and very dangerous to society -- suicide by cop. So, we have to disarm them, turn the fire weapon over, continue to work with them to stop them from recidivating to this violent behavior.

So, there's a big difference with communities. Like I live in North Stamford right now, went to parochial schools. I had a very comfortable life growin' up, from the age of 15 on. I started out in an inner city, and so the drug use in our communities, we've had this problem for years, all
of my lifetime, right. And so now, it's in the other communities, and there's millions of dollars and there's a lot of -- you know, there's a lot of help, there's a lot of noise about it, and that's good because no community should suffer the way opioid drugs can make you suffer. So, I know firsthand what it's like to see people detox and try to stay clean, try to live -- transition from -- well, I put together a program called Restructured Citizens Organization, where you take individuals who have detoxed from gang violence, drug use, and all these other social problems, to keep them on a path of success, transitioning from that lifestyle to a lifestyle of education, providing for their family, giving back to society.

So, it's all right to convince someone at the beginning, but to have them maintain this, it's a lot of work. So, for that matter, I intend to acquire some of the certifications for the peer support specialist and to pursue my master's degree and doing that -- and all for the purpose of providing for my family as well. So, to do that, I agree with everything and support everything that Martha is talking about. Thank you.

REP. SCANLON (98TH): I appreciate that, and again, I thank you for being here all day. I know it's a long commitment, and I'm really grateful for that. And obviously, you and I both know, that communities of color are some of the most underserved mental health populations in ["Yeah, unfortunately" in background] not just this state but in the country, and I think it's really, really important that folks like you are willing to, you know, dedicate some of your time to tryin' to do that, whether it's the
Street Safe and trying to intervene with violence or now with peer support. So, I really thank you for that, for the help with the state, so thank you. Any questions from the committee? If not, thank you very much.

AMIR ABDUR-RAHMAN: Thank you very much. (I'm gonna get somethin' to eat.)

REP. SCANLON (98TH): All right, 7261, Danielle Morgan.

DANIELLE MORGAN: Good evening, Chairman Scanlon, Chairman Lesser, members of the committee. My name is Danielle Morgan, and I'm a family psychiatric nurse practitioner. I've been practicing psychotherapy and psychopharmacology here in Connecticut for the last 20 years. I have a practice in Guilford, in Hamden, and I am the member of a medical staff of a federally-qualified health center right now, but I've managed inpatient detoxes, outpatient post-incarceration clinics, and various treatment communities across the state. I wanna thank, first of all, Representative Jason Doucette, Michelle Cook as well as Jonathan Steinberg for bringing our concept language forward. The Connecticut APRN Society, in getting our legislative agenda together, came up with this, one of the most really pressing problems, the mandated 90-day psychototropic supplies that we get pressed to prescribe by insurance carriers, and these legislators came forward to bring some bills that Representative Scanlon and you folks in the committee have now raised as language. So, thank you very much.
You have a very extensive testimony on paper, but I just wanna sort of give you an idea of what the problem is. So, for many years now, we as prescribers, and that's across the board -- so anyone that prescribes a psychotropic medication in any forum, after a 30-day dispensation, is mandated to prescribe 90 days. So, that could be an OB/GYN, that could be a primary care provider, it could be a pediatric specialist, a geriatric specialist, or a psychiatrist or a psychiatric APRN is then mandated to dispense 90 days, and that is wrought with problems. There is really no reason that anyone should have a 90-day prescribed medication in a psychotropic form unless they're well maintained and it's a maintenance medication, which comes really from just a clinical decision. That's a medical decision-making that occurs between a clinician and that patient.

So, we're hoping that, with this language, we will be able to stop the mandated necessitating of that insurance mandate.

