REP. STEINBERG (136TH): Good morning. And we’re a few minutes passed, so I’d like everybody to settle down if they can. This is the public hearing of the Public Health Committee. Good morning, I’m state Representative Jonathan Steinberg. I was Co-Chair of the Committee. I’m here with Senator Mary Abrams as well as, well, we don’t have, there’s a ranking member.

We will have legislators filtering in and out today. This is one of those days where all of us are at least double booked, if not triple booked. I’ll have to run out myself to vote next door in Transportation.

I want to say in advance, thank you all for your patience because it will be a while before some of you get to testify.
Just to be clear, the first hour we give some preference to elected officials, agencies who will be given roughly five minutes to testify, elected officials and members of the public will have three minutes to testify, which does not include, obviously the time you might get if legislators have questions for you.

Good, nobody gave me the thing about having to, oh, shoot. All right, all right, fine. All right. In the interest of safety, I would ask you to note the location of and access to the exits in this hearing room. The two doors through which you entered the room are the emergency exits and are marked with exit signs.

In an emergency, the two doors behind the legislators can also be used. In the event of an emergency, please walk quickly to the nearest exit. After exiting the room, go to your left and exit the building by the main entrance or follow the exit signs to one of the other exits. Please quickly exit the building and follow any instructions from the Capitol Police. Do not delay and do not return unless and until you are advised that it is safe to do so.

In the event of a lockdown announcement, please remain in the hearing room. Stay away from the exit doors and seek concealment behind desks and chairs until an all clear announcement is heard.

All right. We have a full house today, so I think that’s actually hopefully something we won’t encounter, but you should be aware of those announcements.
Lastly, Room 1C, this floor is reserved as an overflow room. There is audio and visual for members of the public to follow the hearing. We have a full house today. Please try not to block the exits, if you can, so that people can get in and out, particularly legislators running to and from their various other meetings.

So, we will begin today with, okay, with, I believe, it’s Bill 807; is that correct? All right. We’re going to go in order, but I understand some of the legislators may be in transit or in other committees and we will come back to them when they are available.

First up is Senator Bergstein, is she available? No. Next up is Representative Linehan, is she available? See how busy we are today. Next up would be Representative Bolinsky. I believe I did see him here earlier, there he is.

REP. BOLINSKY (106TH): Good morning to all the members of the Public Health Committee. Honorable Co-Chairs, Representative Steinberg, Senator Abrams, Vice Chairs Lesser and Young. Ranking Members Petit and Somers. I thank you for your consideration today as I sit before you and I speak on two bills, both of which were graduated to become committee bills this year. And both of which are very simple, very useful pieces of legislation that have an awful lot of support.

So, I’m not gonna read my testimony to you. You have in writing. Instead, what I’m gonna just do is speak anecdotally, starting with the simpler of the two bills, which is House Bill 5449, it’s AN ACT CONCERNING THE DONATION OF BLOOD BY MINORS.
And this is a repeat of a bill that we had in-house last year. There was a hang up taking that bill from the House to the Senate and then there were also some, some issues with, between the Red Cross and some understandings in the bill which are in the process of being ironed out this year. But the original impetus of this bill came to me from a family in, in Sandy Hook, Connecticut; in my hometown of Newtown, our high school is very active in doing blood drives. And they do them for routine reasons, but they also do them for special reasons.

A student named Harry Eppers came to me back in late 2017. And his mother is afflicted with multiple myeloma, which is a rare form of blood cancer. And Harry came to me in advance of a blood drive, telling me that he expects to have a very successful blood drive and collect almost 100 pints of blood. But he had literally 75 or 80 sophomores that wanted to participate in that high school-based blood drive, except for the fact that Connecticut’s laws, when it comes to blood drives, excludes the donation by anybody under the age of 17, which is different than 45 other states, where the health codes are essentially set up so that somebody that is 16 can donate with affirmative consent and a permission slip, basically from mom or dad.

It’s a safe practice. It’s a good practice. And when you take a look at the landscape of blood donation, ladies and gentlemen, Connecticut is in a constant state of shortage. And I can’t think of anything that’s more of a life-giving elixir than blood because it’s broken down into so many different types of components and, very frankly, not only does it keep people alive on operating room
tables, but it allows people to progress through chemotherapy using derivatives and plasma from it as is the case with Mrs. Eppers.

You also have written testimony before you from Shelley Eppers, the person who is the stimulus behind this initial movement, from her son, Harry, who’s now graduated on to Boston University, Michael Enaye, who is running the blood drives at Newtown High School right now, and a variety of other people.

There doesn’t appear to be any opposing testimony to this bill because it’s just a good bill.

REP. STEINBERG (136TH): Representative, you did say you had two bills to speak to and you’re probably running out of time. Do you want to also address the other bill?

REP. BOLINSKY (106TH): Yes, the other bill that I’m here to speak about to you is House Bill 5444. This is a bill that’s been in process for about three years. And it is AN ACT REQUIRING THE LICENSURE OF ART THERAPISTS. This is an organization that does something very, very unique in the areas of mental health.

I hate to invoke the Sandy Hook reference, but coming out of that community, one of the things that we discovered in the aftermath of what happened on 12/14, children particularly are very, very difficult to reach when it comes to therapeutic methods of, of, of mental health.

Art therapy is a way to break through and as a complimentary therapy, work its way towards larger repressed feelings and, and, and a renewal of mental
health, an airing of issues so that they can be dealt with.

At the same time, as we were talking about this licensure process, it came to light to me that this also is a wonderful, wonderful form of mental health revelation that helps us to be able to reach members of the community that might not otherwise be reached with a traditional therapeutic process. For instance, I have a father with Alzheimer’s. He cannot be reached in normal conversational ways, but when there’s a clinical issue, art therapy is something that can be used to reach people, not just that are young and unable to express themselves, but also it’s a way to reach a portion of an adult’s brain that is suffering from cognitive impairment and; therefore, do good in that way.

In addition --

REP. STEINBERG (136TH): Representative, I’m gonna ask you to, to sum it up, if you might, please.

REP. BOLINSKY (106TH): I’m sorry?

REP. STEINBERG (136TH): Could I ask you to sum up, please? You’ve had absolutely --

REP. BOLINSKY (106TH): I sum up by saying that you have two bills before you, both of which are great bills. Both of which address public health issues, both of which offer unique and positive solutions. So, with all due respect to every member of this committee, first of all, I do say thank you for having this be committee bill, having both of these be committee bills. But I urge your support and I want to do whatever is possible to work hand-in-hand with the committee to move both of these bills
forward and take them to the floor of the House and let’s move them on because it’s good public policy.

REP. STEINBERG (136TH): Thank you, Representative, and thank you for your advocacy once again this year on both bills. We did come very close on the blood donor bill last time and I’m hopeful the committee will recommend it out as well.

Are there any questions or comments from members of the committee? If not, Representative, thank you for your time.

REP. BOLINSKY (106TH): Well, thank you, everybody.

REP. STEINBERG (136TH): Next up is Representative France.

REP. FRANCE (42ND): Good morning members of the Public Health Committee, Co-Chairs, Senator Abrams, Representative Steinberg and the rest of the committee. Thank you for this opportunity. I’m here today to speak in opposition to House Bill 7070. And in the interest of time, I would like to turn it over to Dr. Lin Monte, who will provide a commentary, thanks.

MELISSA LIN MONTE: Thank you. Good morning. My name is Dr. Melissa Lin Monte. I am the Medical Director of the Care Net Pregnancy Resource Center in New London.

We believe in fighting for the life of the unborn who have no voice, just as doctor’s fight to save the lives of babies that are born prematurely.

We provide support and encouragement for all pregnant women, not just the abortion-minded. By no means do we advertise ourselves as an abortion-
providing healthcare clinic. Our website states clearly in multiple different sections and tabs on the website that the Pregnancy Resource Center does not provide abortion services, nor do we refer for them. And there is no false or deceptive advertisement at our centers.

We educate patients about all their options, such as keeping the pregnancy, carrying to term and then possibly putting them up for adoption or termination.

We provide them with evidence-based literature to take home with them and read about all their options, including abortion. Just because we educate patients and answer their questions about abortion, but don’t provide the services of abortion, does not mean we are being deceptive. There is nothing fake about our pregnancy care centers. We provide free pregnancy tests, testing for sexually transmitted infections, and we do ultrasounds to confirm dating and pregnancy and the gestational age of the fetus.

Our staff are medically trained licensed professionals who are certified. It’s not like an on-line course that we take. These, these providers have to do so many ultrasounds to become certified. All of these services are free to our patients. They come out of our operating budget from supporters who believe in our cause. And we do not use any government or tax funding.

There are abortion clinics available to patients who want them. But we, as a pro-life pregnancy resource center, should not be forced to offer abortion as a service. It is our right to practice our beliefs
and the sanctity of life. My time is up, okay, sorry.

But basically, you know, I’m not, I’m not, I’ll be quick. I’m not aware of any formal complaints about patients being misguided or misled in any way. We’re not sure exactly what is deceptive about what we’re advertising. And I just ask that you vote no against this bill and just allow us to continue caring for pregnant women and giving them options to get through these times.

Thank you so much for your time.

REP. STEINBERG (136TH): Thank you, Doctor for coming here to testify today. I’m going to ask that as we continue the hearing today that there be no more signs for or against any particular speaker. Applause are not considered appropriate in this context. I hope you’ll all abide by that. Thank you. We do not want to intimidate anybody else who chooses to testify. This is very important to us. I ask you again, to make sure that we do not hear comments before us that are for and against, other than the person who is testifying.

Doctor, I just want to clarify a couple points, if I might?

MELISSA LIN MONTE: Yes.

REP. STEINBERG (136TH): First of all, you said at one point, if I heard you correctly, that you informed the person who comes in of all their options, was that correct?

MELISSA LIN MONTE: Correct, yeah.
REP. STEINBERG (136TH): So, then does that include the possibility of them seeking abortion as well?

MELISSA LIN MONTE: Yeah.

REP. STEINBERG (136TH): Okay. Good. That’s a very important distinction. Thank you for that.

Secondly, you mentioned that you’ve been very clear about disclosure on your website and through other advertising. Is there any sort of disclosure that you provide when somebody enters your facility, and do you ask them to sign any documentation asking them to acknowledge the services you do and don’t provide?

MELISSA LIN MONTE: Yeah.

REP. STEINBERG (136TH): That’s a very simple answer. Thank you.

MELISSA LIN MONTE: Okay. Thank you.


SENATOR SOMERS (18TH): Yes. Thank you for your testimony this morning. There’s a few points that I would just like to ask for clarification. You are a clinic, so you are inspected by the Department of Public Health every two years, is that correct?

MELISSA LIN MONTE: Yes.

SENATOR SOMERS (18TH): Okay. And also, just to reiterate, if a client comes in and is unsure of how they want to handle their unplanned pregnancy or pregnancy, I guess it would be unplanned, and they ask you specifically about a termination, you will not necessarily, and I’m, correct me if I’m wrong, you will not say, you can go X, Y, Z, but you can
say or you do say, if that’s what your decision is, there are abortion clinics that you can seek out, is that correct?

MELISSA LIN MONTE: Yeah.

SENATOR SOMERS (18TH): Thank you for that clarification.

REP. STEINBERG (136TH): Questions by members of the committee? Yes, Representative.

REP. MCCARTY (38TH): Thank you, Mr. Chairman. And I just wanted to welcome Representative France and the Doctor. And if you could just clarify for me to be sure that I heard properly, did you say that there were no complaints ever for your center?

MELISSA LIN MONTE: Correct, not that I’m aware of.

REP. MCCARTY (38TH): Thank you.

REP. STEINBERG (136TH): Other comments or questions? If not, again, thank you for coming here today. Thank you, Representative France for providing us with this testimony.

I believe that Senator Bergstein is in the house, so to speak. If she is, she will be up next.

SENATOR BERGSTEIN (36TH): Would it be okay if I brought a guest with me?

REP. STEINBERG (136TH): Yes, it would be okay.

SENATOR BERGSTEIN (36TH): Madam Chair, Mr. Chair, thank you so much and ranking members and all members of the Public Health Committee. Thank you for hearing my testimony. I’m gonna be very brief because I actually want to highlight somebody who has great expertise in this subject. We’re
testifying on behalf of the H.B. 5910, which would prohibit the use of PSOA, a chemical, actually a class of chemicals that has been proved to be highly toxic, carcinogenic, and a long lasting in the environment. So, we wanted to talk about the impact on public health.

I’m specifically concerned about children’s health. Before I became legislator, I was an advocate and a supporter of research on how chemicals in the environment impact children’s health and development, how early life exposure can change the course of their health and their life trajectory. PSOA’s is just one of many chemicals that we now have sufficient data on to know that they will have an adverse health impact on children and actually on any person who comes in contact with them.

So, I subscribe to the precautionary principle, when we have evidence that shows that we need to be concerned about a chemical or any other substance because it’s deleterious to human health, that we should act on it.

So, I am in favor of H.B. 5910, in fact I submitted my own bill that was very similar, AN ACT PROHIBITING USE OF PSOA IN FOOD PACKAGING AND FIREFIGHTER FOAM, and why these two areas of use because food packaging is obviously a source of, that comes in contact with people immediately through digestion and chemicals that are used in food packaging migrate into the food.

So, just because we can’t see it, just because we can’t taste it, doesn’t mean it’s not there. It is there. And again, we have evidence to show that it’s highly toxic and causes cancer.
And then regarding firefighter foam, there’s no one better to talk about that than somebody who’s representative of the firefighters themselves.

I’d like to introduce my friend, Rick Hart, who’s a Legislative Director of the Uniform Professional Firefighters Association.

RICK HART: Thank you, Senator, Chairman Steinberg, Senator Abrams, members of the Public Health Committee. My name is Rick Hart, I’m the Legislative Director for the Uniformed Professional Firefighters Association of Connecticut. And we also support H.B. 5910, based upon the issue of the environmental problems that AFFF, Aqueous Film Forming Foam presents when used.

Currently the State of Connecticut supplies and provides eight foam trailers that carry 500 gallons of AFFF that are positioned throughout the state. That’s 3500 gallons worth of this foam, that when used as at a 3 percent foam solution will produce 16,667 gallons of foam. In an emergency situation, it’s impossible to control runoff of this magnitude. So, therefore, what we have is this foam getting into the storm sewer systems, into public waterways or into well systems and contaminating the ground water.

The other issue is the municipality that lays down the foam, that uses this foam, is basically based upon Clean Water Act, using a known pollutant and is on the hook for liability as far as cleanup is concerned.

REP. STEINBERG (136TH): I’m gonna ask you to summarize. The good Senator did use up a bit more of your time than she --
RICK HART: Oh, okay.


RICK HART: So, as a result, we are in support of this bill as there is an intra-agency working group between DPH and DEEP that is working on this problem and in discussions with the Fire Administrator. There is a possibility that a replacement foam is, has been decided upon by the Connecticut Airport Authority, so we may be able to be further along the way in banning these foams usage in the emergency setting.

Thank you.

REP. STEINBERG (136TH): Again, thank you both for your testimony. It does seem that we’re on the right track and I’m encouraged to believe that before the session is over, we can craft legislation that will both meet the need and deal with the bad stuff we want to get rid of.

Starting with Senator Somers.

SENATOR SOMERS (18TH): Good morning and thank you for your testimony. I have a question on the, you said that the Connecticut Airport Authority had a possible alternative. I wanted to know if this possible alternative, has it been tested on Class B fires and what’s it efficacy? And if it’s only a possibility and we pass this law that would ban these fluoro-free foams, what happens if we have a Class B fire, if it hasn’t been proven? Do we have something ready to go that can be used tomorrow, if we pass this bill, that will be as effective as what we currently use?
RICK HART: I cannot answer that question, Senator. Only I was in discussions with the fire administrator and he said that they are close to getting a, approving a replacement foam. Unfortunately, they come under the FAA and DOD specifications, so it has to comply with those specifications, but I’m not privied to that as of yet.

SENATOR SOMERS (18TH): My second question would be concerning the packaging. If this material is proven to be carcinogenic, as we have heard from the testimony, how has it been allowed to be cleared by the FDA and still be used?

SENATOR BERGSTEIN (36TH): Oh, there really, as far as I understand it, there really are very few limitations on chemicals and products that can be used in food packaging. So, we don’t have a robust set of environmental health regulations at the federal level, that’s what I’ve been fighting for and many of us have been fighting for well over a decade.

So, we have the food regulations are much more robust, but what goes into other products are, is less clear. So, that’s an excellent question and I wish that we had federal regulations to enforce having nothing that was at all, either even carcinogenic is a very high standard. Even anything that could migrate from food packaging. Because even if it hasn’t been proven to be carcinogenic, any chemical that migrates from food packaging into our food should be suspect, I think. So, guilty until proven innocent rather than the other way around.
SENATOR SOMERS (18TH): Okay. In my understanding of working with the FDA for years, in order to have something clear, whether it’s the packaging material, whether it comes in food contact or human contact, you have to go through a series of testing, outgassing how the product is packaged, what the shelf life is, et cetera; so, that’s why I’m struggling with the fact that it’s still available under FDA guidelines. They don’t actually tell you what to do, they could be guidelines and they have to clear it. They don’t approve anything; they just actually clear it. That we would, as a state, you know, look to make a change when this new material or alternative materials, are they available and if so, have they been cleared by the FDA for use? I think it’s very wide open right now, and I, I, I think this would be difficult for us as a legislature to pass something, knowing that this product is cleared by the FDA, it’s something that’s acceptable to use, but what the alternative is, we’re not sure if that is, if that makes any sense?

SENATOR BERGSTEIN (36TH): You’re talking about in the firefighting context or --

SENATOR SOMERS (18TH): Or food context.

SENATOR BERGSTEIN (36TH): Well, we had food packaging well before the introduction of PSOA. We had food packaging before the introduction of styrene. Styrene is a known carcinogen and it’s also used widely in food packaging.

So, PSOA, as I understand it is applied to materials because it has a, it has the ability to repel moisture. So, that, you know, maybe that, that specific quality isn’t entirely necessary in all
food packaging and we should be exploring alternatives and I’m sure alternatives do exist. Maybe it’s a question of just being, going back to what we used before PSOA was introduced.

SENATOR SOMERS (18TH): My concern is that, again, we would be the state legislature, legislating that a particular type of packaging that is accepted and cleared by our federal government would not be acceptable here and we would be having a manufacturer of this food product have to put up the product in a different packaging specifically for Connecticut and go through the testing, et cetera, that’s required to be able to maintain expiration and shelf life. So, it’s a slippery slope as far as doing individually as a state. I understand the concern if this truly is carcinogenic, as you say, or, you know, leaks into the food. You know, I don’t know, I haven’t seen the testing. But that’s a slippery slope for us. It’s like changing the packaging on or labeling requirement or packaging requirement on a product that is manufactured for, you know, pharmaceuticals or the, the, the furniture industry. It’s, it’s changing the dynamic for those that have to supply the product to us.

So, that’s my concern. I hear yours and I thank you for your testimony.