REP. SCANLON (98TH): Thank you for reaching out to me a month ago about this ["Yeah" in background] and for sharing your thoughts. And it was definitely helpful for me to sort of, you know, take your opinion into consideration, and then obviously, as you mentioned, there were some other bills. Talk a little bit about the difference between some of the insurance practices and the medical practices because this committee specializes in hearing about those kind of disputes, and I'm wondering if you can offer some perspective between maybe somebody who's getting prescribed a 90-day blood pressure medication, for example, and somebody who's on
psychotropic drugs, and why there is a need for someone like yourself to see that person more regularly.

DANIELLE MORGAN: Sure, thank you. So, psychotropic medication comes with the whole litany of psychiatric care, which is much more varied and much more complicated. Psychosocial stressors and psychotherapy, psychosocial interventions that we've heard about all day now, need to be evaluated much more regularly and much more frequently. Not to sort of medicalize it, but medication associated with chronic disease management in medical forms, like blood pressure or diabetes or cholesterol, is a very unilateral kind of measurement. When we're talking about psychiatric care, we're looking at all sorts of variables. We're looking at safety. We're looking at families and communities. We're measuring suicidality. We're measuring substance abuse parameters. We're measuring a whole host of variables that shift, and ebb and flow, and are constantly in flux.

And sometimes there are things that patients don't necessarily want to address. So, taking the 90-day supply and running with it often encourages patients to not come back for treatment, and then we often don't know what's happening. So then, as we've heard about all day, crises erupt. We're not aware of what those crises are. Then patients will have these very large supplies of medications at their disposal to then enact the dangerousness around those crises.

REP. SCANLON (98TH): Thank you. I appreciate that. Representative Hughes.
REP. HUGHES (135TH): Thank you so much for your testimony. Thank you, Chairman. Can you speak to the complexity of pharmacology in sort of finding the right mix, dose, timing, all of that, and every episode is different, so --

DANIELLE MORGAN: Is the buzzer gonna go off? [Laughing] That's incredibly complicated. That's an excellent point. The art and science of that and the intimacy of that is incredibly complicated. Psychiatric medications are not even effective generally until the 4-to-6-to-12 week period. So, we aren't even set that we're going to continue that medication until that timeframe. We are often changing doses. We're changing timing of doses. We're changing how many pills we're dispensing if we're cutting them in half. There's an entire dance around all of that -- if it's even worth it. We may stop it and turn to other interventions. It's incredibly complicated.

REP. HUGHES (135TH): And wouldn't you say that the default way of prescribing has been if this -- you know, we'll prescribe this, if it doesn't work out, then it's incumbent on the patient, who might be in the middle of an episode, to get back in touch and let me know if it's not working.

DANIELLE MORGAN: Absolutely, so we generally -- the APA standard is really to follow people every two weeks and to keep close track until you've reached this maintenance goal of remission. Insurance companies are generally not motivated by remission. There's a study that I've given you access to that really started, I think, back in 2012 -- this
wealth/spool of 90-day supply push -- that was based on just the Medicaid population, looking at a Walgreens, the retrospective chart review of Medicaid population around chronic disease management and SSRIs, and we don't know what those SSRIs were prescribed for. And indeed, the data showed that they were the least maintained, the least well followed up with, and the least well kept by patients, which is pretty consistent with what we know because how patients maintain those is with consistent psychoeducation and consistent interaction with providers.

So, to get to disease remission, medication is only one piece of it. There are all these other things we've talked about all day, and you need consistent interaction with providers, and giving someone a 90-day supply of medication does not encourage that.

REP. HUGHES (135TH): And would you say, who would be the -- who would be the stakeholder that lost out the most if we -- if we blended the pharmacology with these other non-chemical ways of treating disease, then which stakeholder would stand to lose the most?

DANIELLE MORGAN: If we did not?

REP. HUGHES (135TH): Continue with -- like the standard of 90-day supply.

DANIELLE MORGAN: I can't think of anyone. I mean, patients gain sometimes less of a co-pay, and if we got rid of that, I can't think of anyone -- I don't understand what insurance or pharmacy benefits gain by dispensing more pills in one flow. I've spoken
with people who own pharmacies, and they've told me that pharmacy dispensing fees are so minimal in this day and age that they actually lose money. So, that used to be of benefit to the third-party payer system, so I'm not sure where -- where that benefit is?