SENATOR BERGSTEIN (36TH): May I just, I have one last, and I share your concern and I certainly understand our role as state legislators not to, is not to create a slippery slope. But we do have responsibility and in the absence of federal legislation and the absence of leadership at the federal level, I do think it’s incumbent upon us to do what we can to protect our citizens. And, you
know, I’m a firm believer in science. I’m sure you are too. And when the science is robust, but the federal government has failed to act, I do think it’s our duty to do something.

SENATOR SOMERS (18TH): My suggestion would be that perhaps we get together as the Public Health Committee and write a letter and put some pressure on our federal delegation to make sure they’re the ones that are in charge in Washington, make sure that we put the onus on them to pressure the FDA to make the regulatory guideline changes that are required. I think that would be a, personally a better approach. But thank you for your testimony.

REP. STEINBERG (136TH): Well, Senator, you’re more optimistic than I am that the federal government with the update will take action currently. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. And Representative, or Senator Somers asked my question, but I do have another question. Is this banned in any other state?

SENATOR BERGSTEIN (36TH): I think, I know it has been attempted. I’m not sure, is Anne Hulick here? No. Has it been banned in any other state?

REP. STEINBERG (136TH): If you could repeat that, Senator, because it’s not in the record.

SENATOR BERGSTEIN (36TH): It has been banned in Washington state and there’s several other states that are considering similar legislation. Thank you.
REP. STEINBERG (136TH): Thank you both. We look forward to your ongoing collaboration, if we’re to move such a bill forward.

REP. ZUPKUS (89TH): Thank you.

REP. STEINBERG (136TH): Next up, I understand Representative Linehan is in the room.

REP. LINEHAN (103RD): Good morning. Good morning, Senator Abrams, Representative Steinberg, ranking members, vice chairs and the esteemed committee. I’m here today to testify on House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES BY LIMITED SERVICES PREGNANCY CENTERS.

I have a wonderful little pregnancy center in my district, the Hope Crisis Pregnancy Center. I’ve been donating to the center personally for over 10 years. And in 2017, I took a tour and looked at the materials they give to women seeking help and information.

To the best of my knowledge, the Hope Crisis Pregnancy Center, in Cheshire, doesn’t engage in deceptive practices. And that is precisely why I’m here to testify in favor of this bill. This bill will in no way affect the practices of pregnancy centers which act appropriately.

And while Hope Center, in Cheshire, doesn’t engage in deceptive practices, we do know that others do. For example, a center in Hartford was strategically placed next to an independent abortion provider and had a similar name in order to confuse potential patients.

Additionally, this center has non-medical staff wear lab coats in order to make it seem as though they
provide these medical services, which they absolutely do not. In fact, several centers in Connecticut operate with the appearance of a medical facility and advertise to people as though they offer abortion and emergency contraception, when they are actually opposed to these services.

The women they aim to lure in are in a vulnerable state and they’re looking to receive time sensitive, sensitive healthcare information from qualified individuals. However, none of these centers are qualified or licensed to provide the services that they may seek.

This legislation would ensure that women seeking these time sensitive healthcare services are aware of the limitations of such centers prior to walking in.

I am ardently pro-choice. As such, I believe that utilizing a religious-based support group is absolutely a choice that we need to protect. However, women seeking services should know in advance the limitations of these centers and that they are unable to provide the services that they may seek and not allow the centers to run out the clock on the woman’s ability to receive emergency contraception or abortion.

This bill is a consumer advocacy bill. It will not affect the pregnancy centers who truthfully and ethically provide support services to women. It will simply ensure that other centers, especially those with a history of deceptive practices are held to the same standards as those like Hope Pregnancy Center, in Cheshire. So, women have the freedom to
I urge you to support the passage of House Bill 7070. Thank you.

REP. STEINBERG (136TH): Thank you, Representative for your testimony. I want to also thank you for the point you made that, and this is really for the benefit of everybody here assembled to testify, the intent of this committee is to fashion a bill, which only goes after those who are actually practicing deceptive advertising and other intimidating tactics. It is not intended to do anything to those who are abiding by the rules and are being truthful and forthcoming to those who seek their services.

It’s very important that we make that point. We are only looking to take care of, as we often do in government, the bad actors and leave those who are performing well and ethically alone. And I hope that everybody understands that point. And thank you for making that clear.

REP. LINEHAN (103RD): You’re welcome. And, you know, even if the vast majority of centers are behaving ethically, the point is is that when others do not behave ethically, they are limiting the ability for a woman to get time-sensitive support, right, because we know emergency contraception has to be taken, I believe, within three days. And, of course, abortion services are limited to time as well. So, we want to make sure that the bad actors, as you say, are actually abiding to appropriate rules and that they are not deceptively advertising services that they are unable to provide.
REP. STEINBERG (136TH): Thank you. Representative Candelora.

REP. CANDELORA (86TH): Thank you, Mr. Chairman, thank you, Representative Linehan for your testimony. And I appreciate your perspective. I guess when I first read the language in this bill, what strikes me is generally speaking, you know, as the legislator I think it’s incumbent on us to make sure that we’re passing legislation that, that provides causes of action for individuals in certain practices. So, we sort of have these general laws, I think deceptive practices under the unfair trade practices laws would provide relief for people that have been the victim of, you know, deception or, you know, we have all sorts of other laws, just dealing generically with product liability and things of that nature.

This particular piece of legislation, I think why so many people are upset is, it’s sort of only targeting one part of a medical practice. And what struck me was --

REP. LINEHAN (103RD): Excuse me, I’m sorry, it’s not a medical practice. These centers are not medical practices.

REP. CANDELORA (86TH): I didn’t say medical, I said just a practice.

REP. LINEHAN (103RD): Okay.

REP. CANDELORA (86TH): So, to flip it around, why wouldn’t this legislation be written more broadly, so it’s not just pregnancy centers that are pulled in, it would be any clinic, including abortion
clinics that would fall under these types of provisions?

REP. LINEHAN (103RD): Well, abortion clinics, to the best of my knowledge, do not offer religious services. So, I’m not sure where there would be some sort of crossover there. When you are going to an abortion clinic, you recognize that you can go and have an abortion there. When you are going to a faith-based contractor, who advertises that they have medical services, you are not under the impression that you are going there strictly for faith because these centers cannot provide those abortion services.

So, I think that it actually doesn’t make sense. I recognize where you’re going with that and I, and I see that perhaps you don’t want these wonderful law-abiding ethical practices to be singled out. I know that. And I don’t want that either. But the truth of the matter is, the language in this bill should be so specific that it doesn’t hurt or preclude any ethical-based service from carrying on with what they’re originally doing. I think by broadening it, it actually lessens the intent of the bill. And what we are doing with this bill is simply to make sure that anyone providing faith-based services are advertised as such, faith-based services.

REP. CANDELORA (86TH): And I guess that’s sort of, when I read this bill, I don’t read it that way. I read it as sort of focusing on a particular type of service that’s provided. And that’s where I get a little bit concerned because I think generically what we’ve seen, and I look at things, you know, I try to look at things more broadly; A, we’re providing a cause of action for individuals, which
has the ability for people to sue. So, this can be used as much as a defensive tool or an offensive tool. And I think my concern with the public policy in this is regardless of the good actors, this bill will have the unintended consequence of eliminating, you know, the pregnancy center that’s in your town that might be a good actor, because anybody now could sue under these provisions.

REP. LINEHAN (103RD): Respectfully, I see what you’re saying. But when we’re talking about good actors versus bad actors, there’s no way I could possibly sue a crisis pregnancy center for advertising that they give faith-based services when I want to go in and have an abortion. They have never advertised that they offer abortions. They’ve never advertised that they offer emergency contraception. There’s no ability to sue there for something that they don’t offer. Were the ability, and, and, I’m not a lawyer, so I don’t know if this, if this is the case, but if, if a faith-based center advertises that they can help with abortion services and I walk in and they don’t actually have those abortion services, isn’t that then deceptive practices? Do you see my, do you see the distinction?

REP. CANDELORA (86TH): I, I, I get your point and I guess my, my response would be, we already, I think under current law, somebody would already have the ability to sue.

REP. LINEHAN (103RD): But we, we don’t want to get to the point where they sue. Because what’s happened is, ultimately, if we get to the point where they sue, we’ve already stopped a woman from being able to get the services that they intended to
get. What we would like to do is make it so that deceptive advertising practices cannot take place in order to block a woman from being able to get those services. We’re talking about time-sensitive services. We know that abortions can’t be performed after a certain number of weeks. We know that emergency contraception takes, you know, it’s only applicable in a certain window.

So, to get to the point where you sue, we’ve already lost, everybody’s lost. So, we’re looking at putting guidelines into statute that would essentially let everyone know that it is illegal to advertise for services that you cannot provide.

REP. CANDELORA (86TH): So, I guess, we could have this dialogue later --

REP. LINEHAN (103RD): Sure.

REP. CANDELORA (86TH): -- but that’s exactly what this law does, is it creates another avenue to sue. So, so, what I would see would be more litigation, not less. And maybe there would be a way, I mean, I think the law’s already addressed deceptive practices, but maybe there’s a way to do this that isn’t so offensive to the good actors because I think that’s what’s going on here is, is the way this is drafted, it’s essentially creating causes of action that pull in all the organizations.

REP. LINEHAN (103RD): I believe that we are always open to conversation. But I will say that the best way to not be sued for a bad action is to not be a bad actor.

REP. CANDELORA (86TH): Thank you.
REP. STEINBERG (136TH): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (114TH): Thank you, Mr. Chair. Thank you, Representative for your testimony. I have a couple of questions for you. Do we know of any of these faith-based centers that have advertised for abortion?

REP. LINEHAN (103RD): Yes, we do.

REP. KLARIDES-DITRIA (114TH): And we have pictures of this in print and the places where they were?

REP. LINEHAN (103RD): Yes.

REP. KLARIDES-DITRIA (114TH): And has someone reported that to DPH or Consumer Protection?

REP. LINEHAN (103RD): Yes.

REP. KLARIDES-DITRIA (114TH): Okay. And we have that on record?

REP. LINEHAN (103RD): Yes.

REP. KLARIDES-DITRIA (114TH): We can look that up?

REP. LINEHAN (103RD): Absolutely. As a matter of fact, in Hartford there was an ordinance passed in order to stop that from happening. And now we’re looking to do that on the state level.

REP. KLARIDES-DITRIA (114TH): Okay. I would like to see that, if possible.

REP. LINEHAN (103RD): Sure, we can have that provided for you.

REP. KLARIDES-DITRIA (114TH): And then, also, as far as a woman being in that situation, being pregnant, trying to figure out what she wants to do,
whether she goes the faith-based route or she goes to an abortion clinic, obviously is her choice. But it exactly is her choice. So, we need to have some responsibility with ourselves to search out different options. Now, I’m under the impression that the faith-based organizations do give you your options. And if you end up wanting abortion as an option, we’ll refer you out because they don’t perform that.

REP. LINEHAN (103RD): So, that is what is supposed to happen. That’s not always what happens. So, what happens is is that, and again, it’s not with everyone, it’s with certain bad actors. For instance, I went into the Hill Pregnancy Center and I sat down, and I looked at all the materials that they have. They are very specific with the fact that they are faith based. They are located next to a church. All of these things will tell you that this is what they do.

However, there are other places that you would go where they would simply try to stretch the things out. They would say, well, if you’re interested in this, maybe we will sit and talk a few times and they’re basically trying to run out the clock. And I agree that choice means choice. You need to know where you, you have many opportunities to go to different places. And I believe that faith-based centers are absolutely included in that and should continue to be included in that. However, when you are going to a faith-based center, you should know that it’s a faith-based center. When you are going to a medical provider, you should know that it’s a medical provider. And there should be no overlap in the advertising of those things, when a faith-based
center can never be a medical provider. That’s where, that’s where we’re finding this is happening.

So, for instance in my testimony, the faith-based center was located next to an abortion provider and their staff would wear medical coats. Well, if you are someone who is in a sensitive state and you are concerned and you think you’re gonna go to this place that you researched on the internet, but then you walk up and there’s some very nice people standing in lab coats coaxing you in, at what point are you told that this is not a medical practice? You’re not.

The lab coats tell you, you know, maybe not outright in that point, but it makes you think it’s a medical center. That is a bad actor. And many of the people here today are most likely not the bad actors. We are not targeting those people. We welcome the services that they give. And I, like I said, I’ve been donating to one for over 10 years. However, we have to ensure that the bad actors are behaving more like the good ones.

REP. KLARIDES-DITRIA (114TH): Okay. Thank you very much.

REP. LINEHAN (103RD): Thank you.

REP. KLARIDES-DITRIA (114TH): Thank you, Mr. Chair.

REP. STEINBERG (136TH): Any comments or questions? Senator Somers.

SENATOR SOMERS (18TH): Good morning, thank you --

REP. LINEHAN (103RD): Good morning.

SENATOR SOMERS (18TH): -- for your testimony. I think it would be very helpful if you could name the
faith-based organizations that you’re referring to that have behaved in the manner that you’re describing? That would bring some clarity, I think to folks that are here.

REP. LINEHAN (103RD): I don’t want to get it wrong, so I’m going to look it up.

SENATOR SOMERS (18TH): Okay. And then I struggle with, you know, sort of the narrative or the description of bad actor versus not a bad actor, because I do believe that if you’re a faith-based organization, you don’t, you probably don’t believe that you’re a bad actor. So, I’m trying to define deceptive because we all can have a different perspective on what deceptive is. And so, is deceptive like you described, wearing a white lab coat? Because I know there’s plenty of places that I go to that somebody’s wearing a white lab coat and they’re not a medical doctor or clinician, they might be a nail technician or they might be, you know, something else. They might work in a lab. So, I think that it’s, I hear what you’re saying as far as a situation in Hartford, per se, where a clinic, that I’m assuming from what you said, is faith based, opened up next to a women’s clinic, and I can see how that could be confusing.

The trouble is I’ve seen that this, same type of legislation has tried to pass in other states, and it’s been challenged now because of your First Amendment right. We really can’t tell somebody where they can set up shop and where they can’t. This bill give the Attorney General a whole new set of powers to be able to go after these so-called bad actors. And, you know, the majority of the centers or clinics that I have visited have been very above
board and truthful and out there in what they provide and what they don’t provide.

So, my concern is that, you know, the language here, if you read it, it is targeting pregnancy centers, whether we want to agree or not, it is targeting them. And I can understand how those who are, you know, following their beliefs and are being honest and disclosing the information on what services they provide and what other services they don’t provide are feeling targeted also.

So, I think it’s important, can you tell us the names of those centers? Is there multiple, is there one? I understand the ordinance that passed in Hartford is not enforceable. So, what are we really doing here?

REP. LINEHAN (103RD): So, there are multiple questions in that question. So, I’ll attempt to answer. So, being put on the spot, I hadn’t had, I don’t have them with me. I do know that there, I don’t know the names. I know that there’s one in Middletown, there was one in New London and in Hartford, whether that’s an inclusive list, I don’t know.

REP. STEINBERG (136TH): If you wouldn’t mind, Representative, subsequent to this hearing if you could provide that information for the benefit of --

REP. LINEHAN (103RD): We can absolutely do that --

REP. STEINBERG (136TH): Thank you.

REP. LINEHAN (103RD): -- sure. And regarding the language of the bill, you know, I have the utmost faith in Senator Abrams and Representative Steinberg, and I believe that as we sit here today
in a public hearing that they can work together to find the language that would achieve the ultimate end that we’re looking for in this bill and we will continue to do that. I believe this is a great jumping-off point. But, once again, I have faith in my colleagues that they will be able to get to the bottom of what we want to achieve here, while still protecting good actors.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for your testimony.

REP. LINEHAN (103RD): Thank you very much. I appreciate your time.

REP. STEINBERG (136TH): We’re reaching near the end of our hour, where we give a little preference to elected officials. I’ve been made aware that the Attorney General of the State of Connecticut is in the room. And I’m hoping that my colleagues will allow us to, him to go next, so as to be within that first hour, and if any object, welcome, Mr. Attorney General.

ATTORNEY GENERAL WILLIAM TONG: Good morning still, I think. Chairman Steinberg, Chairwoman Abrams, and Ranking Member Petit and Ranking Member Somers. I must say it’s a little strange being on this side of the inquisition, but happy to be with you this morning.

I’m joined by counsel to the Attorney General, Nicole Lake, and we’re here to testify in strong support of House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.
I’m here this morning not to engage in a philosophical debate about abortion or choice. I’m here in my capacity as the State’s Chief Civil Law Enforcement Officer, charged with enforcing the state’s consumer protection laws along with Department and Commissioner of Consumer Protection.

This bill is pretty straightforward. What it does is it creates a mechanism by which the state, acting through the Attorney General, can enforce the state’s consumer protection laws and protect consumers and people living here in Connecticut from false and deceptive public advertising practices.

I want to make it very clear that what this bill does is it creates not a private right of action for an individual, but it creates a mechanism by which the Attorney General can enforce this law. And it does focus on false, misleading or deceptive practices.

It’s really important also to note that it focuses on the public advertising conduct and not the private counseling conduct. So, this is really ex-ante when you’re looking at a website or public advertising on a side of a bus or through print, radio or television. We’re focused on that conduct.

What this bill does not do is focus on people who are simply exercising their constitutional rights to free speech and to articulate their views, particularly on religious matters and on abortion and also as, Dr. Monte testified, protection of the life of the unborn. I want to acknowledge that there are some limited services, pregnancy centers that openly acknowledge in their advertising that they do not provide abortions or emergency
contraception and that they believe abortion is wrong. And while as a policy matter, I disagree with that. I strongly respect their First Amendment right and the rights of those centers to express that opinion.

And so I want to articulate again and emphasize that this bill in no way addresses the right of an organization or an individual or a center to articulate that position. We just want to make sure that people do so openly and that there is no intent or action to deceive or mislead people that help their services that they believe to be offered are, in fact, offered when they are not.

Let me just also address a couple of additional points. This bill will fill potentially an important enforcement gap, that my good friend Representative Candelora referenced, the Connecticut Unfair Trade Practices Act, CUTPA, CUTPA is a well-known and understood law under the state. Our 49 other peer states have a similar law. That law addresses trade or commerce. And so working with the Department of Consumer Protection, we usually go after bad actors, for lack of a better term, in the marketplace engaged in commercial activities.

The challenge that we face is that somebody engaging in deceptive or false advertising in the healthcare space may by their corporate structure or by the way in which they communicate their views, they may avoid trade or commerce of a designation as engaging in trade or commerce. So, that is a gap that this bill seeks to fill so that in the event that somebody speaking on these issues can do so without engaging in trade or commerce, CUTPA would not apply. And this bill would give the Attorney
General’s office the authority to bring an enforcement action in any event.

Thank you so much.

REP. STEINBERG (136TH): Thank you, sir. A couple of questions.

ATTORNEY GENERAL WILLIAM TONG: Sure.

REP. STEINBERG (136TH): You’ve heard in some previous discussion today concern about clarity, a definition of what deceptive or false might mean in this context, as the Attorney General tasked with having to litigate against, as we call them bad actors, and let me add that we don’t consider them bad people.

ATTORNEY GENERAL WILLIAM TONG: Right.

REP. STEINBERG (136TH): It’s a phrase we used around here often, and we don’t mean it to be pejorative other than beyond that fact that their may be abiding by the law. Do you foresee any problems in being able to distinguish what is deceptive or false in this context?

ATTORNEY GENERAL WILLIAM TONG: No. There’s probably no better term, better developed term in the law than deceptive, false or misleading. That doesn’t mean it’s easy to identify what something is when it’s false, deceptive or misleading. But there’s probably no three words that are more often litigated, not just in state courts here in Connecticut, but across the country. Because as I said, all 50 states have laws very similar to CUTPA and have laws that protect their residents from unfair trade practices. So, it’s something that we would look to the case law to understand. It’s very
fact intensive, fact specific and it would be up to a judge or a jury to decide once we put on our proof whether a practice is false, deceptive or misleading.

REP. STEINBERG (136TH): Thank you. Another question. You made reference earlier to the term, commercial. We understand that some of the centers that we’re talking about provide all of their services free of cost. Why does the term, commercial, apply in this context?

ATTORNEY GENERAL WILLIAM TONG: So, that’s the challenge and that’s why there may be an enforcement gap. If somebody provides this service for free or for no fee, then they may not be engaging a trade or commerce under the purview of the Connecticut Unfair Trade Practices Act. And that’s why this legislation is important and necessary because otherwise it may be that the Attorney General’s office in the State of Connecticut cannot act.

I should note that commercial speech as a matter of free speech is entitled to less protection, as most lawyers know, than political speech. But that commercial speech that is misleading or deceptive is entitled to no constitutional protection.

REP. STEINBERG (136TH): Given that distinction, one last question, then I’ll hand it off to Senator Abrams and others.

You heard a comment that there was a concern about some sort of explosion of litigation on your part, if we should change the law in this case. Do you foresee such a huge increase in litigation activity?
ATTORNEY GENERAL WILLIAM TONG: I don’t. We have limited resources. We have a strong consumer protection department here in this state, as is our tradition and we have a strong partnership with the Department of Consumer Protection, but we certainly don’t have the resources to be overaggressive or to target service providers that aren’t breaking the law. There’s just, there isn’t time, money, lawyers, people to waste our time.


SENATOR ABRAMS (13TH): Thank you. Thank you. My question is, if similar kinds of efforts had been made both at the, in other states and in municipal levels and have been challenged, how do you feel in terms of the way this bill is written and whether or not you think it would hold up to any challenges?

ATTORNEY GENERAL WILLIAM TONG: So, I believe that the language in 7070, closely tracks language from a San Francisco City ordinance that was upheld as constitutional by the Ninth Circuit Court of Appeals in the First Resort vs. Herrera case.

SENATOR ABRAMS (13TH): Thank you. And do you feel that there, there was some questions being asked about whether or not this is happening. I know that you’re newly appointed --

ATTORNEY GENERAL WILLIAM TONG: Yeah.

SENATOR ABRAMS (13TH): -- and elected. And I’m wondering what your opinion is about the need for something like --

ATTORNEY GENERAL WILLIAM TONG: So --

SENATOR ABRAMS (13TH): -- this in our community?
ATTORNEY GENERAL WILLIAM TONG: -- let me complete my previous thought, which is, as far as I know, the Ninth Circuit, which is one of the highest federal courts in the land, based on the west coast. The Ninth Circuit is, as far as I can tell, the highest court that has passed on this issue. And the Supreme Court denied cert on this case, meaning the Supreme Court declined to take it up to date or at least in that case. So, as far as I can tell, the Ninth Circuit’s word on this issue on a statute that closely mirrors this draft stands as upholding the constitutionality of language much like the one in this draft.

In talking about the need, I’m aware of the Hartford example. I visited the Hartford example personally. It does seem to me to be very close, a pregnancy, a crisis pregnancy center, I will describe it as being right next to another women’s reproductive healthcare provider that provides abortion. They seem to be very close; the names seem to be easy to conflate. They’re on the same campus, in the same, essentially the same location. So, I have firsthand experience and knowledge of, of that example. I’ve also reviewed a number of websites and advertising by such healthcare centers here in Connecticut. They strike me as potentially misleading. They make reference to abortion and abortion-related services. They do present images that suggest that healthcare is being provided. I’m really providing this information based on my initial reaction and not on a thorough analysis, but I did go back and review the factual record before I testified and have seen evidence that suggests to me that it could be misleading or deceptive.
SENATOR ABRAMS (13TH): Thank you very much.

REP. STEINBERG (136TH): Representative Cook, followed by Representative Candelora.

REP. COOK (65TH): Thank you, Mr. Speaker. Hello, Attorney General, it’s nice --

ATTORNEY GENERAL WILLIAM TONG: Hello, Representative, it’s nice to see you.

REP. COOK (65TH): -- to have you in front of us. It is very strange to have you on that side, but we’re happy that you’re there. I just have two quick questions. Piggybacking on the conversation on the Ninth Circuit Court on the west coast.

ATTORNEY GENERAL WILLIAM TONG: Yes.

REP. COOK (65TH): In the State of Connecticut specifically, have we had any legal challenges in this regard?

ATTORNEY GENERAL WILLIAM TONG: I’m not aware of any.

REP. COOK (65TH): Thank you. And then the next question that I have is, our former person to testify had spoken about the false representation of people wearing white coats. So, my question in that, as we talk about consumer protection and specifics and the law, I, I struggle sometimes with the identity of whether you wear a white coat or pink or what have you, and we know we’ve done identification legislation here for badges on your, your position and your credentials.

In the consumer protection rights component of the law, and false representation, would that fall under
any of that, if you’re identifying yourself possibly as a medical professional and you are not?

ATTORNEY GENERAL WILLIAM TONG: So, there’s nothing in the law that says, white coat, if you’re not a doctor equals deception. That is a fact-specific inquiry that depends on the case. And if we had a case and it were litigated, a judge or a jury would decide whether or not the wearing of a white coat in that instance actually deceives somebody. But let me just say, I walked in, there’s a couple of people behind me wearing white coats, I assumed immediately that they’re doctors. But that’s an important point, right, and I think that’s probably how a judge or a jury would see it. And if we decided to bring an enforcement action, we would weigh whether the people wore white coats, whether the white coats had embroidery, whether there was advertising that featured white coats, whether there was language that suggesting that they were healthcare providers or doctors. I think it’s really important to note that some people might say that this is a healthcare facility or that they provide medical services or that they are medically trained staff, but they may not be medical doctors. And I think that that, it depends on the level of detail to determine the level of deception.

REP. COOK (65TH): Thank you for that. Thank you, Mr. Chair.

REP. STEINBERG (136TH): All right. Representative Candelora, followed by Senator Lesser, followed by Representative Klarides-Ditria.

REP. CANDELORA (86TH): Thank you, Mr. Chairman, and thank you, Attorney General Tong.
ATTORNEY GENERAL WILLIAM TONG: Good to see you.

REP. CANDELORA (86TH): You too. I guess I was gonna start out with a different line of questioning, but I want to pick up where Representative Cook left off, because I think this sort of points to one of the issues. You know, earlier we had talked about the language of false, misleading and deceptive well established. And when you think about advertising, you know, the words are on the print and I think it’s more definitive.

The colloquy that I just heard is now getting to the way people dress and whether or not that could rise to a cause of action. And so, can you, I guess understand or appreciate where this language could potentially be gray enough, where this industry is concerned on how to even dress, if they’re trying to perform a service versus, you know, an internet advertisement; in both situations potentially what I’m hearing is the State of Connecticut could have a cause of action for either one.

ATTORNEY GENERAL WILLIAM TONG: I would find it hard to believe that standing alone the mere fact of wearing a white coat would be sufficient for the State of Connecticut acting through its Attorney General to bring a cause of action.

As you know, Representative Candelora, as former colleagues on a judiciary committee, you know, I have applicable duties as all lawyers do, not to bring frivolous cases or lawsuits that are totally unjustified or unsupported by the facts.

So, I think you’d have to have a pretty compelling set of facts in order to bring an enforcement action. So, it would go well beyond somebody’s mode
of dress. It would be their mode of dress, coupled with their public advertising, coupled with statements that they’ve made to people. We’ve heard reports of people soliciting on the street, you know, in public spaces or even in parking lots.

So, all of that would have to come together to make a compelling case for me or an Assistant Attorney General to walk into court and say with a straight face, we have a good cause of action, judge, we should proceed, beyond for example, a motion to strike or a motion to dismiss of some kind.

So, with that being said, the second point which I think you were alluding to is, if this has the salutary effect of encouraging people to thing twice about making misrepresentations in an area where people are vulnerable or easily deceived or are facing what is probably the biggest crisis in their life, certainly at that moment, maybe for their entire lifetime, an unwanted pregnancy. I can’t imagine how hard that must be, particularly in most cases for a young woman.

Facing that crisis in one’s life, we want people, service providers to be particularly careful and thoughtful in the manner in which they engage with someone facing an unwanted pregnancy. And if they need to think twice about wearing a white coat because they’re not a doctor, I think that’s a good thing.

REP. CANDELORA (86TH): And I think, what I’m concerned about is, I think these faith-based services are very important in our communities because women that have unwanted pregnancies can
also be faith based. And so, they might want to identify to provide those services.

My concern, and why I’m asking this question is, any legislation we craft, I want to make sure that it would be narrow enough to not discourage these institutions from even existing in the first place.

The difference between this legislation, I think, and my recollection with CUTPA is that, am I correct, under CUTPA, it is a private cause of action; but in all of those cases, the Attorney General is, is made party to those suits, those lawsuits in terms of you receive notice of them when a private individual files a CUTPA action, am I correct?

ATTORNEY GENERAL WILLIAM TONG: Right. So, in, in, under CUTPA, in coordination with the Department of Consumer Protection and the Commissioner, we can bring an action in the name of the State of Connecticut. If there is a private right of action, then yes, the Attorney General gets notice. There’s a three-year statute of limitations on the private right of action, which is an important detail.

REP. CANDELORA (86TH): And have you received any cases dealing with pregnancy centers alleging, under CUTPA, deception or --

ATTORNEY GENERAL WILLIAM TONG: I’m not aware of any. I should know, as you know, I’m still in my first 30 days, so.

REP. CANDELORA (86TH): So, and I appreciate that. I say that too because I’m wondering if, if in fact a court has made the determination that the contractors would not fall under CUTPA?
ATTORNEY GENERAL WILLIAM TONG: I’m not aware of any such determination in this state. I’m aware of a Massachusetts precedent that, as a lawyer, gives me pause. And under Massachusetts law, and I am not intimately familiar with the facts of that case. I do know the holding. But under Massachusetts law it calls into question whether in Massachusetts the conduct that we’re discussing now at a, you know, we’ll call it a limited pregnancy services contractor, whether that’s covered by Massachusetts’ version of their Unfair Trade Practices Law.

REP. CANDELORA (86TH): Thank you. I don’t have any further questions.

REP. STEINBERG (136TH): Senator Lesser, followed by Representative Klarides-Ditria, followed by Representative Hennessy.

SENATOR LESSER (9TH): Thank you, Mr. Chairman, and thank you, Mr. Attorney General for coming here today. I was just sort of following up just real quick on, on Representative Candelora’s testimony. I was struck by his choice of phrase at the sort of outset of his line of questioning, which is to refer to the, to the standards as an industry. I think one that I think is instructive in how we might be able to view them with regard to the CUTPA and commercial speech. But I guess I wondered if you could clarify a little bit more on what the Supreme Court held last year, in 2018, in the case titled, National Institute of Family and Life Advocates vs. Becerra. My understanding is that concerns, although it concerns somewhat similar areas, it was a very differently constructed statute in the California statute that the Supreme Court struck down on a narrow 5 to 4 margin, involved the issue
of compelled speech by centers. Is there any provision of the bill before us, that, that concerns compelled speech?

ATTORNEY GENERAL WILLIAM TONG: No. It’s a very different set of facts. We had an informational hearing on that case and its implications last year in the Judiciary Committee. This is a different set of facts. And, and again, I think great lengths were taken to ensure that the language here closely mirrored the language that was accepted by the Ninth Circuit.

SENATOR LESSER (9TH): And so there’s nothing, through you, Mr. Chairman, there’s nothing that in this proposal here that would seem to cross, in your professional opinion, any requirement that the Supreme Court has laid out with regard to compelled speech. Thank you.


REP. Klarides-Ditria (114TH): Thank you, Mr. chair. Thank you for your testimony today. Nice to see you.

ATTORNEY GENERAL WILLIAM TONG: Nice to see you.

REP. Klarides-Ditria (114TH): Just one question. Do you feel your office will have to hire any additional staff to address these concerns?

ATTORNEY GENERAL WILLIAM TONG: No.

REP. Klarides-Ditria (114TH): Thank you.

ATTORNEY GENERAL WILLIAM TONG: You’re welcome.

REP. Klarides-Ditria (114TH): Thank you, Mr. Chair.
REP. STEINBERG (136TH): Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chair. Attorney General Tong, it’s nice to see you.

ATTORNEY GENERAL WILLIAM TONG: Nice to see you, Representative.

REP. HENNESSY (127TH): Thank you. So, I just wanted to, you know, weigh in on the aspect of the white coat. Obviously, the white coat has a loaded image in the public mind. It’s, it’s, it’s not by accident. The religious clergy, they have their, their clerical uniforms and the medical field has their uniforms also that they, that means something. It means, it means respect, it means, the medical field.

So, I just wanted to point that out. Thank you, Mr. Chair.

REP. STEINBERG (136TH): All right. Any other comments or questions for the Attorney General? If not, again, thank you for your testimony --

ATTORNEY GENERAL WILLIAM TONG: Thank you.

REP. STEINBERG (136TH): -- and for your patience. We have concluded the first hour. We will be moving and alternating now between members of the public and elected officials. We’re on Senate Bill 807, Dr. Bill Nash, if he’s available.

WILLIAM NASH: Good morning. Senator Abrams, Representative Steinberg, and Members of the Public Health Committee, my name is Dr. William Nash. I am here representing the Connecticut State Dental Association, in terms, and we are referring to the bill, Senate Bill 807.
As you’ll see from my testimony that this is a request merely to lay a, a deadline that will, that is for dental assistants to complete certification of an exam on infection control.

This is, would be the third time this bill has been up, this deadline has been extended. And the problem here basically is that as, in my testimony, the exam that was chosen had a high failure rate for a lot of the dental assistants, about 30 percent failure rate.

Now, the problems are, there are many problems with this exam. The exam is meant to measure excellence in this field, it’s not measured, it’s not designed to measure competence and that’s what we need, we need competence. We need dental assistants to know what to do, when to do it, and materials, proper materials and that sort of thing.

So, I know the barrier has been that many of the assistants that have failed have English as a second language. The exam is given in English. And so that results in a certain amount of failures just on that level. Right now, Public Health Committee, UConn Dental School and the CFDA are working together to develop an exam that will accomplish what this bill intends to do, which again is to test competence and the ability to do their jobs properly without asking questions that are in our minds irrelevant.

I cite one of them in the testimony about the hand sanitizer. I didn’t know that either, by the way. So, any questions?

REP. STEINBERG (136TH): Thank you, Doctor, for your testimony. We do recognize it’s been a problem and
thank you for pointing out that it’s often a language issue, which has led some people to repeatedly fail this test. And we are trying to address it in an appropriate manner in conjunction with the Department of Public Health.

WILLIAM NASH: Okay.

REP. STEINBERG (136TH): Comments or questions? Are you going.

SENATOR SOMERS (18TH): Yes. Thank you, Doctor, is it your experience that people who might not be able to pass this test are still competent at the, at the job requirements for it?

WILLIAM NASH: Yes. I mean, you know, we know several instances of assistants who have been working under the supervision of a dentist and doing these procedures properly for several years and they just have a problem with exams. Some people have problems with exams. I might also point out that the, a fee for the exam is quite high, it’s $250, which is often borne by the employing dentist. But if you’re someone who is not presently employed or you have a dentist who chooses not to pay that fee, that’s a lot of money for someone in that, that practice.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Mine is basically along the same lines. So, in your opinion, delaying this further doesn’t impact the health of dental patients in the State of Connecticut?

WILLIAM NASH: No, because I think the people who have failed the exam, it’s been at that barrier we
are talking about that the exam is not designed to measure competence. And I think, and ultimately, the responsibility for this lies on the dentist. We have to be sure that they are doing their jobs right. And so, you know, we should be, we should be on top of them already.

REP. STEINBERG (136TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. Good morning.

WILLIAM NASH: Good morning.

REP. ZUPKUS (89TH): Just a simple question because I agree, competency is much more important that somebody can do their job, knowing how much alcohol is in hand sanitizer or something, I have no idea.

How many people have lost their jobs due to this testing right now?

WILLIAM NASH: No one has lost their jobs because the deadline has not been crossed. But the estimate is somewhere between 6 and 800 people.

REP. ZUPKUS (89TH): And is that of April? When is the deadline?

WILLIAM NASH: April 1st is the deadline.

REP. ZUPKUS (89TH): Right. Okay. Thank you.


SENATOR SOMERS (18TH): Yes, good morning, and thank you for your testimony. We have a similar situation with funeral directors in the past few years, where we were able to extend the limit for them to take their exam. From what I’ve learned, this is really based on infection control, how we handle certain
things or that’s the area that there’s the issue in. And if the dentist is ultimately responsible, has the dentist had to take this exam and would they pass?

WILLIAM NASH: I certainly hope so. Things have obviously changed since I was in dental school. And we have continuing education courses. Dentists, it’s certainly the obligation of dentists to be able to do this sort of thing. I know that at UConn, they’re basing this exam that they’re developing is based on what they give the students. So, so it’s the same material basically.

SENATOR SOMERS (18TH): And has there been any reported incidents of infection transmission because of lack of infection control procedures in dental offices that you are aware of that have been reported to the Department of Public Health?

WILLIAM NASH: No examples of disease transmission, no. There’s been complaints about what seemed to be improper practices from dentists. But I’ve not heard of any transmission of diseases.

SENATOR SOMERS (18TH): Thank you for your testimony.

REP. STEINBERG (136TH): Thank you. Other questions or comments? If not, Doctor, thank you for your testimony today.

WILLIAM NASH: Thank you.

REP. STEINBERG (136TH): We’re now gonna alternate back to elected officials. I understand that we have another elected official who is time constrained and is at the end of his window. If everybody’s okay with it, I’d like to bring forward
Mayor Bronin of the City of Hartford. Welcome, Mayor Bronin.

MAYOR LUKE BRONIN: Good morning, thank you very much, Mr. Chairman, members of the committee. I am here today to testify in support of House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

I am proud to be here again to support an ordinance, excuse me, a bill that is similar to the ordinance we have enacted at a local level. I think many of you know, we passed an ordinance about a year ago that is now in effect in the City of Hartford. That ordinance was passed when we became aware of deceptive practices occurring inside the City of Hartford, where a crisis pregnancy center located, just outside of the doors, just across a few feet away from a full service clinic. And its own words, was designed and intended to “lure” women away from that full service clinic.