REP. HUGHES (135TH): I suspect that originally it was the drug companies, but I don't know.

DANIELLE MORGAN: Yeah, I'm at a loss.

REP. HUGHES (135TH): That that benefited -- this practice -- but I hear ya.

DANIELLE MORGAN: Thanks.

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

DANIELLE MORGAN: Thank you.

REP. SCANLON (98TH): Geraldine Tookey.

GERALDINE TOOKEY: Good evening, Senator Lesser and Representative Scanlon and this distinguished panel. I so appreciate having this opportunity to come before you and bring forth some patient concerns that I have. I also have a copy of the study that Danielle was alluding to, if anyone wants it. I have submitted a written testimony that has some of the pros and cons of the Medicaid study.

So, the reason I'm here today is I'm a pediatric nurse practitioner. I am dual certified in general pediatrics as well as child, adolescent, and young adult psychiatry. I can take care of the physical
and emotional needs of both the pediatric patients up to the age of 26. I am currently working at the Institute of Living, providing services for young people between the ages of 18 and 26. I was so struck by the power of this committee. How exciting. There is a sign that I think is very appropriate for this moment with these people, everyone here. It says, through these doors walk -- work -- through these doors walk important people doing important things, and this is one of the signs at the Institute of Living, but I see this here because the work you do is going to impact our families, our children, and our community for years to come -- and I thank you.

One of the reasons I am here is I can speak with one patient to two of the bills that we are having considered. The House Bill 7125 on parity as well as my current support for the 90-day limit. I have a patient who is 18 years old. His father died two years ago. His mother is having chemotherapy for cancer. He comes to me with depression. He has been on the psychotropic, Geodon. Geodon is a medication that has a side effect of affecting the heart. I am concerned. I have this 18 year old. We, in psychiatry, have to really be aware of the choices we make and how it impacts the physical health of our patients 20, 30, 40 years down the road.

So, I meet this young person, and he is sedated. He is tired. So, I wanna change his medication. So, I call up the pharmacy. I call up the insurance company. I wanna change him to another medicine. They say it's not on the pharmacy -- it's not on the formulary. So, they said, if I find two research
articles, they will consider it. I find two research articles, and I submit those research articles, and then they said no. Finally, on my third phone call, and this takes at least an hour to an hour-and-a-half each phone call -- 'cause I'm on hold (I have speaker phone) -- then I'm able to get this medication approved. And so, that's just an example of the amount of time that I am spending with insurance companies trying to get care for my patients when I could be actually interacting.

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

GERALDINE TOOKEY: Okay, thank you.

SENATOR LESSER (9TH): Appreciate it. Next up, we have Joy Avallone on 7263. Good afternoon.

JOY AVALLONE: Chairmen, Ranking member, members of the committee, I am Joy Avallone, General Counsel for the Insurance Association of Connecticut, a state-based trade organization representing the interests of the Connecticut insurance industry.

I wanna thank you for the opportunity to come before you and offer comments in opposition to House Bill 7263, AN ACT PROHIBITING INSURANCE COMPANIES FROM USING SEX OR GENDER IDENTITY OR EXPRESSION AS A FACTOR IN UNDERWRITING OR RATING PRIVATE PASSENGER NONFLEET AUTOMOBILE INSURANCE POLICIES. The IAC opposes this bill because it will make it more difficult for insurance companies to accurately assess risk and accurately price premiums, and will likely result in consumers with low risk paying
higher premiums to subsidize consumers with higher risk, who will likely pay less.