Our ordinance contains two basic components. The first requires a posting of notice, if there are no medical professionals on site. And the second, as is the case with this proposed bill, it prohibits deceptive or misleading practices.

I believe that this is something that one should support, regardless of one’s position on choice that this is about the basic principle that women deserve access to accurate information when they’re making decisions about their health and their future and that no woman deserves to be deceived or mislead about the range of options being presented to them or the range of, of counseling or healthcare options that are being offered where they are.
So, I strongly encourage the committee to support this bill. Encourage the legislature to do the same. Thank you very much for the chance to testify.

REP. STEINBERG (136TH): Thank you, Mr. Mayor. I believe the ordinance that is now in effect in the City of Hartford is different than the original ordinance that was passed a little while ago, based on information from the California decision. Could you just clarify what the difference is?

MAYOR LUKE BRONIN: Sure. The ordinance actually is in effect as it was originally drafted. We enacted the ordinance with a delayed implementation date of July 1, so that we could assess the Supreme Court’s decision. We examined the Supreme Court’s decision closely. We’ve consulted with a number of lawyers and we believe that the local ordinance would be upheld, that our ordinance is consistent with, with the decision that ultimately came down.

So, we, as of October 1, we then pushed a little bit further to gain greater confidence, but as of October 1, our ordinance as enacted is in effect.

REP. STEINBERG (136TH): Thank you, Mr. Mayor.

SENATOR ABRAMS (13TH): Good morning, Mayor, thank you for your testimony. As you look at putting this ordinance into action, do you feel, I feel there’s been some questioning along the way. I don’t know how long you’ve been here, but about some ambiguity as to what would be deceptive practices versus not, versus a center that just wants to provide care other than abortion, more religious counseling and
that somehow they’d be held to an unrealistic standard of some kind. Could you speak to that?

MAYOR LUKE BRONIN: You know, I would first of all, defer to the testimony of our Attorney General, who recently testified. Although I am a lawyer, I’m not here in my capacity as a lawyer. I would say though that there’s extensive case law on what a deceptive practice is, and I don’t think that concerns about ambiguity should cause anyone to object to this proposed legislation. I mean most of the text, as I recall, have to do with the likelihood that the conduct or the advertising would deceive, you know, whether a reasonable person would interpret the, the advertising or the speech in a certain way and whether that misleading or deceptive conduct or speech would cause someone to act in a certain way as a result. So, I think there’s extensive case law on what a deceptive practice is.

SENATOR ABRAMS (13TH): Thank you.

REP. STEINBERG (136TH): Yes, please.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you. I guess, as a Mayor, you must be familiar with other examples of, of just in terms of commercial speech of this is being engaged in deceptive marketing practices just as a normal course of consumer protection. Can you speak to specific concerns that you saw that caused the city to enact this ordinance? What, what, what problem are we trying to solve here? Mayor, I think your microphone may have gone off.

MAYOR LUKE BRONIN: Is that better? Thank you, Senator for the question. We were responding to complaints that were brought to our attention from a
woman who had, who had themselves been subject to deceptive practices in Hartford. And again there were a couple of, a couple of things in particular that were concerning to us.

As I mentioned, the particular crisis, pregnancy center in Hartford was deliberately located just across the way, I think within about 12 feet from the doors of the existing full-service clinic that on some occasions staff at the crisis pregnancy center would actually tell women arriving for their appointments at the clinic that their appointments were, in fact, at the crisis pregnancy center. That staff of the crisis pregnancy center explicitly said in social media posts that their objective was, “to lure women away from the full service clinic.” That the way in which the clinic was set up was designed to create the impression that it was a medical office. Everything from, you know, rooms with exam tables and pharmaceuticals on the shelves to the, the attire of the professional of the staff of the clinic.

So, for a number of reasons we were concerned that the objective of that crisis pregnancy center was to deceive, which is why we focused on two things. One, requiring disclosure whether there was, in fact, medical personnel on site. And number two, a prohibition of deceptive practices generally.

SENATOR LESSER (9TH): Thank you.

REP. STEINBERG (136TH): Representative, no, no, no. Again, Senator Somers.

SENATOR SOMERS (18TH): Yeah, thank you for your testimony and what you’ve described doesn’t sound like it is something that should be allowed to
happen from your description. I have a question, was, is there or was there medical personnel assigned to this clinic? Was it a clinic, a center, what were they called?

MAYOR LUKE BRONIN: I believe it was called, the name of this particular center was, I believe, called the Hartford Women’s Center. It was not a full service clinic. There, there --

SENATOR SOMERS (18TH): My question was, did they have medical staff?

MAYOR LUKE BRONIN: To my knowledge, they did not have medical staff. Of course, if they did have medical staff, then they would not be required to post a notice that they do not have medical staff. But when, when women are coming in there to consult with the expectation that they’re talking to a medical professional who can offer them objective advice and counseling on a full range of options available to them, they have a right to know whether or not they’re medical staff.

My understanding is at the time we enacted this ordinance, there were not medical staff. I cannot speak to whether there are currently medical staff there.

SENATOR SOMERS (18TH): Okay. Because I heard you say, unless I didn’t hear it right, that one of the misleading items was that when a person came in, there was pharmaceuticals on the shelf. And I’m struggling to understand how they could have pharmaceuticals on the shelf if they didn’t have medical staff there to be able to have the pharmaceuticals on the shelf?
MAYOR LUKE BRONIN: So, you’ll, you’ll forgive me if I probably spoke overly broad if there were pharmaceuticals. I don’t know whether they were prescription medications on the shelf or not. There were, there was equipment and they may have been over the counter drugs. But I think the atmosphere of the clinic, as described to us, was one that was designed to create the impression that it was a medical office.

SENATOR SOMERS (18TH): Thank you for that clarification.

MAYOR LUKE BRONIN: Thank you.

SENATOR SOMERS (18TH): So, if a clinic or a center, I keep saying, I don’t want to mislead with my, with my language. So, if a center has medical staff, let’s, I’m saying, three times a week, how would you handle that? Would you put the sign out that says, no medical staff only on the days that they’re not there?

MAYOR LUKE BRONIN: So, I think the first important clarification, Senator, is as I understand it, the bill that’s before the committee does not have a similar requirement that there’s a disclosure of, you know, the absence of medical professionals. In Hartford’s case, at any time there is not a medical professional on staff, then we would, our law, our ordinance would require that such a notice be posted.

SENATOR SOMERS (18TH): Thank you.

MAYOR LUKE BRONIN: Thank you.
REP. STEINBERG (136TH): Are there comments or questions? If not, thank you, Mayor for joining us today to --

MAYOR LUKE BRONIN: Thank you.

REP. STEINBERG (136TH): -- bring your perspective from Hartford. Thank you very much for your time. We’ll now shift back to the members off the public. And next up on Bill No. 807, is Steve Karp, K-a-r-p.

STEPHEN WANCZYK-KARP: Good afternoon. I’m fighting a little bit of laryngitis, it is a little problematic for testifying, but so is the language in the bill that we’re talking about is a little problematic. I’m Steven Wanczyk-Karp, I’m Executive Director for the National Association of Social Workers, Connecticut Chapter.

We’re here in opinion and asking to delete Section 13 of Raised Bill 807. We think the intent of this bill made, was meant to, for us, but reality, by tying in the title protection to licensure, it means that only licensed social workers could call themselves a social worker. That means that all people with bachelorette degrees and social workers, I think seven programs in Connecticut, would not be able to use the title social worker. Any master level social worker, who’s not licensed would not be able to call themselves a social worker. At least 60 or 70, and there’s, I think would not be able to call themselves a social worker under this, under this language. You need to understand that licenses for clinical practice and you can’t practice clinically without a license. However, there’s many other aspects of social work practice that are not clinical. Nonetheless, these are individuals who’ve
gotten their degrees in social work from an accredited program and have the right and deserve the ability, the ability to call themselves a social worker.

As this committee knows, there’s half a dozen bills that were introduced by legislators, asking that there be generic title protection, meaning that there would be title protection for the term social worker. Those bills cover the waterfront, if you will, where this language really is very restrictive would become very problematic and actually all of our MSW and BSW programs would be negatively affected by many of their graduates who simply would not be able to utilize the term because it was entirely restricted to a license.

So, we do ask you to support title protection in general, but to delete this section of this bill and move forward with other legislation that addresses the full needs of our profession.

REP. STEINBERG (136TH): Thank you for your testimony and for clarifying where we may not have considered all the ramifications of those in the industry. You understand the problem that we believe exists is that there are individuals out there who because of the sort of generic understanding of the term, social worker, may be misrepresenting their backgrounds and levels of education. You know, by deleting this section, is that sufficient, do you believe, for us to differentiate between those who have gone for the extra education and how do we refer to those who have not achieved that so that the public has a clear understanding of the difference?
STEPHEN WANCZYK-KARP: So, I think for people with social work degrees, there’s a number of other titles that could be used, human services worker, case manager, social services worker, protective services worker, case worker, there’s a lot of other titles that would indicate that they hold a degree. So, we’re not saying people shouldn’t practice or be able to practice, we’re just saying that if you call yourself a social worker, you should have the degree and the clients should know that you’re a degreed individual. By taking this section out and moving forward with one of the bills that was raised, by tougher title protection, that would really rectify our concerns. We do know of practice situations where people have been harmed by someone called a social worker, one very good example, is that we had a situation where someone called our office because a worker was contacting the client and asking her out, repeatedly asking her out for a date. The client contacted the agency. The agency said, well, we terminated him. He no longer works here. They contacted us, but they’re not a social worker, so there’s no way you can file a complaint with the Department of Public Health or through us.

So, this is somebody who’s out there saying they’re a social worker, violating ethical practice, and it reflects on our practice as well as being harmful to clients, so, that’s where we’re really sort of getting at with the legislation we introduced.

REP. STEINBERG (136TH): And thank you for that. And we, we appreciate your collaboration in making sure we get it right for taking the time to testify today. Are there others who would like to comment, or questions form the committee? If not, thank you
for your testimony today and we really appreciate it.

STEPHEN WANCZYK-KARP: Thank you.

REP. STEINBERG (136TH): We’ll now rotate back to elected officials. If I have it right, there’s been a little bit of jogging positions, it would be Representative Dubitsky next. If not, you guys can fight it out, but I think that’s right.

REP. DUBITSKY (47TH): Good afternoon, Chairs and Vice Chairs, Ranking Members and Members. I’m State Representative Doug Dubitsky. I’m from the 47th District, which is a big swath of Eastern Connecticut. With me today is Alice Ainsley and I’d like to give her an opportunity to make a quick statement and then I’ll have some remarks as well.

ALICE AINSLEY: Good afternoon, my name is Alice Ainsley. I was going to the womens center since 2012. I found out I was pregnant with my son. I moved recently from New York. I was alone. I have very little family here in Connecticut. I had my son very early. He was born premature, 24 weeks. He was born one pound. He is 6 years old now. The womens center helped me a lot. They helped me had a community with my child, through sign language, they showed me different things to take care of him. They never neglected me. They never lied to me. We prayed together beyond his health. And I’m very thankful and I’m helpful, thankful and I’m glad that I met them, and they helped me to this day.

REP. DUBITSKY (47TH): I’ve been through much of the testimony that’s on the system. I admit I didn’t read it all, but I did spend quite a bit of time looking through it. And I didn’t see anybody who
testified who claims that they were deceived in any way by any of the practices of any of these centers. There appear to be legislators who claim it and elected officials who claim that this is an issue. But it appears to me to be a solution without a problem.

Some of the other testimony was about a deceptive atmosphere. We’re gonna regulate atmosphere now? People wearing lab coats. I thought back in my memory to any doctor I’ve ever had, none of my doctors wore lab coats. However, I had a couple of mechanics that wore them. I had, there are people in the meat processing business that I’ve been involved in who wear lab coats. There are people when I, I did some work in Germany all the stagehands wore lab coats. So, wearing a white lab coat does not mean that somebody’s a doctor. It means they have clothes that they don’t want to get soiled, and that’s not an indication of any deceptive practice.

There is also some testimony about where these facilities are located. They are located where they can find space, where they can find women who need their services. It would be pretty silly to locate them in places that are not convenient to the people who they’re seeking to give services to.

There was also some testimony about having it be deceptive that they go out and solicit in parking lots and at night. They’re a faith-based operation. They go to where the people are that they want to be able to give services to. And if that means finding women who are in a parking lot at night or homeless or sleeping under a bridge, well, that’s what they
do. They go there and they try to give services to those people.

So, again, I’ve not seen that there’s any ground swell of people claiming to have been deceived. And I believe this bill, 770, is a solution in search of a problem.

REP. STEINBERG (136TH): Thank you both for your testimony. Thank you very much for taking the time today to, to give us your personal story about your experience with us. Representative, I do have a few questions for you.

You made reference to the fact that the preponderance of the testimony on the website may indicate one direct. As a Representative, do you typically only look at the numbers of people who testify on one side or the other before you make up your mind on how to vote on a particular bill?

REP. DUBITSKY (47TH): No, I don’t. But I do go through the testimony and I see what people are saying. And I didn’t see any, not a single person who claims to have been deceived. Now, I could have missed it, there’s an awful lot of testimony on there. And as I said, I admit, I didn’t read every single one of them. But I did spend a good deal of time looking through that and I didn’t see anybody who claimed to have been deceived.

REP. STEINBERG (136TH): Well, I think you raise a good point. There is a lot of testimony. Every member of this committee will take that very seriously. I think that every member of this committee will also take very seriously the, the, not simply the number, but the specifics related to
a lot of the testimony. And we take all of that into account on this committee.

Is it correct, Representative, that you are an attorney?

REP. DUBITSKY (47TH): That’s correct.

REP. STEINBERG (136TH): So, you must, I don’t know what area that you practice in, but you must have some experience with litigation as it relates to deceptive practices and untruthful advertising?


REP. STEINBERG (136TH): So, then you are familiar with the specifics of the bill. You heard the testimony today of our Attorney General. Do you agree that it is possible for us to build a case, conceivably, based upon the facts that meet the standard for litigating on such an issue?

REP. DUBITSKY (47TH): I’m sorry, are you saying that based on what the Attorney General said, is there a case against a specific center or --

REP. STEINBERG (136TH): Actually, that’s not what I’m asking, Representative. Let me try to make that clear for your behalf. The Attorney General made some statements about his understanding about litigating lawsuits as they relate to deceptive practices and untruthful advertising. I just wanted to get your point of view as to whether you agree or not that there could be sufficient evidence to make such a case in the State of Connecticut?
REP. DUBITSKY (47TH): Again, you’re asking me if it’s possible under the Unfair Trade Practices Act to make a claim of unfair and deceptive advertising?

REP. STEINBERG (136TH): I am asking that question, sir.

REP. DUBITSKY (47TH): I imagine that a, if an entity engaged in unfair and deceptive trade practices, they would be subject to the Unfair and Deceptive Trade Practices Act.

REP. STEINBERG (136TH): Did you also happen to hear the testimony by the Attorney General which relates to what he believes to be a bit of a loophole as it relates to noncommercial activities and the importance of this bill to meet that loophole?

REP. DUBITSKY (47TH): I was out of the room when he mentioned that, but if that is a loophole in the Unfair and Deceptive Trade Practices Act, my suggestion would be, why don’t we just say, okay, that now covers entities that are not commercial entities as opposed to targeting specifically one group of faith-based centers, if, if, if, if the Attorney General has identified a problem with the, with CUTPA, let’s fix CUTPA to encompass any noncommercial activity. But to say that it only applies, this loophole only applies to faith-based pregnancy centers, I think is, is unfairly attacking a section of our community that does a lot of good and that has done nothing to be targeted.

REP. STEINBERG (136TH): Thank you. I think you raise an interesting point that maybe we should consider the broader thing, that might be a matter for the Attorney General to recommend. We’re here today to talk about a very specific instance. I do
disagree with you that this is intending to attack any party. This is merely, as we often do in government, an effort to distinguish between those who are operating in good faith, trying to help people and those who may engage in activities that are less than truthful and that may mislead people into making decisions they might not otherwise make if they had full information.

So, those are the distinctions we’re trying to make here with this bill. We’re working very hard to make sure that we get the language correct so that we do not discriminate, that we are not unfair to any party. And we appreciate the fact that you are supportive of this community, as we all are within the context of what their free speech and free religion rights might be.

Senator Abrams.

SENATOR ABRAMS (13TH): Just a quick comment. Thank you for your testimony today and for coming in. And it’s nice to hear that your son is doing well and that you got the services that you are looking for. So, all of those are wonderful things. And I want to reiterate what Representative Steinberg was saying is that it is not our intention to keep someone like yourself from getting the services that you’re looking for, only to make sure that if women are looking for different services that they’re clear about what different centers offer them and do not.

So, thank you very much for being here. Appreciate it.

ALICE AINSLEY: Thank you.
REP. STEINBERG (136TH): Senator Somers, followed by Representative Candelora.

SENATOR SOMERS (18TH): Good afternoon now and thank you for being here and sharing your story with us. I have a question for Representative Dubitsky. Representative Steinberg had just asked you about what the Attorney General had said and your opinion, and it’s an interesting idea to sort of close the loophole on the Unfair Trade Act. However, one of the things I heard the Attorney General say, which for me is ambiguous is, he used the words potentially deceptive and potentially misleading. And I think that leads us down a very nebulous description. I’m struggling with what specifically deceptive may mean, let alone potentially deceptive or potentially misleading.

How, in your legal opinion, do you define potentially misleading and potentially deceptive?

REP. DUBITSKY (47TH): Well, I can’t give you a legal opinion or I’d have to charge you for it. But I, I don’t know what potentially misleading is or potentially deceptive. It either deceived somebody, in which case they may have a claim, or it didn’t. To say that something is potentially deceptive, essentially gives the government the power to control speech. Everybody can be confused by something. The question is, did something deceive you into doing something that you wouldn’t have already done? You know, that’s a very different standard than something that is potentially deceiving. You know, the Attorney General and some of the other witnesses talked about lab coats, you know, when I see a lab coat, I don’t automatically think doctor, some people may.
So, is wearing a lab coat potentially deceiving. You know, I see guys that work in the freezers, they wear lab coats all the time. You know, is the fact that a, a crisis pregnancy center is located directly across the street from an abortion clinic, is that deceptive? You know, would somebody, if somebody, you know, looks at their GPS and goes to the left instead of the right, they can say that they were deceived in some way.

But, you know, why was that put there? They say, to lure people over there. Well, their, their business model is to give services to people in crisis. So, when people in crisis are in that neighborhood, they are there to service them. So, I have no idea what potentially deceptive is, especially since I have not seen anybody who claims to have been deceived.

SENATOR SOMERS (18TH): Thank you. That’s something that is concerning on the testimony that I heard with potentially in front of those two words. Thank you.