By way of background, auto insurance is sold in accordance with cost-based pricing, which prices the insurance products according to the insurer's best estimate of how much the insured is likely to generate in claims and which takes into account numerous rating factors, including driving record, age of driver, age and model of car, miles driven, etc., which are all incorporated in order to develop rates in an equitable manner. Now, generally speaking, the more information available to insurers, the more accurate the assessment, the more equitable the rates will be for all of their consumers. Now, accurate risk assessment and underwriting allowed for appropriate and reasonable premium setting ensures that policy holders will pay based on the risk that they represent and not the risk of others. So, those representing lesser risk will pay less in premiums, and those representing greater risk will pay more.

By way of example, younger men, in particular, tend to be much more risky to insure than their female counterparts, and as such, typically will pay much higher rates. Female drivers from age 16 to 24 pay, on average, $500 dollars less a year for the same policy than their male counterparts. If you remove gender from the equation, what you're gonna see is basically the premiums are gonna end up leveling out. So, females are gonna end up paying more; males are gonna end up paying less, just so they can subsidize the risk.
Now, I think it's just important to note also that there are only six states that have actually banned the use of gender in pricing auto insurance or required unisex pricing. Those states are California, Hawaii, Massachusetts, Montana, North Carolina, and Pennsylvania. Montana was the first state to implement this unisex insurance legislation, which went into effect in 1985. Under Montana's laws, insurers are required to offer the same prices and benefits for auto insurance regardless of the gender of the consumer. And while unclear whether or not there's an actual direct correlation with this, I think it's important to note that Montana is now -- their average rates for auto insurance are about $1600 dollars a year, which is 13 -- over 13 percent higher than the national average. In summary, the IAC [laughing] opposes this legislation and asks you to do the same.

SENATOR LESSER (9TH): Thank you. Thank you, Joy, for your testimony. You know, you -- in your example that you cited of young men being more risky drivers than young women, that -- that sort of conforms with the bias that I had prior to this session. I think when we -- when we raised the bill, I think what we were responding to was reports out of California that, in fact, insurers are pricing the opposite, where they're charging women more for insurance than men. Is that something that you think is typically the practice?

JOY AVALLONE: I think that the -- the historical data will show that women, especially with the younger demographic, that women actually -- they're paying less because they pose less risk, and that's because men, typically based on a number of factors,
including their driving record, they're more likely like to not wear a seatbelt, to drive more expensive cars. There are just a number of different things that are taken into consideration. That's typically reflected in the premiums. So, California may be unique in that sense, but I think across the board, the vast majority of states see the opposite.

SENATOR LESSER (9TH): And do we have that data for Connecticut? Is that something that's available somewhere? Is that something that the Insurance Department or someone else would have?

JOY AVALLONE: Yeah, I'm happy to look into it. I wasn't able to have that information for today, but I'm sure that that would be helpful to you, so, of course.

SENATOR LESSER (9TH): Okay. Thank you. Other questions or comments from members of the committee? If not, thank you very much. Oh, I'm sorry. Yes, Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Chairman. So, listening to the discussion here, and I'm going back to the experiences of friends and associates of mine having literally young men and women in the same family, and they pretty much have validated what you've said about a daughter having a lower rate than a son would in the family, with basically the same driving record. And it sounds like that's probably a fairly correct analysis from what you've said based on the statistics in here. So, in essence, we would see female drivers having their rates go up in that -- in that bracket, age bracket?
JOY AVALLONE: Well, yeah, 'cause you would have to have a -- the risk remains the same. So, the premiums would have to level out. So, typically, the data shows -- historically, the data shows that younger men engage in more risky behavior and then -- and they're involved in more accidents. Like that's generally what the information is out there. So, and maybe -- I guess it's important to consider gender, especially when people are starting driving out. They may have the same record, but the information is gonna be limited. Maybe they've only been driving for a year. They haven't had an opportunity to engage in accidents, or they haven't had that experience, but ultimately, yes, there's going to be a leveling out of premiums. So, if the premiums go down for the more risky male counterparts, then the premiums are going to have to level out, and they're gonna have to go up for the females, who have historically been less risky.

REP. DELNICKI (14TH): Is there any point in age where that changes?

JOY AVALLONE: I do think that the information that I've seen anyway does reflect that there's like a narrowing of the gap as individuals get older. But because the algorithms are so complicated and vary from company to company, I think they also take into account like the age of the consumers and other factors as well.

REP. DELNICKI (14TH): And how many years of reference data have you been looking at or is available for making this analysis?
JOY AVALLONE: I don't know exactly how far back this data goes, but I do know that this is something that we've consistently relied on year after year.

REP. DELNICKI (14TH): And one final question on the data itself. You don't know how many years back that you do have in the way of data, but from recent time, say past 10-20 years, have you seen or has there been any trend change from what you were talking about in young men paying a higher rate than young women?

JOY AVALLONE: I think with regard to especially younger men and younger women, in that particular demographic, that age demographic, I think it's been fairly consistent. That's the research that I've had the advantage to look at. Beyond that, I -- I guess can't speak to that, and I would be happy to look into that, but I don't know for sure.

REP. DELNICKI (14TH): And one -- actually one final question here --

JOY AVALLONE: But I guess what I would say is that over time, as that information becomes available, that's going to be reflected in the premiums because it affects the insurer's livelihood and also their consumers.

REP. DELNICKI (14TH): Now that we have different insurance companies offering rates based on utilizing a tool that records your data and bases -- I'm assuming bases your rate on the data that's in that little data recorder that you plug into your car, do we have any information pertaining to that -- on what kinda trends there are?
JOY AVALLONE: I -- I'm unsure. I wasn't prepared to speak to that today, but I'd be happy to look into that for you.

REP. DELNICKI (14TH): Yeah, 'cause it seems to me that would be a -- a good check on what we're talkin' about here because that's -- well, you know, maybe not -- I'm just thinking out loud here. If somebody's willing to take that and put that in their car, they're probably going to be a very, very cautious driver.

JOY AVALLONE: I -- I would assume that that would be the case [laughing], but again, I am unsure.

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

SENATOR LESSER (9TH): Thank you, Representative Delnicki. I was doing a little bit of Googling, and it turns out that there was -- I think the California law relied on a 2017 Consumer Federation of America study that purported that generally women do pay more -- despite being less risky -- do pay more for insurance than men, at least in many cases. You're not aware of any other studies that indicate otherwise?

JOY AVALLONE: I am aware of that study, and I think that that study was criticized and particularly because it relied on quotes and not actual premiums.

SENATOR LESSER (9TH): Do you -- but do you --
JOY AVALLONE: But I am unaware of other ones. That frankly is the only one that has kind of gone against the grain.

SENATOR LESSER (9TH): Okay, well it would be helpful to us as we're tryin' to figure out what -- I mean, when you anecdotally tell me that, you know, a 21-year-old man would be charged than a 21-year-old woman, that makes sense to me. What I'm not -- what I'm having a harder time sort of seeing is why, if women are generally safer drivers than men -- you know, find out what's happening in the real world in terms of what the data suggests as to whether or not we have equivalent adult drivers and women charged more. And so, if you're telling me that that's not happening, then it would be helpful to see data. Is that data -- you don't know if that data is available through the Department?

JOY AVALLONE: There is some data that I've cited within my testimony, but I would be happy to look and see if I could get direct data from different departments as well.

SENATOR LESSER (9TH): Okay. That'd be helpful. Thank you.

JOY AVALLONE: Thank you.

SENATOR LESSER (9TH): Any other questions. If not, thank you very much. Next up, Eric George, also from the Insurance Association. Good afternoon, Eric.

ERIC GEORGE: Good afternoon, Senator Lesser, Representative Hughes, Representative Pavalock-
D'Amato, Representative Delnicki, Senator Bizzaro -- I could say everybody right now. I work with Joy over at the Insurance Association of Connecticut, and as an anecdote, I suppose, I have both a son and a daughter, and I will tell you my son is much more risky than my daughter in every capacity known to man. But, that's not what I'm here to speak about right now. I'm here to speak about House Bill 7262, AN ACT WHICH WOULD PROHIBIT LIFE INSURANCE COMPANIES FROM USING GENETIC INFORMATION.