REP. STEINBERG (136TH): Before I turn it over to Representative Candelora, I just want to follow up on a comment you made. I do believe that contact is relevant in these instances. If I’m in the meat packing district and I see somebody in a white coat, I would not necessarily assume that they’re a medical practitioner. However, in a setting which purports to be a clinic or a health center, I believe that there’s perhaps a different expectation and perception based upon the average person’s experience.

So, I do find your argument a little disingenuous. Representative Candelora.
REP. DUBITSKY (47TH): Well, I would just say to that, if you start talking about potentially deceiving in context, then it becomes a very subjective criteria and a very nebulous standard. And if you’re going to put a law into effect in this state that is going to potentially subject people to liability, I think it’s, it’s the legislatures obligation to make it clear enough that they know what is allowed and what is not allowed. And the standard that, that the Chairman has just articulated, sounds very subjective to me and if I were representing one of those centers, I would have no idea what to tell them they can and can’t do.

REP. STEINBERG (136TH): I’m not a lawyer, sir, and I understand that you are. But I am aware of something that’s called a reasonable person standard and I do believe that in the context of a number of different facts purported, the context is relevant. I think a reasonable person would be able to make a distinction between somebody in a meat packing context and a medical context or a health clinic context. So, I guess we’ll agree to disagree on that point, sir.

Representative Candelora.

REP. CANDELORA (86TH): Thank you, Mr. Chairman. I think, I first want to thank you for coming in and testifying and sharing your story. It’s important for us to hear. And Representative, I should have probably asked this of the Attorney General, but you are a lawyer, you’re familiar with the laws. And I know you used the word, attack. And I think given the number of people that are here testifying against the bill, there seems to be that perception that there’s an attack.
And I’m thinking that we’re talking about, you know, this cause of action and what it means to deceive. But I just want to back up to Section 3 of this proposed bill, is essentially providing the Attorney General a private cause of action against a private business or a private entity, just generically speaking.

Are you familiar with any laws in the State of Connecticut that provides our Attorney General with the ability to bring a private cause of action against a business for deceptive practices?

REP. DUBITSKY (47TH): Well, in the CUTPA context, it would, the, a person who claims to have been deceived is acting as a private Attorney General, which is a, a term that means that they are acting not only on behalf of themselves, but on behalf of society. But at the same time, they’re required to notify the Attorney General and Consumer Protection that this is going on to allow them to step in and become parties to that cause of action or to bring their own cause of action but in that, in that action, so.

I can’t, just because I can’t think of one doesn’t mean one doesn’t exist. But I don’t know of any other statute, off the top of my head, where the Attorney General can just come in and file a civil suit based on, on what I think is going to be found to be very nebulous criteria.

REP. CANDELORA (86TH): And I appreciate that because, I think, you know, under CUTPA we do provide the notice to the Attorney General because I think that it’s broadly written to include any services because you have a public policy to want to
prevent deception. And so that sort of encompasses, you know, any service or any business that’s being deceitful. We have those statutes in place. But here what we’re attempting to carve out is a specific segment, a specific service that’s provided in the State of Connecticut that’s giving the Attorney General essentially a private cause of action, which is different because as we know, the state has the pockets. So, an Attorney General would never, would have all the money in the world and all the attorneys in the world to bring lawsuits against an entity who is then left to defend it, left to pay the higher insurance premiums and all the other costs associated with it.

As I wanted to put that on the record and ask that question at least of an attorney, because I think that’s a very different, the very distinction here of what’s going on with this legislation. It’s not just a private cause of action, but it’s enabling the state to take action against something that I think traditionally the State of Connecticut has never done before.

Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you both for your --

REP. DUBITSKY (47TH): Thank you.

REP. STEINBERG (136TH): -- time today. We will now return to Senate Bill 807. Next up is Gary, Dr. Gary Toubman, please.

GARY TOUBMAN: Dear Senator Abrams, Representative Steinberg, and Members of the Public Health
Committee, my name is Dr. Gary Toubman, and I am currently a general practicing dentist in Newington. I have lived and worked in Newington for over 36 years, and I am the incoming president of the Hartford Dental Society. I also have served in the United States Public Health Service, serving as a rural dentist in the 1980’s.

I am speaking in support of raised Senate Bill 807, expending the length of on-the-job training by six months will allow the Connecticut State Dental Association, UCONN, and the Department of Public Health time to work together to create an alternative to the Dental Assisting National Board infection control examination.

Currently, there are many competent dental assistants doing an exquisite job in their office with infection control, but they are not good test takers. Those with certain learning disabilities cannot complete the test in the given time frame and those of our assistants for whom English is their second language; for example, my dental assistant came from Russia at the age of 34 years old, also have trouble passing this commonly-known DANB, D-A-N-B, infection control exam. If these and my dental assistants are unable to pass this specific test, they will lose their jobs, with no exceptions. My dental assistant has told me and been told by many of her colleagues who have taken the exam, and ultimately failed, that it does not measure their knowledge of infection control processes and protocols.

Quite honestly, I am fearful that many talented dental assistants, and the vast majority of them are women, will be fired because they are forced to take
an exam whose format is unfair to them. For this reason, and the aforementioned issues mentioned previously, I urge you to support Section 14 of Senate Bill 807.

Thank you.

REP. STEINBERG (136TH): Thank you, Doctor. You’re not the first to testify here today about this problem. Obviously, the immediate remedy is to extend the deadline once again and to make sure we afford these people more time.

But perhaps you’d choose to comment on what the longer-term solution is. Clearly we cannot offer this test in a multiplicity of languages. And we also want this to be a fair standard for those who are going to be dealing with the public’s health.

Do you have any other thoughts on what we might do in order to make sure that those who are truly qualified are able to pass the test and provide care?

GARY TOUBMAN: Excellent point. And the way I’ll comment is, it’s my understanding that there are four different examinations available nationwide. And that the State of Connecticut has selected the DANB format. One option might be to select the different examination that other states might offer. I’m not an authority on which states offer what exams.

The second option that I potentially propose or that our Connecticut State Dental Association offers is more training, hopefully through the University of Connecticut to help with their mastery of infection
control as deemed by the Department of Public Health.

I will mention that infection control is a mandated yearly requirement by our Connecticut State Dental Association, and as Dr. William Nash who testified earlier, who is a past President of the Connecticut State Dental Association mentioned, is that we as dentists are openly responsible for the maintaining proper infection control standards in our office. So, that’s how I would address that, sir.

REP. STEINBERG (136TH): Again, I was really explicitly talking about the standard testing procedure by which we provide ourselves with assurance --

GARY TOUBMAN: Okay.

REP. STEINBERG (136TH): -- that people are qualified. Thank you for pointing to us that there are other test options. It’s again something that we’ll need to take up with the department to see if we can address this problem.

Are there other comments or questions from members of the committee? If not, thank you -- no, Representative Comey.

REP. COMEY (102ND): Thank you. I was just, thank you, chairman. Thank you for your testimony --

GARY TOUBMAN: You’re welcome.

REP. COMEY (102ND): -- sir. Is this just a written test that we’re speaking with, it’s not a hands-on test? Is there a hands-on portion?

GARY TOUBMAN: You bring up a great point. From what I’ve been told, it is not just a written test,
but it’s a timed written test. So, those people who might have a test-taking disability, and I’ve read in the paper frequently that there’s a lot of media about disabled standardization of disabled who are forced to take standardized tests. And there was this one in the paper about somebody in Connecticut engineering who has test anxiety syndrome. And that there was a contention with that individuals should be allowed an extended period of time.

For our requirement, which is at DANB test, it’s timed, and I’m also told that for each question that the test taker will engage in, if they get it right, then the level of the next question is harder. So, it’s not just a straight multiple-choice test. That it is really graded against those that are successful. So, I hope that answers your question.

REP. COMEY (102ND): Yes, absolutely. Thank you.

GARY TOUBMAN: Great.

SENATOR ABRAMS (13TH): Are there any other questions or comments? Thank you very much for your testimony.

GARY TOUBMAN: Thank you for your time, I really appreciate it.

REP. STEINBERG (136TH): I have a bad tendency to wander. Next up would be Representative O’Neill.

REP. O’NEILL (69TH): Good afternoon, and I want to thank the Chairs and the Committee and the Ranking Members for allowing me to testify on 6134 and for bringing 6134 to have a public hearing. Before I proceed, I have some written testimony, which I believe has been submitted. And I need to correct that to some extent. And towards the end of it, it
relates to the actions of the Southbury Board of Selectmen. And I just want to make it clear that the Southbury Board of Selectmen has postponed the action that I described there until they get some financial data. So, they didn’t just table it, but they tabled it with a concern about something in particular that they were looking for.

I’m not gonna read through my testimony, as I say, it’s been submitted to you. But just to briefly explain why this bill is here. The problem that this bill seeks to solve is that the Department of Public Health without either statutory authority or a regulatory authority or regulations they might have issued, has created a system by which an ambulance organization, if it seeks to go from basic life support services to advanced life support services, is required to get the permission or the support from the CEO, Mayor or First Selectmen of the municipality in which they are going to be operating.

For those of you that may not be familiar, as I was not familiar until recently, all of the towns in Connecticut, I believe, have at least one PSA, Primary Service Area, and that Primary Service Area provides basic life support. There’s the EMT who shows up when you call 911 for an ambulance. Not every community has a similar service area authorized for paramedic services. Some of those are still unassigned as I understand it. Southbury happens to be one of those communities with no such assignment. And what the Southbury Ambulance Association has been trying to do is to move from basic life support to advanced life support, so that they can have an in-town paramedic.
Currently there’s a contract with a commercial ambulance service that provides paramedic services by way of having a paramedic be dispatched from their location in Waterbury, which is 10 miles away, and they are then intercepted, or they get to the scene where the incident is occurring that needs a paramedic and they back up or they supplement the ambulance that has already been dispatched by one of the three ambulance services that exist in the town of Southbury. In that regard, Southbury is very unusual because most towns have only one primary service area.

For historical reasons, Southbury has three, one related to Southbury Training School, one for the rest of the town, most of it, and then one for a condominium complex called Heritage Village, which is a sort of self-contained adult community of about 4,000 people that for four decades has had its own ambulance operation.

There is, the problem is that if you don’t get the letter from the Mayor or the First Selectman, then you don’t even have a complete application in the eyes of the Public Health Department. And therefore, they won’t even consider the application and give you a chance as it were to make your case for why you should be upgraded.

Attached to my testimony is an OLR memo, not a full-blown report, but they did look into it, where they found that there was neither statutory or regulatory authority. And they consulted with the department and the department said they agreed, there is no statutory or regulatory authority that, to base this requirement upon. And they went on to explain, and there’s an attached email, I believe, from the
department’s legislative liaison that what they’re really trying to do is make sure the municipality is aware of the application and that they don’t have an objection to it. And to make sure that there’s an opportunity for interaction between the ambulance that’s seeking the upgrade and the municipality so that they can coordinate their various activities.

And what concerns me is that one individual has been empowered to make essentially a life or death decision about whether this application goes forward. And it could turn into a life or death decision in terms of the community itself, in terms of people’s, the service level that they get. And based on the statutes that we do have, and I did hear the buzzer, so I’m gonna try to wrap up. I think that the agency is imposing an undue burden on an applicant by requiring this letter.

And just to give you an idea of, and Southbury is apparently an unusually contentious community in this regard, the typical letter of support is, I’m told by the department four or five lines long. The letter that Southbury tried to discuss with it’s Board of Selectmen to come up with as a potential letter of support in a draft format, was five pages long, single spaced. And it ended up with about eight conditions, mostly relating to the finances of the ambulance organization, which according to the department are really not part of the whole consideration that they are making about whether or not to approve these kind of things.

But the purpose of this bill is to basically tell the department, stop requiring this letter before you even allow the people to file the application.
REP. STEINBERG (136TH): Thank you, Representative, for bringing this issue to our attention. You made mention earlier of the municipality having suspended a decision while they do financial investigations. Perhaps you would know, is the genesis of this particular requirement because of the municipalities fiscal responsibility with regard to these ambulances; why would the municipality be involved in the first place?

REP. O’NEILL (69TH): Well, as I understand it, and I’ve spoken to First Selectmen in another town right next door who also happens to ride the ambulances and is an EMT, and she has told me that the municipality has no responsibility for picking up the costs of when an ambulance run occurs. And so, it’s, it’s not clear to me what the, why there should be a concern.

I will tell you, in Southbury’s case, there is an ongoing disagreement between some of the people on the town boards, particularly the Board of Finance, which believes that the town is not being adequately reimbursed for the costs that it is paying for, it’s about $280,000 a year for a contract with Campion Ambulance and it’s receiving about $140,000 a year reimbursements from the, two of the three ambulances that do bundle billing that in effect collect money for the advanced life support services, the paramedic services that the town is paying to Campion. And apparently there’s a belief that they should be getting more. And there’s an argument about whether or not there’s, that they can prove somehow that they’re entitled to a larger share.

But that’s an issue about the financial arrangement between the town and the ambulance services that
effectively working as collection agencies for the town as opposed to whether or not the life support services, advanced life support services are really necessary in the town. In fact, the First Selectman of the town, as to my testimony, filed an application for advanced life support services to be done by the town through its police department, which is a little unusual because Southbury doesn’t have an organized police department, it still is a state trooper town. But be that as it may, the application was signed saying, we need basic life support services to be delivered locally in town. And yet it’s saying, but we don’t want it to be done by the people who are actually currently providing those kinds of services. That application was withdrawn because that was all contingent on the state giving to the town a free ambulance or, and other equipment as well without going through all the procedures of declaring surplus property and bidding it and offering it to the state agencies and all that sort of thing. But that’s a whole other story as well.

But the point is that there doesn’t seem to be a really good reason for why the financial disclosure that’s being asked for is being asked for, before the town will go forward with this application or allow the ambulance agency to go forward with the application. It’s, but what, you know, this may or may not ever affect Southbury, because if we do pass a bill, it will be October probably before it goes into effect, maybe even longer, maybe January of next year, maybe this will all get resolved long before then. But it highlighted for me something that when I asked, well, where’s the statute for this, why is it just the First Selectmen that makes
this decision and not the board or, you know, somebody else that’s involved with EMS services to make a decision because there are EMS committees, I guess in most or if not all towns to decide these kind of things. And I wasn’t really given a good answer, other than the agency said, well, this is how we want to do things.

REP. STEINBERG (136TH): Well, thank you for that clarification. You mentioned this may be resolved in Southbury. But for the broader benefit of all communities in Connecticut, are you aware of how widespread the problem is in terms of ambulance services, getting permission to upgrade to the advanced care model?

REP. O’NEILL (69TH): As far as I know, this is the only town, Southbury is the only town that I know of where this kind of a situation has occurred. There have been upgrades in other communities, for example, New Milford, which went through a process and did, in fact, this ambulance association did increase their level of service with the cooperation of the town.

And as I understand it, this has been at times like some kind of debated issue in other communities. So, I don’t know how widespread it is, but I know that it’s been coming up as more and more people expect to see a paramedic in town. The idea of a fly car coming in from a more distant location such as a city where you’ve got a commercial ambulance service to provide this sort of service, I think more and more people are beginning to believe that that’s just not good enough, that they want something that’s gonna be there in five or six minutes as opposed to 10 or 12 or 15 minutes to get
the, the transport or at least to get the paramedic to get to the scene. And this may be a function of the people watching things on TV where, you know, you call 911 and before you put the phone down, there’s a paramedic walking through the door, which may create unreasonable expectations of just how quickly things can be done.

But clearly it’s been going on for at least three years, this debate in Southbury about whether or not to have an impound or if they still rely on somebody from out of town to provide the paramedic services. And I think the consensus has drifted to the point where it’s gotten to, where people do expect that they want to go in that local paramedic. I’m guessing that that’s gonna be happening in other towns that don’t have a local paramedic, if they can figure out a way to do it. Southbury is big enough that maybe they can make it happen. Smaller towns may not.

REP. STEINBERG (136TH): One last question. I presume that you’ve had some communication with the Department of Public Health and that the reason this bill is coming forward is that DPH has not indicated their willingness to interpret that requirement differently than they have in the past?

REP. O’NEILL (69TH): That’s correct. They’ve, they’ve said that that’s there policy, that’s the way they’re doing it. And I’ve gotten a couple of emails from the legislative liaison. I spoke with the Commissioner. I spoke with the, well, then Commissioner Dino, and I went also with the head of the OEMS and they’re pretty much committed to continuing to do things the way that they are doing, even thought it at least strikes me as it’s not
really legally authorized statutorily or regulatorily authorized. And in addition to that, when I ask them what happens if you can’t, if there’s no letter forthcoming from a CEO or there’s a conflict, and the answer was, well, they need to talk to each other to work things out. And that’s, that’s good, that I think that they should encourage dialogue. But at some point, we’re talking about a very important public safety issue that needs to be resolved at these local levels.

REP. STEINBERG (136TH): I agree with you on that point. Any other comments or questions, Representative, you have the floor.

REP. BORER (115H): Thank you, Representative, for testifying. I’m not sure if you said it earlier, but is your fire department a paid volunteer, a paid fire department or a volunteer fire department?

REP. O’NEILL (69TH): It’s a volunteer fire department. And the, the ambulance is partly volunteer and partly paid people because it’s hard to find people. But the fire department is definitely a volunteer fire department.

REP. BORER (115H): So, it’s a volunteer fire department, so they are not paramedics?

REP. O’NEILL (69TH): No, no, they’re, although that was something that kind of tumbled out during the course of the conversation that the Board of Selectmen was having about this was, in addition to having spent some time trying to develop a plan for having the town create it’s own paramedic service, the First Selectman also gave, said that he was thinking that maybe they should have a paid fire
department and all the firefighters could become paramedics.

REP. BORER (115H): So, I would say, we went through something. We have a paid fire department. But we went through something similar maybe 15 years ago for a requirement for a paramedic in the fire department, a paid fire department. And it’s so great to have trained paramedics accessible at all of the events. And, you know, I know the ambulance is there in a very short period of time, but having them amongst the residents, you know, and onsite is always an extra benefit to having paramedics that are local.

REP. O’NEILL (69TH): Well, I think there’s, I, I think there’s a consensus that that’s what should happen, and the problem is, who should deliver those services, whether it should be the town setting up its own organization which is going to be fairly costly or having a private organization that’s basically saying that they’ll do it without it costing the town anything.

REP. STEINBERG (136TH): Representative Comey.

REP. COMEY (102ND): Yes, thank you, Chairman. Thank you for your testimony. You got me thinking about some of the other things that, if, if, if you’re, is there another community in Connecticut that, that is set up where all these individual, such as Southbury Training Center or the Heritage Village, that you mentioned, are there other communities in the state that, that have their own departments running independently like that?

REP. O’NEILL (69TH): Not that I’m aware of. Southbury has a funny history because the training
school was built in the 1930s and ‘40s, and it’s been kind of a separate operation in many ways, sort of self-contained. And then Heritage Village was this huge condominium complex that came into existence in the 1960s and ‘70s. And actually both of these things tended to dwarf the town at the time because the town, the rest of the town was much smaller rather than those two things that were being created in many ways.