We very much appreciate the intent of this legislation. Just so you know, we are working very closely with Speaker Aresimowicz's office, who was the genesis of this bill, and we do have concerns with the bill in its present form. It is an outright prohibition. Just so you know, we strongly -- the IAC strongly supports a consumer's ability to use and share their information, including their genetic information, with whomever they wish. This would be an outright ban on that. And also, it may go without saying, but I want to point out to folks that the nature of life insurance underwriting necessarily deals with very personal information, very critical information, that it is our duty -- I represent the life insurers -- it is the duty of the life insurers to keep that information confidential, to protect that information. And I am here to say (1) that we do appreciate the level of interest in this, (2) that we do believe that consumers should have the ability to consent to the use of their information -- consent to the use of their information, and (3) I'm very hopeful -- I'm actually very optimistic that we are going to be able to work together -- and our conversations with the Speaker's office have been terrific -- towards a
resolution. And those are my comments on House Bill 7262.

SENATOR LESSER (9TH): Are there questions or comments? Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Hi. Thank you for your testimony. I'm just confused. I'm confused about the bill. Is this being done now? Like do they -- can you explain the process 'cause I've never heard of this.

ERIC GEORGE: So, if a -- if a consumer consents, just like other pieces of information pertaining to the consumer, they can share that information. The insurance company can have access to that information to assess premiums. I will say that in life insurance you might query as to why is this so important. Life insurance, much different than other forms of insurance, has one bite of the apple -- one. So as much information and the most accurate information is critical. However, there are no instances, and actually Representative Delnicki and I had this conversation -- we do not require it. It is not something that a life insurer would say that you need to have done. We would not require a genetic test to be done. If a consumer consented -- if a consumer had a genetic test done, consented, then that could go into the premium setting for their life insurance policy.

REP. PAVALOCK-D'AMATO (77TH): Right, so this is -- this is addressing you asking or you testing? Again, that's ask --
ERIC GEORGE: We would not be able to -- we would never be able to use it. It's not even asking. We would never be able to use it. We don't ask now, and we would never ask in terms of having somebody do a test. That does not happen.

REP. PAVALOCK-D'AMATO (77TH): And this bill refers to "collect genetic information" so I guess it's --

ERIC GEORGE: For the purpose of setting premium. I'm sorta paraphrasing there, but --

REP. PAVALOCK-D'AMATO (77TH): Okay. So, when it says collect genetic information in this bill, I'm not sure whether it means you sending out some type of test or you just asking the questions. That's what I'm confused about in the bill.

ERIC GEORGE: Also recognize that life insurance companies, as far as I know, do not actually perform the tests. I mean --

REP. PAVALOCK-D'AMATO (77TH): The tests, right. ERC GEORGE: Right. I mean, other bodies -- authorities do the testing.

REP. PAVALOCK-D'AMATO (77TH): Right. Or let's say you authorized or requested the test, do you do that?

ERIC GEORGE: Who is "you" -- the individual?

REP. PAVALOCK-D'AMATO (77TH): The life insurance company.
ERIC GEORGE: We would not. It starts with the individual.

REP. PAVALOCK-D'AMATO (77TH): Right, so that's why I'm kinda confused by the language in this bill 'cause it makes it sound like you're asking --

ERIC GEORGE: Well, I think that probably some of your confusion is very founded, and that's why, you know, one of the several reasons, that we're working with the proponent of the bill to craft legislation that gets to what they are seeking. Yes, the information they want to be protected, and we want to protect the consumer's consensual ability to share that information if they wish.

REP. PAVALOCK-D'AMATO (77TH): Because the statement of purpose says to prohibit life insurance companies doing business in the state from acquiring genetic testing or using the information in connection with life insurance policies. So, like, maybe you -- I can understand at least the request for using genetic information, but requiring genetic testing, I -- like you just testified that that's not done, so I'm confused as to why that's in this bill if it's not being done already.
ERIC GEORGE: I guess you're asking me a question that I am unable to answer.