So, I think conceivably there might be, might have been or might be a town out there that had maybe the University of Connecticut, maybe and perhaps Mansfield or maybe Farmington and John Dempsey Hospital. I don’t know what the relationship, I could imagine if you have a state facility, you might have picked up a second one because the state wanted to do its thing with its own ambulances. But I can’t imagine too many other places that would have had three, especially a place the size of Southbury, which is 20,000, less than 20,000 people.

REP. COMEY (102ND): Great. And just one more question. So, if you don’t have paramedics nearby and someone has a, you know, has some sort of life threatening issue, you have to wait 20 minutes till somebody comes from Waterbury to save a life?

REP. O’NEILL (69TH): Well, hopefully it’s not quite that long and that they could be there in a little closer. But depending upon what part of Southbury it is, yeah, it could be 20 minutes.

REP. COMEY (102ND): And is that -- yeah.

REP. O’NEILL (69TH): One thing though to bear in mind, at least again something I learned in this whole process. The first few minutes after any
ambulance arrives is basic life support. So, advanced life support only is done after basic life support is performed. So, the time lag may not be quite as big. But no matter what it is, if it’s you or a loved one, that’s not getting immediate attention from a paramedic, it becomes an issue of concern to people and they’ve expressed those concerns.

REP. COMEY (102ND): Yes, because it’s my experience that some of the first responders are not carrying things like a life-saving medication, like Epinephrine or, you know, maybe some other life-saving medicine. So, I would think that this would be an important consideration. I mean, 25,000 people is not something to sneeze at.

REP. O’NEILL (69TH): No. And as I said, I think there’s a consensus in the community, it’s a bizarre situation and it’s made more difficult because of the DPH requirement that they can’t even at least get the hearing or at least get there case, so to speak, in front of the department because the application is considered incomplete in the absence of a letter from a First Selectman.

REP. COMEY (102ND): Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, we will move back to the public. The last person with testimony with S.B. 807, is Dr. Allen Hindin.

SENATOR ABRAMS (13TH): Thank you, Doctor.

ALAN HINDEN: Senator Abrams, Representative Steinberg, and Members of the Public Health Committee, I’m Allen Hindin, I’m a general dentist.
I’ve lived in Danbury and practiced in that area since 1974. I have experience in school-based, hospital, private practice and convalescent home care. And I’d like, I’ll be very short. I’m gonna skip off of my notes.

As dentists licensed in Connecticut, we have to take mandatory continuing education on a regular basis regarding infection control. The problems with the DANB exam, and I can say this as a former member of the National, the Joint Commission on National Dental Board Examinations and the Chair for one year, is that it’s not particularly valid in the sense of measuring what we do in practice.

It’s a very good academic tool, but it’s not a very good practical tool. What we get in our continuing education courses of practical means to run a dental office and to keep it safe. There are means to, to present and examine that information. The military occupational specialties all use them, there are three or four different other organizations that have tests. And I think DPH was well intended when they went to DANB, but it was one of those times when good intentions had unintended consequences. And moving the date of expiration from April 1st to three to six months further out, will give the various organizations that have the skills to put something better together the time to do it.

With that said, that’s all I really want to ask you to do. So, I’d like to speak in support of S.B. 807 and hope you’ll take it seriously, get it done, and we’ll go back to work.

SENATOR ABRAMS (13TH): I just have one question. This deadline has been on the horizon for a while.
I take it that people knew what the difficulty was, and the challenge was that people weren’t meeting it. So, pushing it out even six months, is that still gonna solve the problem because it seems like, you know, it hadn’t been addressed for a while?

ALLEN HINDIN: I don’t want to guarantee you we won’t be back here. But I think, I think the incentive at this point is there. I think there’s enough concern on the part of DPH and the university and the dental association to work together and get the job done.

I think the issues with DANB were looming and it’s sort of like being on the train coming closer to the station, suddenly we’re here and the doors aren’t working. So, I think you won’t see us again, at least on this issue.

SENATOR ABRAMS (13TH): Thank you very much. Any other questions or comments? No. Thank you very much for your testimony.

ALLEN HINDIN: You’re welcome.

SENATOR ABRAMS (13TH): So, we’re gonna go back to public officials and Representative Lanoue.

REP. LANOUE (45TH): Thank you, Madam Chairwoman. My name is Brian Lanoue, State Representative from the 45th District, comprising of five towns in Eastern Connecticut. I submitted written testimony, but I’ll be brief in saying that I’m here to speak in opposition to Bill 7070, DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

I had the pleasure of visiting the Womens Center of Eastern Connecticut, in Willimantic not all that long ago. I was highly impressed by the facility
they had. They’ve been around 30 years assisting women with unplanned pregnancies, offering different services, support, counsel, referrals where necessary.

So, I think they’re absolutely excellent. I think this bill will put an undue burden on them, if passed, to potentially be tied up in litigation and complaints, I think and a lot of times very frivolous complaints to take away from what they’re really trying to do. But without further ado, I’m going to speak less. I’d like to turn the microphone over to a client of the Womens Center of Eastern Connecticut, Jessica Talley, to speak as far as her experiences, so you can have that firsthand account.

JESSICA TALLIE: Hello. Thank you for listening to my testimony today. I, I just want to say that my experience at the Womens Center of Connecticut was only positive. It was never deceiving. They are very clear walking in the door what they represent. And got what they provide, the services they provide. And I just want to speak for the women who are looking for options that are not abortion, you know, some women that I think it’s important for us to have our choices there. Not everybody with an unplanned pregnancy is looking to get rid of their baby. And it’s really important to keep these centers open for women and families that need guidance still.

Yeah, and, yeah, I just think it’s really important to keep a faith-based center open for women looking for options rather than abortion. And I just, yeah --
SENATOR ABRAMS (13TH): You can finish your thoughts. That wasn’t meant to cut you off in that way.

JESSICA TALLIE: Thank you. Well --

SENATOR ABRAMS (13TH): Did you have anything else you wanted to say?

JESSICA TALLIE: I just, sorry, yeah, I just think it’s really important to have this option available and I think the bill, H.B. 7070, will put a burden on centers like this and if they’re not available, then I don’t know where people in my position would have to turn.

SENATOR ABRAMS (13TH): Thank you very much. You did a good job. And I’m glad that you got the services that you were looking for. And I just want to reiterate that this isn’t about limiting the services that are available to women, just that the centers are honest about what services they provide or do not provide.

JESSICA TALLIE: Okay.

SENATOR ABRAMS (13TH): So, I’m glad that you had a good experience. Thank you very much.

JESSICA TALLIE: Thank you.

SENATOR ABRAMS (13TH): Any questions or comments? Representative Betts.

REP. BETTS (78TH): Thank you, Madam Chair, and thank you both for your testimony and really, actually, we’re actually a pretty friendly crowd, so you don’t have to be nervous. But I just wanted to appreciate you being able to share a personal
experience because that really does inform us of things that we’re not personally informed about.

JESSICA TALLIE: Yeah.

REP. BETTS (78TH): And it gives us some kind of perspective of what’s going on. And in the center that you chose, were you, did you select it because somebody had mentioned it to you or did you look it up or what, what led you to the clinic that you went to? And it is really important to know that you didn’t feel like you were deceived when you went in there. So, that’s helpful to know that.

JESSICA TALLIE: So, I went to the Womens Center in Killingly, Connecticut and also Willimantic, Connecticut, by referral. And, yeah, I don’t know.

REP. BETTS (78TH): Did you, when you went there, did you go there because some people had recommended it, or you had heard about it or --

JESSICA TALLIE: It was definitely something I was familiar with through my community, my church community. And but I didn’t, I wasn’t, I didn’t know exactly what went on there until I had an unexpected, unplanned pregnancy and then I went there and was educated and informed of everything that they do and the services that they provide, the education they provide, right off the bat. And it was completely clear to me what they did and what they were for. And it was, it was not deceiving at all.

REP. BETTS (78TH): Well, thank you for sharing that personal story. It’s very hard to do a lot of times, in public. And again, I thank you very much
for that. And I’m happy it met your expectations and thank you again for testifying.

JESSICA TALLIE: Thank you for hearing me, yeah.

SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Hi. Thank you for your testimony and thank you for sharing your story. I have just a question for you. With your experience that you’ve had with an unplanned pregnancy, would you feel comfortable recommending a center like the one that you went to to a friend or a colleague that is in the same situation? Do you feel that with your experience, what you experienced, that that person would be given fair and accurate information on what the options are for her?

JESSICA TALLIE: I do believe. I have actually recommended the center to other people. And I’ve had, I’ve known people that have gone there by, by recommendation and benefitted from going to the center.

SENATOR SOMERS (18TH): Thank you.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for that testimony. Just to follow up on it, just --

JESSICA TALLIE: Yeah.

REP. PETIT (22ND): -- specifically, if you recall, were you told verbally or saw written material that said, your options are, you know, have the baby, keep the baby, give the baby up for adoption or termination; was that relayed to you orally and in written material or do you not recall?
JESSICA TALLIE: It was relayed to me in written material and the women at the center were definitely, definitely spoke to me about my options, I think, and what they, what they stand for. They are, they are a center that doesn’t do, doesn’t participate in abortions and yeah.

REP. PETIT (22ND): And they told you that?

JESSICA TALLIE: Yes.

REP. PETIT (22ND): Up front?

JESSICA TALLIE: Yes, they --

REP. PETIT (22ND): Did you feel pressured to make a decision one way or the other or did you feel like they laid out the options for you fairly?

JESSICA TALLIE: Not at all pressured.

REP. PETIT (22ND): So you would be comfortable in sending other friends there because you felt like they gave you what the multiple options were and were fair about it and didn’t give you undo pressure?

JESSICA TALLIE: Right. Yep, they gave me clear options and there was no, no pressure to participate one way or another in what they were doing and the services that they were providing. They just gave me facts and they did not try to persuade me one way or another.

REP. PETIT (22ND): Well, thank you. That’s helpful.

REP. STEINBERG (136TH): Are there other comments or questions? If not, thank you for your testimony today. We really appreciate it.
JESSICA TALLIE: Thank you for hearing me.

REP. STEINBERG (136TH): We now move back to the public and to Senate Bill 380. The first up is Louise Pyers.

LOUISE PYERS: Okay. Good afternoon, Senator Abrams, Senator Lesser, oh, he’s not here, Representative Steinberg and other members of the Public Health Committee. And I want to say a special thank you to Senator Somers for introducing this bill, 380. That’s okay. We, yes, I am Louise Pyers, Executive Director of the Connecticut Alliance to Benefit Law Enforcement, the coalition of police professionals, licensed mental health providers and other stakeholders dedicated to the mental health and well-being of those in law enforcement and the communities they serve.

Through training, mental health training, support and advocacy. I am writing to you in support of Proposed Bill No. 380, AN ACT CONCERNING MENTAL HEALTH AND WELLNESS TRAINING AND SUICIDE PREVENTION FOR LAW ENFORCEMENT OFFICERS.

Police officers work in very toxic environments on a daily basis. They are exposed to traumatic events that most of us cannot even imagine. They see things that no one should see. Yet, they continue to go to work every day in service to their communities. It can take its toll. As the brain tries to protect itself from the onslaught of the cumulative stress officers face and trauma, it can cause changes in behavior that can lead to relationship problems, addictions and even suicide.

If a police officer currently under current law, statute, seeks help for suicidal thinking that may
require an in-patient stay in a hospital, he or she can face serious ramifications up to and including one’s job and livelihood due, due to a change in a state statute that became effective in 2013.

In essence, anyone who voluntarily admits himself or herself for an inpatient stay in a psychiatric hospital will lose the capacity to carry a weapon for six months.

For a police officer, this means they are unable to carry out the duties of their profession without a weapon to protect oneself and others. An officer risks losing his or her livelihood.

No other segment of the population faces job loss because they have to wait six months to carry a weapon after an inpatient psychiatric stay. Many officers will not seek help under these circumstances. The current statute does nothing to encourage our officers to seek help, in fact, it’s a deterrent.

Prior to this change in statute, officers were given a Fitness for Duty exam, administered by a specially trained Psychiatrist so that they could safely return to work if that exam was found positive. I hope we can go back to that option, so officers can seek help without fear.

Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for your testimony. If you know, so, so if you’re admitted for a psychiatric admission is it for any diagnosis, regardless --
LOUISE PYERS: Any diagnosis.

REP. PETIT (22ND): Any diagnosis.

LOUISE PYERS: Uh-huh.

REP. PETIT (22ND): And if --

LOUISE PYERS: It’s a mental health diagnosis.

REP. PETIT (22ND): A mental health diagnosis, okay. And if you surrender your weapon, are you ineligible for any form of duty or can you perform duty within a stationary administrative duties or does it only keep you from doing out in the public kind of duties?

LOUISE PYERS: It depends on the size of the department. In a larger department, they might be able to be given light duty. But in smaller departments the options, usually, you know, it’s not there. I mean, we’re talking about carrying an officer of six months. It is a big deterrent and what often happens is, a lot of officers will be afraid to get any kind of help, even if it’s outpatient because of this law.

REP. PETIT (22ND): Could you comment for how would the, how does the outpatient, if someone sought assistance for outpatient depression, how does that impact them?

LOUISE PYERS: Well, it’s the message that it gives basically. It gives a larger message that, you know, you’re not ready for duty, if you’re seeking mental health treatment. And we do know that officers face a lot of stressors, more stressors than in many other professions. And their suicide rate is quite high. They are three times more
likely to die by suicide than by assault. So, we do know of any profession, they can certainly, and we encourage them to seek mental health treatment to keep themselves healthy, so that they can have long and healthy careers.

REP. PETIT (22ND): And the psychiatric exam you referred to, when does that come into play currently?

LOUISE PYERS: Well, it’s, it’s, it was an option at the time where, this was prior to 2013, where if an officer went through an inpatient stay, there’s an option for the police department to either go with what the attending physician at the hospital says this person’s ready to go back to work or to order their own Fitness for Duty exam by a doctor, who could then determine if the person’s ready to return to work.

REP. PETIT (22ND): Thank you. Thank you, Mr. Chairman.


SENATOR SOMERS (18TH): Good afternoon and thank you for your testimony. I too think that this is a very important issue that the Public Health Committee should take up. We in the public health have talked about how important mental health is. We want to work on the stigma associated with mental health and this is a perfect example that our law enforcement men and women are put in a situation that really no other profession is pushed in. And that they experience on a daily, if not hourly basis, a sense of heightened alert. They never know what they’re gonna walk into, what the situation is, what it will
turn. And quite frankly, they don’t know if they’re gonna return to their families at the end of the day. That is very different than any of us up here or probably out in the audience have to experience on a daily basis.

And you can imagine what kind of toll that can take on your mental health and wellbeing. It’s my understanding right now to circumvent the law that we have, many of our officers received help sort of on the downlow outside of the state, which is not helping, it’s not the way that we should be. Mental health should be out in the front, it should not be stigmatized, and it should be something that we all have an ability to have access to without the fear of losing our job.

With that being said, you can see, quite frankly, some of the studies have shown when we’re not providing that type of mental health relief for those who need it, depending on what we see for trauma, et cetera, that leads to a massive increase in divorce rates. It leads to obviously suicide rates of the folks that in an industry or profession that it is difficult at this point to get anyone to want to become a police officer with all the scrutiny, et cetera that goes along with it in this day and age.

In Illinois last year, they did pass, actually two years ago, they passed a law which is very similar to what we’re looking to do here, which simply states, I’m just gonna read it really quickly, that no law enforcement officer employed by a unit of government shall have his firearm revoked for an extended period of time or his job denied because a patient or the officer has visited a mental health
facility within the last five years, unless, and this is the caveat, the department receives an affirmative in writing statement by a treating clinical psychiatrist or psychologist or physician that the officer is a threat to himself or to others.

And I think that’s something that we should look to go back to, so we can encourage those that are on the first line of defense for all of us here, that protect us every day, have access to the care that they need without fear of losing their job.

Thank you.

LOUISE PYERS: Thank you.

REP. STEINBERG (136TH): Thank you, Senator.

Representative Klarides-Ditria.

REP. KLEARIDES-DITRIA (114TH): Thank you, Mr. Chair. Thank you for your testimony today. As the wife of a detective, I see daily the stressors that our law enforcement personnel go through. We talk about in public health every day that we need to protect our mental health. So, why would we go ahead and punish the men and women that are putting their lives on the line every single day for us.

So, I think to Senator Somers’ point, we need to protect them and not punish them for getting the help that they need for the stressors and the daily horrors that they’re forced to see.

Now, granted, they’ve chosen this line of work and I thank them every day for it because they’re the ones that are out there protecting us and knowing that we go to bed every night that we’re protected, and we have someone watching us.
So, I fully support this bill and hopeful encourage everybody to as well, thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you. Any other, yes, Representative Arnone.

REP. ARNONE (58TH): So, as a son of a 33-year-old, 33 year police officer, detective also, I grew up with this. And with the problems that all officers have with denying that they have any mental health issues. And to hold it inside, sometimes is a, just a ticking time bomb. And it’s extremely important just because of the stressors they have contributing to the job, we shift the work and, you know, unpredictable situations every day that we need to move forward on, encouraging them to get the help that they need. Even if it’s a minor mental health issue, because all minor issues can explode into major ones in this kind of career.

So, I too, look forward to seeing this bill move. Thank you.

LOUISE PYERS: Thanks for your support.

REP. STEINBERG (136TH): Any other comments or questions? If not, thank you for your testimony today. Once again, we will rotate back to elected officials, if I could find the right sheet of paper. I believe next up is Steven Hernandez.

STEVEN HERNANDEZ: Good afternoon, distinguished Chairs, Ranking Members and other distinguished members of the Public Health Committee. My name is Steven Hernandez, I’m the Executive Director of the Legislatures Commissions on Women, Children and Seniors and Equity and Opportunity. I am joined by
Leila Ensha, who is our exceptional intern from the Yale School of Public Health. Today we are testifying in favor of raised House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

As written, we are, I wanted to focus on a couple of things really that were the subject of today’s testimony. Firstly, I wanted to thank the individuals who have received services from the good, I should say the majority of good actors from what we’re understanding in this field. I think it’s critical, the commission was an active participant in our Safe Havens Law, which was strengthened just a few years ago.

And we feel that it’s critical that every option available to, to a woman with an unexpected pregnancy be available, including options that include advice based, faith-based advice and faith-based options.

But I did want to point out a couple of things. One, this is really a deceptive practices bill. And it’s written very narrowly as such. And, you know, one thing that I did want to clarify is that nowhere in the bill does the bill describe or prohibit potentially deceptive practices. I think that’s a, I think that would be ambiguous and I would recommend against it if it were found to be in any subsequent draft.

Secondly, this does not create, just to repeat the Attorney General’s testimony, this bill would not create a private right of action. We think that’s critical. There are many examples in Connecticut law and in laws of other states, where Attorney
General’s do have injunctive powers or at least the power to request an injunctive relief when, when deceptive practices, whether they be in a trade, in a trade context or in a context in which there is such an overwhelming public interest in having the deceptive practice stopped or ceased and desist that this would not be atypical.