SENATOR LESSER (9TH): Thank you, Representative. Representative Delnicki. [Unclear background talking] So, I'm gonna sort of repeat a question I believe Representative Pavalock-D'Amato asked, but I
know that they can do this now -- are you aware -- are life insurance companies currently receiving data on a voluntary basis?

ERIC GEORGE: Yes. Yes. Yes, they are. Yes.

SENSOR LESSER (9TH): And they are able to price in genetic data into life insurance plans?

ERIC GEORGE: If that is provided, yes.

SENSOR LESSER (9TH): Okay. Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair. So, if somebody voluntarily offers up their genetic information, whether it be through a blood test, whatever, and they know that they have an excellent genetic makeup. For whatever reason, they've had testing done before. Would they then be able to obtain a better rate on life insurance?

ERIC GEORGE: I have to say presumably so. I don't engage in this. I represent those companies, but in terms of the actual use of the information, I think that region -- reason would dictate that the answer to your question is yes.

REP. DELNICKI (14TH): And I only throw that out --

ERIC GEORGE: I'm not a geneticist, and I'm not one of the actuaries who works for a life insurance company, so I'm not trying to be -- I'm trying to answer your question head on, but I have to defer to a significant degree to the professionals who set that. And when you say, will it go down -- I mean,
that's a -- that's a very strong like almost de facto statement, and I would have to say that reason dictates that it would, but I can't go farther than that. You understand what I'm saying?

REP. DELNICKI (14TH): No, I fully understand what you're saying, and I just raise that issue because there are some folks that have actually had the genetic testing to find out whether they have any issues that are gonna pop up in the future. I know a number of folks that have had that done. And that's what kinda spurred that question when you made the comment there because if I knew I had a great genetic makeup there, and I had no susceptibility based on the genetics -- and you kinda have that feeling from your family based on their family medical history and you have it done -- then if I were going to apply for life insurance, I would want to offer that up to try to get a better rate. Or, let me rephrase that, I would only offer it up if it would get me a better rate.

ERIC GEORGE: So, much of what you're -- I mean, it's not a perfect analogy, but I think that you made this analogy already when the last speaker was up and you were talking about UBI, usage-based insurance, which is otherwise known as telematics, and that was the chip that you were talking about that you plug into a car. And you are correct. I am not aware of anybody who would be a subpar, poor driver, who would acquiesce and volunteer to have such a device included and installed in their car to demonstrate and prove that they are, in fact, a poor driver. [Laughing]
REP. DELNICKI (14TH): Point well taken. Thank you for coming forward, and this is one of our more pleasant conversations in your testimony.

ERIC GEORGE: I know. We're growing Tom.

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

SENATOR LESSER (9TH): Thank you, Representative. Thank you. Are there -- no other questions from members of the committee? Thank you.

ERIC GEORGE: Okay.

SENATOR LESSER (9TH): Next up, Subira Gordon. For the first time before the Insurance Committee. I have to follow you around -- that's kind of my job.

SUBIRA GORDON: [Laughing] Hi, Represent -- sorry, I didn't mean to do that -- Senator Lesser and other Ranking Members of the Insurance Committee. My name is Subira Gordon, and I'm the Executive Director of ConnCAN. It's great to see you up there, Senator Lesser, glasses and all. I would like to thank the committee for raising Senate Bill 974, AN ACT ESTABLISHING A TASK FORCE TO STUDY METHODS OF DEVELOPING, EXPANDING, AND IMPROVING THE INSURANCE INDUSTRY WORKFORCE IN THIS STATE.