And again, finally, I would be weary of expanding out our trade practices law to include faith-based, faith-based services that are not, that are not trade practices. I, I’m really weary of blurring that very good and strict line between the power of the state over trade practices and, and faith-based advice.

That is the substance of our testimony and, of course, I am open to questions at your discretion.

REP. STEINBERG (136TH): Thank you for testifying here today. Would the doctor like to make any comments or --

LEILA ENSHA: Thank you. First of all, I’m not a doctor, but I appreciate it.

REP. STEINBERG (136TH): I start off calling everybody a doctor to be on the safe side.

LEILA ENSHA: Not those credentials quite yet. I’m a student of the School of Public Health at Yale, a graduate student. And studying public health, we know that timely access to medically accurate evidence-based healthcare and health information is a public health tenant. And that’s really what this bill is about. So, everything that he just said and other folks testified, this is about making sure that when you’re accessing healthcare you know what
you’re receiving and that all of your options are presented to you to make really the best informed decisions for yourself, for your body and for your family.

Thank you.

REP. STEINBERG (136TH): Thank you for that. I appreciate your testimony in terms of reiterating some of the points we’ve heard today. This is already early in our full day’s hearing. Interesting that we’ve heard a lot of conflicting comments about the status of the current law and what this particular proposed bill would do.

Just to comment, I think that we still have more work to do to understand the ramifications of specific language, because it’s very important for us, if this bill is to go forward for us to get it right and make sure that we are not creating consequences that were never intended and that we are targeting, indeed, only those that potentially would be misleading members of the public.

So, thank you for that. Are there any other comments or questions? If not, thank you of your patience today and thank you for your testimony. We are now back to Senate Bill 380. Chief Jim Viadero.

JIM VINDERIO: Thank you.

REP. STEINBERG (136TH): We’re gonna give an award for handwriting at the end of the day.

JAMES VIADERO: Good afternoon. My name is Chief James Viadero from the Newtown, Connecticut Police Department. I have 33 years of law enforcement experience; 30 with the Bridgeport Police
Department, three with Newtown as their Chief of Police.

I’m here to speak on behalf of the Connecticut Police Chiefs Association in support of Senate Bill 380, promoting mental health wellness for officers.

As Chiefs of Police, we have been charged with changing the culture around our officers seeking mental health treatment. We are charged with making sure our officers are physically healthy, mentally healthy and emotionally healthy. Although well intended, some of the state statutes that were put in place around gun violence as a result of Public Act 13-3, had an unintended effect. It basically prohibited our officers from seeking mental health treatment. The stigma that’s attached and the barrier that’s put in place as a result of that bill has kind of perpetuated our officers not seeking treatment for mental health disorders.

Currently the way the bill is, the law is enacted right now, an officer who seeks mental health treatment and voluntarily admits himself into a treatment facility is subject to a six-month suspension of their right to carry or possess a firearm.

The detriment that those officers fear that they may lose their job, or they may lose the economic ability to sustain their families. And it’s prohibitive to officers seeking that treatment. You know, we urge our officers and the stressors that they deal with on a day-to-day basis to take care of their physical, psychological and emotional wellbeing. And we view this as a prohibitor for that very reason.
This past year in 2018, 159 officers died as a result of suicide. In the line of duty 144 officers died. So, as we can see in the statistic for suicides is not a firm statistic. We feel that there might be more out there. I mean, 2017, the number was 159. And in 2016, it was 140.

I personally know three officers within the last three years that committed suicide. In the State of Connecticut active officers, six officers in the last three years have committed suicide. So, it is definitely a problem that we’re trying to grapple with.

And as the Chiefs of Police, like I said before, we’re trying to change the culture of going out and promoting this type of treatment for our officers.

I’m happy to be joined today by James Rascati, who is a member of Behavioral Health Associates, they’re an EAP provider for 58 towns and municipalities. They represent a number of police departments in the State of Connecticut. Jim.

JAMES RASCATI: Thanks, Chief. I’m a social worker with 40 years’ experience and for the past 30 years, I’m on the faculty at Yale Department of Psychiatry School of Medicine.

Over the past 15 years, I responded to multiple line of duty deaths, as well as eight police suicides, one of the most devastating events any law enforcement agency can ever experience. I also responded to the Manchester Police Department after HDI, and a week after the unspeakable tragedy at Sandy Hook was called into work with the Newtown Police Department, with whom we continue to work.
It is from my clinical, academic and hands-on experience with law enforcement that S.B. No. 380 must be passed. First responders, law enforcement in particular are usually reticent to use mental health services for many reasons such as stigma, confidentiality concerns and the ever present and accurate fear that using them will jamb them up on their careers, which is patently false.

And yet the research is very clear, police officers have higher rates of divorce, alcohol abuse, acute stress, post traumatic stress, deposition and suicide than the general public. We know clinically that stress builds up over time. Police officers see things that many of can never even imagine. They often times see the worst that humanity has to offer. When officers erroneously think that accessing mental health services will negatively impact their careers, this creates a recipe for disaster.

Although I understand why the original law was passed after Sandy Hook, about the administration to a psychiatric hospital and a loss of one’s gun permit, it makes absolutely no sense to apply this law to law enforcement. And it is my opinion they should be exempted by it. As a seasoned behavioral health professional, working with law enforcement, we do not need another obstacle to prevent an officer from seeking appropriate mental health services.

Imagine this, six, seven years after Newtown, a Sandy Hook, a Newtown officer because they’re stressed with deposition, gets admitted to a hospital. He has the potential to lose their gun
for six, actually not a potential, they will lose their gun for six months.

REP. STEINBERG (136TH): I ask that you summarize. Unfortunately, the buzzer went off at the beginning of your comments.

JAMES RASCATI: I'm sorry. I would just, our goal should encourage appropriate use of mental health services and I strongly encourage this committee to pass this and hopefully the larger body will pass it as well.

REP. STEINBERG (136TH): Well, thank you both for your testimony. I didn’t mean to cut you off, other than to be fair to others. There is a certain irony with all the stressors we put upon our first responders that we actually are not appropriately addressing the stress, but adding a new stressor, which keeps them from seeking the help they really need. So, I agree with you. I think the intent was good, following Sandy Hook. And often times is the case, we do not fully appreciate all the consequences of some of our actions.

Senator Abrams, followed by Representative Petit.

SENATOR ABRAMS (13TH): Thank you very much for being here and certainly I agree that this is an unintended consequence, and we want to do whatever we can to set for the first responders and encourage anyone who would need it to seek mental health treatment.

Thank you.

REP. STEINBERG (136TH): Representative Petit.
REP. PETIT (22ND): Thank you, Mr. Chairman. Chief, a nuts and bolts question. If someone has a psychiatric administration, is it a regulatory move such that you as the Chief Police Officer remove their service weapon or any and all weapons that they possess, remove from the home and who has possession of the weapons?

JAMES VIADERO: We’ll be notified as the statute is now, the Department of Mental Health is notified, DESPP is notified and then they make a notification for that individual that they have to turn in their weapons. And if they have a permit, revoke the permit. As a result, if they’re a police officer, we’re also made aware that there’s a revocation for six months. So, we’re forced to take that, that action and revoke their privileges to be officers out in the field.

I think as Ms. Pyers said before, depending on the size of the department, larger departments are able to absorb those individuals, possibly give them a light duty position. Smaller agencies are forced to make a decision as to whether, what status of that officer is gonna be for the remainder of that six months.

REP. PETIT (22ND): Thank you. And Mr. Rascotti.

MR. RASCOTTI: Yes.

REP. PETIT (22ND): What would, what would your suggestion be if this goes forward, what do you think the appropriate approach would be if someone seeks treatment, gets administration for severe deposition, suicidal ideation; would you want to go forward with something where it’s there own psychiatrist that clears them back to duty again or
a panel clears them or what, what would you think the appropriate approach is?

MR. RASCOTTI: No, Ms. Pyers already referenced, it’s a Fitness for Duty evaluation by either an experienced psychiatrist or psychologist. And most police departments do do that. If they have concerns about an officer, his or her ability to function, they will send them for a Fitness for Duty evaluation.

JAMES VIADERO: So, I wholeheartedly concur with Ms. Pyers because she’s absolutely correct.

REP. PETIT (22ND): And, Chief, you have the ability to require that of any of your officers, regardless of --

JAMES VIADERO: Absolutely. If we, if at any time we have any doubts about the officer’s wellbeing, we have an option to send them for a Fitness for Duty. Most certainly as a result, an individual voluntarily admitting themselves for a program, we would want to do that as a backup to make sure that that officer is fit to come back for duty.

REP. PETIT (22ND): Thank you both. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Are there any other questions or comments from these people? If not, thank you.

JAMES VIADERO: Thank you very much.

REP. STEINBERG (136TH): Thank you for coming today, you give us a very important perspective.

JAMES VIADERO: Thank you.
REP. STEINBERG (136TH): I understand that Representative Phipps is currently on his way here. So, we will move on to Representative Gilchrest, please.

REP. GILCHREST (18TH): Good afternoon, Senator Abrams, Representative Steinberg and Members of the Public Health Committee. Thank you for the opportunity to testify in support of House Bill 7070 AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS. I’m Jillian Gilchrest, State Representative from the 18th District.

And way back in, not too long ago, but in 2008, when I served as an Executive Director of NARAL Pro-Choice Connecticut, we began looking into these crisis pregnancy centers here in the state. Since then, according to research done by NARAL Pro-Choice Connecticut, women who have visited a CPC in our state were told that they were sinning for getting an abortion, that they may not make it out alive and that some women are left with half a baby inside of them having an abortion. That research can be found on NARAL’s website.

When a woman seeks healthcare in Connecticut, she should receive healthcare. She shouldn’t be advertised to on buses, the web, billboards and in office windows with messages that trick her into thinking she’s accessing healthcare.

If CPC’s, one, offer religious based advice and care for pregnant women so be it. But purposely deceiving women into thinking that they are accessing reproductive healthcare in order to push
religious doctrine is deceptive and should not be permitted in the State of Connecticut.

If CPC’s in the state are participating in this type of behavior, then this law that you’re talking about doesn’t apply. As the former executive, I’m sorry, as the former Director of Health Professional Outreach at the Connecticut Coalition against Domestic Violence, I’m particularly concerned with victims of intimate partner violence.

Many female victims of IPV experience reproductive coercion. One study found that women with unintended pregnancies were four times more likely to experience IPV than women whose pregnancies were intended.

Abusive partners may hide or destroy birth control pills, poke holes in condoms or remove a condom during sex, pressure a partner to become pregnant when she doesn’t want to be, or threaten violence if a partner doesn’t comply with an abuser’s wishes to terminate or continue a pregnancy.

In these instances, female patients need to be able to access comprehensive reproductive healthcare services, free from pressure and lies.

Last year I wrote an op-ed for the Connecticut Mirror that described the scene at a CPC, except the patient I described was a man seeking a vasectomy. A man seeking a vasectomy would be pretty peeved if he researched a procedure, located a urologist, scheduled an appointment, and took time off of work only to discover that he’d been tricked by a religious organization who opposes his legal right to obtain a vasectomy. This obviously doesn’t
happen to men in Connecticut, but it is happening to women. These practices are sexist and they’re wrong.

We have an opportunity to change this, you have the opportunity to change this, by passing HB 7070.

Thank you for the opportunity to testify today.

REP. STEINBERG (136TH): Thank you, Representative for your testimony and your specific background as it relates to this. You probably haven’t heard all the testimony that precedes yours, but a number of members of the committee expressed that they believed that this was a bill seeking a problem that didn’t exist. And yet, you made mention of the fact that over the period of years that you’ve been able to record a number of instances where deceptive practices have actually taken place, is that correct?

REP. GILCHREST (18TH): Yes, just like in the pro-choice movement, there are conversations about how we can ensure women have equal access to reproductive healthcare, in the movement to prohibit or make abortion illegal, those organizations and entities also have strategies. And crisis pregnancy centers are a strategy of the anti-choice movement. And so since I was executive director in 2008, we knew that there were religiously-based organizations that strategize about opening these centers near women’s reproductive health clinics in order to trick and deceive women.

And the research that I cite from the NARAL Pro-Choice Connecticut, they sent undercover shoppers into these crisis pregnancy centers to see what would happen. And the information I provided in my testimony comes directly out of their report from
those women who went into those crisis pregnancy centers in the State of Connecticut.

REP. STEINBERG (136TH): Thank you. We will review that testimony carefully because it does, I think, demonstrate that this is not a hypothetical, but actually may be occurring.

You also make reference to the term, intimidation. Now, that’s not explicitly the aspect of this bill. But why is it that you find that something that we should be considering today, given where the bill is focused?

REP. GILCHREST (18TH): And you mean in particular that women feel intimidated?

REP. STEINBERG (136TH): Yes.

REP. GILCHREST (18TH): In that I’m citing the experience of women outside of the Hartford CPC. And I think we should be looking at that because we know about that particular situation because there was a reproductive health clinic directly across. So, when women would go over to the reproductive health clinic they were able to share those experiences of intimidation. We don’t know what’s going on in other parts of the state. And so, I do think it’s important to look at that arena because there could be women across the State of Connecticut who are being intimidated to not use the legal services that are readily available to them.

REP. STEINBERG (136TH): Thank you. Again, this is complicated and so much of the testimony we’ve heard here today is anecdotal as opposed to statistical, but even a small number of such instances, I think
give us all reason to pause and consider whether there is a legislative remedy. Senator Abrams.

SENATOR ABRAMS (13TH): Thank you for your testimony. We’ve heard a lot this morning about concern that this is an attack or that somehow we’re looking to shut down religious services. What, what’s been your experience or how would you respond to that?

REP. GILCHREST (18TH): So, I think it probably was 2008 or 2009. I was on a panel discussion up at the University of Connecticut, where I was speaking as the Executive Director of NARAL Pro-Choice Connecticut and there was an Executive Director of the CPC in Willimantic, I don’t recall the name. But like I’ve heard from other crisis pregnancy centers here today and in the past, they do bring value to a community. And so I, I think it’s fine for them to exist. And like I said in my testimony, that’s wonderful that they’re providing services. What I don’t stand for or don’t want the state to stand for are deceptive practices that make women think that they’re going to a health clinic and when they arrive, they’re actually at a religiously affiliated organization that can provide them a variety of other support.

Again, that’s fine for them to exist to do that. This isn’t an attack on that. Just be clear on what the services are you provide and that you aren’t a health clinic.

SENATOR ABRAMS (13TH): Another point that’s been brought up a lot today is just in general deceptive practice in any kind of a consumer-related venue.
How do you see this as being different than a general consumer issue?

REP. GILCHREST (18TH): So, I know that there are -- why is this different is the population of individuals we’re talking about are going to get services that they might not be sharing with folks outside their family. So, seeking an abortion is a private matter. Seeking reproductive health clinic is a private matter. I mean, we have healthcare laws that protect folks because we know this. And so, if someone is deceived at a CPC, then using the typical resource that others might use, recourse that others might use with different entities, it isn’t the same. And so, I do think we have to treat this problem differently.

SENATOR ABRAMS (13TH): Thank you very much.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for your testimony. Given your experience, a basic question, when women are looking for this type of counseling and service in the modern era, is it, do you have an idea of the breakdown in terms of word of mouth, look on their phone and do a search, et cetera? What’s your feeling or is there data on how women choose these places in general?

REP. GILCHREST (18TH): I don’t have concrete data, but I would think it would be most likely via the web, and to your point, looking it up on the phone. I do believe that the research from NARAL Pro-Choice Connecticut shows that many of these CPC’s are located along bus lines. Because I think when we are talking about women who are more likely to use these services, these are lower income women and so
they would be easy access to one of, to a clinic. And so, if they are to look it up on their phone and then see that it’s along a bus line, I think those are the things they’re looking at, convenience of how can you access the services.

REP. PETIT (22ND): And in terms of this specific group of women who are victims of intimate partner violence, if they have access to any one of the 18 domestic violence shelters, I assume most of the time then, their referral or suggestions come from the specific facility there and does CCADV, per se, have a policy for how to, how to direct women or how to not direct women in terms of providing them choices?

REP. GILCHREST (18TH): They do not. That would fall to each of the 18 member programs. And I believe that some of the, some of those 18 programs across the state do partner with the CPC’s for such things as baby bottles, blankets, some of the other services that might be provided at that CPC. And so there are partnerships taking place. Our programs would be clear on where those services end and that, that CPC can’t provide them with comprehensive reproductive healthcare.

REP. PETIT (22ND): So, I guess, finally as I’m hearing the testimony today, I wonder if, you know, in your opinion, given your experience, if it’s adequate for women to know via a website and via written materials and via one-on-one that a particular facility provides the ability, you can have your baby, you can have your baby and keep it, you can have your baby and give it up for adoption, or you can go for termination and we provide one, two and three or we don’t provide three or et
cetera. Would that type of approach be, because we seem to be getting hung up in the, the wordsmithing of what’s deception, what people wear, what people’s perception of things are versus what we should actively provide people in terms of information?

REP. GILCHREST (18TH): I think that if these entities can be clear on what type of entity they are and what they provide, that’s best.

REP. PETIT (22ND): Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Are there any other questions? Yes.

SENATOR SOMERS (18TH): Good afternoon and thank you for your testimony. I’m trying to find your testimony online here, but. You were, I think you said you were the, previously the Executive Director for NARAL, is that correct?

REP. GILCHREST (18TH): Yes.

SENATOR SOMERS (18TH): Okay. So, one of the things I thought I heard you say was that women should be able to go to a health clinic to obtain services. We heard today in testimony that some of the organizations actually are health clinics, they’re inspected, they have clinical staff. And they’re actually inspected more frequently than someone like a Planned Parenthood. So, are you saying that, the folks that we heard from today testified in front of the legislature that they very clearly state what they provide and what they don’t provide. It seems to me what I’ve heard is a lot of focus on a particular center in Hartford as what everyone’s referring to as the bad actor, but the person that, or the clinic that has tried to intentionally
deceive women from getting the, I guess, the alternatives that are available.

How would you classify deceptive? Do you think it’s deceptive for faith-based organizations to promote themselves as women’s resource centers and when someone comes in and they are asked about their options, they very clearly tell them what they are. And if someone asks them about a termination, they clearly state on their website, that’s not something that we do here; I think, for me, I understand we don’t want women to be deceived, but it’s also very nebulous as far as what deception and misrepresentation is. So, can you speak to that at all?

REP. GILCHREST (18TH): Sure. I think from, if you heard from folks, and I do apologize that I wasn’t in here all day. If you’ve heard from pregnancy centers who have been clear that they are not using the deceptive practices and are identifying, identifying what services they do provide, and are being clear with their, with the patients or customers who come in, then this legislation wouldn’t apply to them. I think we’re hearing about the CPC in Hartford because we actually know the most about that one. But again, I would reference NARAL Pro-Choice Connecticut report, and it’s available on their website, which shows that those deceptive practices that we know to be true of Hartford are happening at other crisis pregnancy centers in the state. And so, I think this bill, at least in my mind, is to address those practices and wouldn’t impact the non-bad actors that are already onboard and providing the information.
SENATOR SOMERS (18TH): I guess I haven’t read that report. What are the other centers that are, what are the deceptive, specific deceptive practices that these other centers that NARAL has, you called them secret shoppers?