So, since the 18th century, insurance has played a dominant role in Connecticut's economy and continues to do so today. At nearly three percent with more than 60,000 insurance industry jobs, Connecticut ranks first in the nation in employment in insurance carriers as a percentage of total employment, according to a recent study from PwC. Connecticut
industry -- Connecticut insurance jobs are also high paying, with an average annual wage of around $90,000 dollars. So, I wanna thank this committee for raising this bill, as this is a really important issue.

I also wanna highlight a bill that's in the Higher Ed Committee, House Bill 6778, which is handling this issue holistically, kind of looking at high-paying jobs and in-demand jobs across the state. As you are aware, the workforce of the state -- sorry -- the education needs of the state are not directly aligned to what the workforce needs are. So, this bill is a great step in the right direction to try to solve some of the needs for insurance industries and making sure that we're connecting those who are in our higher ed and K through 12 institutions to make sure that they're ready -- they're career ready -- for the jobs that are actually in Connecticut. I know we talk a lot about bringing jobs to Connecticut, but this job -- this bill is really good because it's actually talking about the industries that are already here, and we know that we wanna keep them in the state, so we should be investing in the workforce in the pipeline for those individuals -- and also commending the fact that this is looking at being a debt-free mechanism because, as you probably are aware, Connecticut has one of the highest debt burdens, and low income families are among the highest rate of default rates for student loans. And so, Colorado and Tennessee are doing a lot of work around this and also Utah, and I just heard, I think, South Dakota is also doing some work in this area, so I would commend -- I really commend the committee for this bill and look forward to working with you on this issue.
SENATOR LESSER (9TH): Thank you very much. Are there questions from members of the committee? Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Didn't we -- I think we passed this bill in 2017. Didn't we, I believe -- or something similar?

SUBIRA GORDON: Higher Ed had a version of this bill that was -- it wasn't insurance related, it was more broadly apprenticeship. That was done in 2017. I'm not sure if Insurance did a bill in 2017. It may have.

SENATOR LESSER (9TH): I think -- I think Insurance did pass a workforce bill, but I don't think it was this specific context.

REP. PAVALOCK-D'AMATO (77TH): Okay. All right. Thank you for your testimony, and I agree. I think it's a great bill, and hopefully we'll pass it and hopefully the Senate will pass it too, so that way we can actually, you know, work and get people employed in this industry. So, thank you.

SENATOR LESSER (9TH): Thank you, Representative. Representative Vail.


SUBIRA GORDON: Senate Bill 974.
REP. VAIL (52ND): Okay. All right. Thank you.

SUBIRA GORDON: All right.

SENATOR LESSER (9TH): Thank you, Representative Vail. So, my understanding is this bill also contemplates looking at income-sharing agreements as one of the ways to achieve debt-free education. Those would require a student, upon graduation, to pay back a certain percentage of their income for a set number of years. Those have been criticized by some as sort of indentured servants. There has been -- there have been attacks on proposals along those lines. Are you open to -- is ConnCAN open to those kinds of agreements as a potential way of getting students through education without accumulating debt?

SUBIRA GORDON: So, I think it's -- I mean, obviously, there would have to be a way to get out of it, but I do think that for many students who are essentially low income and don't have -- I think this is a better move than having them be indebted, go into high levels of student debt. I think this is a great way to be innovative on how we look at providing education, and I don't -- I wouldn't use the word indentured servitude -- I would say you're making an investment in your future. And once you're -- we're doing -- we're looking at this also in the realm of education and student loan forgiveness, and I think when you think about these investments, if someone -- if you're getting essentially a free education, there needs to be something that's tied to it in the next five years or so.
SENATOR LESSER (9TH): Thank you very much, and I also wouldn't use that term. I just wanted to play devil's advocate for a second. Thank you for your testimony here, and always good to see you in front of the Insurance and Real Estate Committee. Any other questions or comments from members of the committee. If not, thank you very much.

And that concludes the list of speakers we have listed currently. If there are other members of the public who wish to testify, please identify yourselves. If not, I'd like to adjourn the meeting -- the public hearing of the Insurance and Real Estate Committee. Have a good evening everyone. See you on Thursday.