REP. GILCHREST (18TH): Yep.

SENATOR SOMERS (18TH): Are they paid to go into these facilities? Are they interns, do they get credit to do this or how does that process work?

REP. GILCHREST (18TH): It is all detailed in the report. I believe they were volunteers at the time. They were not paid; they were volunteers who went into crisis pregnancy centers across the state. And I only pulled a few of the things from that report. And I think, and it was that they were sinning for getting an abortion. That they might not make it out alive if they went to a Planned Parenthood, for example, or that women are left with half a baby inside them, which we know all of those things are completely false. So, those were just some of the examples that were cited in that report.

REP. STEINBERG (136TH): I am sorry to interrupt, but may I ask the members of the public who have yet to testify, please not interrupt the testimony with any other comments. It’s important we give everybody full respect. Please continue, Representative.

REP. GILCHREST (18TH): And so, yeah, I don’t, you know, I don’t have the report in front of me. But I can get it to you. I’d be happy to send it along.

SENATOR SOMERS (18TH): So, just so I know, I just want to be, I don’t have the report. Does the
report identify, this is very important to me to have the details. Does the organization, the clinic, the non-clinic, the center, and what was, what specifically happened to the volunteer or the secret shopper that went in?

REP. GILCHREST (18TH): I know that specific crisis pregnancy centers are identified in the report. I can’t recall if then, the examples given are linked to them. But I am happy to go back and look and see and get that information to you.

SENATOR SOMERS (18TH): What I’m struggling with is, I completely understand the idea of we don’t want deceptive practices. We want women to be able to be informed and make their healthcare decisions based on facts. The problem is, when you look for me anyway, when you look at this whole situation, we have an organization that is sending people undercover as secret shoppers into an organization. We don’t know what the conversation was before. We don’t know how, what context it was made in. And it’s very anecdotal. It’s, it’s not true data, as far as I’m concerned.

So, you know, what you consider or what a deceptive practice may be for some person, may not be for someone else, based on the whole context in which this secret shopper was given that information. I’m not saying the information is correct or right, but it’s hard to legislate based on secret shopper data, if that makes any sense.

And I would prefer, if we’re gonna do something to go the route that we’ve talked about with looking at the unfair trade for non-commerce businesses, I think that might be a cleaner way than try to really
distinguish what is deceptive, what’s potentially deceptive, what’s misleading and what’s not misleading because again, you know, this is within the context of a volunteer, their interpretation, unless it’s recorded, unless it’s in writing, it just makes it difficult to base legislation on what I consider not, not actual data, if that makes any sense.

So, we’re trying to figure out how to fix a deceptive practice without going to, going to a place that we don’t really need to get to. So, that’s why I’m asking such specific questions on this, if that makes any sense. And your, your example that you gave as far as the vasectomy, if you Google that, you’re not gonna have it come up with a pregnancy crisis center, so I think that’s a little different as far as, you know, a man wouldn’t experience that. I wasn’t clear on your analogy in your, in your testimony. I’m not, if you could explain that?

REP. GILCHREST (18TH): Sure. So, my point is that the mere fact that we’re having this conversation, to me, highlights how sexist a practice this is because, of course, this wouldn’t happen to men. We don’t have religious organizations that are falsely advertising for men who are seeking a vasectomy to try and prevent them from going in and doing a procedure that will prevent them from being able to have children later on.

So, the mere fact that we’re here having this conversation, to me, highlights the sexism that is involved in crisis pregnancy centers. And to your other question about research or the conversation about this, again, having been the Executive
Director back in 2008, this is not a new issue. I have met and spoken with women who have been impacted by this. And even though the one example we have is of Hartford, I think is telling of what is happening across the state. And so, I do feel as though we do have enough research. And if this is even impacting one woman, we have the ability to have legislation that requires these crisis pregnancy centers to just advertise appropriately. And to the point that was made for the ones that already are, this wouldn’t impact them.

SENATOR SOMERS (18TH): If I could just follow up with, you used the word, deceptive advertising, so can you speak to that specifically?

REP. GILCHREST (18TH): Sure. So, if you go on to these websites, some of them, not all, if you go on to some of the websites, it, they have co-opted the language of reproductive health and choice to make it look as though they’re a full-service clinic, when in fact they are not.

SENATOR SOMERS (18TH): Can you speak to co-opted, the language of reproductive rights, like can you say something specifically that you’re speaking to?

REP. GILCHREST (18TH): I would have to go back and pull up the website. I can’t, off the top of my head, think of the example. But I know you are hearing from organizations later who will have that specific info.

SENATOR SOMERS (18TH): Yeah, that would be helpful because, you know, in doing, doing our own research, just going online and looking at some of the different offerings that are provided, whether they’re faith based or not, they are not all faith
based. The ones that I looked at specifically, they’re very clear and there’s a disclaimer on almost every page that they do not provide this particular service. So, that’s why it’s important, when I hear testimony that these organizations have co-opted reproductive health, I need to see again the data of what they’re saying that, that is making you believe and others that are testifying, believe that it is deceptive. That’s what I, I, we need to get to.

REP. GILCHREST (18TH): Okay, we’ll be happy to provide that.

SENATOR SOMERS (18TH): So, if you have that, that would be really helpful. Thank you.

REP. STEINBERG (136TH): Thank you, Senator. I think we’re all interested in getting as much information --

REP. GILCHREST (18TH): Sure.

REP. STEINBERG (136TH): Any other comments or questions? Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chairman. Thank you. I apologize for coming in in the middle of your testimony. But I, like Senator Somers, I just need some more information.

REP. GILCHREST (18TH): Okay.

REP. ZUPKUS (89TH): And I guess I’m just gonna ask, I know we all, this has all been talked about deceptive. What are you looking for? Like give me an example, what do you want to see happen? I know deceptive advertising. Do you want certain language
on a sign, outside a door, on a website? Give me an example of what you want to see, please.

REP. GILCHREST (18TH): So, I mean, I would turn back, but what I’m interested is just these entities being clear on what the services are that they do provide and that they are not a health clinic again, unless they are, and they can then be clear about that. But that they are not a health clinic, that they are a religiously affiliated organization.

REP. ZUPKUS (89TH): So, you want a sign? I’m gonna use a sign as an example or a website. Are you looking for something to say, I’m a faith-based organization. I do adoptions. I do work to keep your baby and we don’t do abortions. I mean, is that what you’re looking for?

REP. GILCHREST (18TH): Yes. Because right now on the website when you go to one of these websites and I will provide you with an example, it resembles closely a health clinic website. And a woman going to that website, there’s a very high likelihood she would think that she is getting an appointment at a reproductive health clinic.

REP. ZUPKUS (89TH): So, I, too, Googled both. I Googled abortion clinics. I Googled pregnancy clinics, like whatever, and I kind of got the same on both sides of the fence. So, and again, is there a problem if a woman walks in, not really sure what she wants to do with her child, maybe thinking of an abortion and she walks in and somebody says, well, these are your options, that being one of them and talks to them about the others, if that’s what her interest is. So there’s --
REP. GILCHREST (18TH): I have no problem in that. What we’ve been told and what the research shows in this state and across this country is that when a women enters a crisis pregnancy center, again, not all, but when she enters a crisis pregnancy center she will not be told about her option to have an abortion. And, in fact, she will be told things such as a half a baby will be left inside you and you won’t make it out alive, which are not medically accurate and intimidation and meant to scare.

REP. ZUPKUS (89TH): So, where, and again we need the data because I know you say across the country. We’re looking at Connecticut right now, that’s what we have control over. And I would, was that a woman that came and said that that it happened to her or is that where the secret shopper is coming in? What or who and what did that happen to?

REP. GILCHREST (18TH): Yes, so NARAL Pro-Choice Connecticut did an investigation where they used volunteers and they do have a very comprehensive report that I’m happy to provide to you all, where a number of women had things said to them. I did refer to them as secret shoppers, but it was volunteers, it was a research project, it was a research project that was modeled off of recommendations by NARAL Pro-Choice America and so I’m happy to share that information with the committee.

REP. ZUPKUS (89TH): Thank you.


SENATOR ABRAMS (13TH): Representative, you mentioned something briefly in your comments about a
strategy. If you would like, can you expound upon that a little bit?

REP. GILCHREST (18TH): Sure. So, again, having been the Executive Director of NARAL Pro-Choice Connecticut and having worked with different nonprofits here in the state, when you’re affiliated with a national organization and you’re part of a national movement of which I was, the pro-choice movement, you strategize different messaging and different ways that you can promote women’s reproductive health. The same thing is happening on the anti-choice side. And so there are anti-choice groups in every state who are affiliated with a national organization and they’re working to do the opposite, to prevent women from being able to access comprehensive healthcare. And one of their strategies is opening crisis pregnancy centers in low-income communities, closely located to full reproductive health clinics as a way to deceive women and to prevent women from getting an abortion.

SENATOR ABRAMS (13TH): Thank you.

REP. GILCHREST (18TH): You’re welcome.

REP. STEINBERG (136TH): Any other comments or questions? If not, thank you, Representative for your testimony today.

REP. GILCHREST (18TH): Thank you for the opportunity.

REP. STEINBERG (136TH): All right. Now, we are back on Senate Bill 380, Zak Leavy, I believe.

ZAK LEAVY: Good afternoon. My name is Zak Leavy, I’m a Legislative Advocate for AFSCME, Council 4, which represents over 30,000 public employees as
well as over 2,000 dedicated municipal police officers. I’m here today to testify in support of S.B. 380, AN ACT CONCERNING MENTAL HEALTH AND WELLNESS TRAINING AND SUICIDE PREVENTION FOR LAW ENFORCEMENT. I’ve already submitted my testimony online, so I’ll just summarize.

We want to thank Senator Somers for proposing this bill as well as the bipartisan proponents who have been working to make this reality over the last several sessions. This bill would fix a problem with current statute where an officer could lose their service weapon for six months and even up to 60 months for simply getting the treatment they need. We believe that this is an unfair punishment and this bill would address that and allow for an officer who is doing the right thing and getting the treatment that they seek to get and being able to have them retain their employment still without having any undo penalties.

As the Chief has mentioned before me, the CBS News reports that there are about 159 police officers who took their life in 2017 and 161 in 2018, but I agree with what he said, that there are most likely more as this is a difficult statistic to track.

We support this bill and the important protections that it adds for police officers and hope that the committee as well as both chambers will also approve it. And I’m happy to answer any questions.

REP. STEINBERG (136TH): Thank you for your testimony. I think what we’ve heard here is pretty consistent today and I think you get the sense the committee is committed to seeing if we can make the circumstances better for all those who put
themselves in harms way. Are there any comments or questions? If not, thank you for your patience and thank you for testifying.

ZAK LEAVY: Thank you.


REP. PHIPPS (100TH): To the Chairs, thank you for allowing me the opportunity to speak and to the rest of the committee, it’s a pleasure and honor to be in front of you all. I think one of the greatest opportunities that we have as legislators is to be able to build a platform, but often times I think we have to step down from that platform and elevate folks that are closest to the work and closest to the challenges.

So, today I proudly and gladly yield my time to Jordan Goldberg of the National Institute of Reproductive Health to speak on this. And I will also say as a man of great faith and a member of Cross Street AME Zion Church, one of the largest churches in Middletown, Connecticut, that truth is one of the pinnacles and cornerstones of our work. So, I am glad that we are going to be talking about truth and honesty as we go forward. With that, Jordan.

JORDAN GOLDBERG: Thank you very much. I really appreciate the opportunity. And thank you to the committee for the opportunity to testify. I’ll be brief. My name is Jordan Goldberg, I’m an attorney. I’m the Director of Policy at the National Institute for Reproductive Health. I’m just going to talk about the constitutionality of the proposed bill, and I’ll be happy to take questions.
As you heard earlier, in 2017, the Court of Appeals for the Ninth Circuit upheld a San Francisco ordinance that’s very similar to House Bill 7070. The court upheld that the ordinance clearly regulated commercial speech and that this type of prohibition against false, misleading or deceptive advertising adequately balanced the state’s interest in preventing consumer deception, especially with regard to women seeking reproductive healthcare services with the First Amendment rights of the centers. Although the plaintiffs in that case appealed that decision to the Supreme Court, the Supreme Court denied Cert, leaving the Ninth Circuit’s decision in place. In the past, the Supreme Court has said that the government may ban forms of discrimination, sorry, forms of communication that are less likely to inform the public than to deceive it.

Like the San Francisco ordinance, House Bill 7070, would prohibit limited service pregnancy centers only from engaging in false, misleading or deceptive advertising practices about the services they provide. It would not regulate, limit or impact any advocacy or other speech or conduct, including what they wear. These centers would be free to truly, truthfully advertise anything about the services they actually do provide. And any information about their ideas, their beliefs or even their own preferences for how a woman facing an unintended pregnancy should act.

Pregnant centers have argued that their speech should not be considered commercial because they offer their services for free. But a number of federal courts have rejected that. The center’s
decision not to charge fees can’t mean that they’re exempt from otherwise significant government interests. And it would be really problematic to find that the state has less power to protect those who could seek out and need free services, than it does to protect those who can afford to pay for them.

I’ll stop there with the time, but I’ll be happy to answer questions. Can I wrap up, is that okay?

REP. STEINBERG (136TH): Please proceed.

JORDAN GOLDBERG: I wanted to note that also in 2018, the Supreme Court struck down a statute, an unrelated statute that was also aimed at preventing women who are or might be pregnant from being deceived when seeking services. But that statute again as completely different. It compelled pregnancy service centers to make certain types of disclosures and speech, including putting up signs.

House Bill 7070 just doesn’t raise those same constitutional questions. It only prohibits false, misleading and deceptive speech. It does not require any specific speech. It doesn’t require any disclosures. It strikes a careful balance between the compelling interest of the state and ensuring that women are not deceived, when seeking reproductive healthcare and the First Amendment rights of the center. So, I strongly urge the committee to pass this legislation and I’ll be happy to answer any questions.

REP. STEINBERG (136TH): Thank you both for your testimony. And thank you for particularly your last comment, because I earlier tried to get someone who was testifying to clarify the difference between the
vote in the Supreme Court and this particular bit of legislation. I think you clarified it for the benefit of the members of the committee that these are different in terms of what activity they’re seeking to, to end. So, I think that was very important. Are there any, any committee members who’d like to ask a question, comment? Senator Somers.

SENATOR SOMERS (18TH): Seeing as we have you as an attorney, can you describe specifically what would be considered deceptive or misleading about the advertising?

JORDAN GOLDBERG: So, I think we heard from the Attorney General earlier and from, from everyone who had a law degree, I think, that deception and false and deceptive language in advertising is something that’s fact specific that a court or an attorney looking at the situation would have to specifically address. But I wanted to point out a couple of things that I did see in Connecticut. So, when women enter search terms like pregnancy into a search engine, they might come up in a Google search with something like a Google header, which shows the search terms that are relevant to the woman who is searching or for the person. You know, you could put in cat clinic and get a vet. One of the facilities in Connecticut comes up with a header, abortion, Woodstock, Connecticut, abortion clinic info, abortion costs. And that is the pregnancy resource center that doesn’t offer abortions. If you were looking for an abortion clinic, you might see that and think, oh, abortion, Woodstock, Connecticut and click on it. That is deceptive if you’re looking for a particular kind of service. I
can’t say for sure, not being the one enforcing it, whether that would rise to the level. But federal courts and state courts often interpret deception in advertising based on the context.

SENATOR SOMERS (18TH): Okay. We also heard from the Attorney General, the term potentially deceptive or potentially misleading. How would you put that into the context of this particular law?

JORDAN GOLDBERG: The legislation doesn’t talk about potentially deceptive; it talks about false, misleading or deceptive. And so I think that the Attorney General’s office, I’m sure, in their Consumer Protection Unit and any court who would be looking at this would be looking at, is this deceptive. And I think Mayor Bronin spoke to the types of standards that courts use. I’m not gonna try to recall from memory as he did, but I had it somewhere on a piece of paper. There are few factors, including what would a reasonable person think when they were seeking out a particular service and did the deception in the advertising change their conduct? If you were looking for an abortion and you Googled it and you came across this ad that looked as if it was offering you an abortion, does that change your conduct? Did you then go to that facility or call them?

In other parts of the country, where similar legislation has passed, San Francisco, some similar things were debated in Baltimore, there was evidence and in some of the larger entities that run protective services, there are sort of national groups that are networked together under a few umbrellas including Care Net and a few others. They have, in court documents, said things like, they are
intentionally vague. They, when someone calls and they are looking for an abortion, don’t explain that you’re not going to offer them that service. So, I think part of it is the response that they get when they get that phone call. But more importantly is that when they advertise, when they enter the marketplace, which is the same marketplace as any other reproductive healthcare facility, there’s no way for even a reasonably discerning customer or client or patient to discern between, oh, this facility offers abortion care and this one don’t.

SENATOR SOMERS (18TH): So, you said, when they enter into the healthcare market. I think you just said that, right? Entering into the market. But if these facilities are not clinics, they are resource centers, is that considered entering into the healthcare market, if they’re just providing resources, they’re not providing ultrasounds, et cetera, they’re just providing the resources, is that considered in the healthcare market?

JORDAN GOLDBERG: I was actually talking about from the perspective of the patient or client or person. She goes to look for services, she’s not in the position to know what other people are charging or not charging for those services. She’s looking for a specific set of healthcare services. So, for example, if you go onto the Yelp service, it’s not fancy, but if you go on to Yelp online, and you put in abortion in Connecticut, you get a list of, in theory, places where could obtain that service. Several of them are abortion facilities and several of them are crisis pregnancy centers or pregnancy resource centers. As a consumer or client or patient, I don’t know. Unless those ads are quite
clear, and they’re not necessarily quite clear. So, where this legislation is only targeting the ads themselves that are deceptive.

SENATOR SOMERS (18TH): Just a follow up, not to belabor this, but this is like very detailed. So, if I go, I went on earlier and I, on Bing and then on Google, Googled abortion, abortion services and I got a whole bunch of things on where to go, you know. But I didn’t see, when I clicked on the link, in my search, I didn’t find any of these pregnancy resource centers. But if you typed in the word abortion services and you clicked on it and it turned out it was a pregnancy resource center. And on their page it said, we provide these resources and there’s a disclaimer that says, we do not provide abortion services, would that be considered misleading for you?

JORDAN GOLDBERG: I think as you, as the committee has been saying in hypotheticals, this is tricky to really drill down on what any specific situation would lead to. I think it depends on the website and where the disclaimer is and what else the website says, it’s all about context. So, if the website is really vague, thinking about abortion, come here first and then the disclaimer is in tiny, at the bottom, and a reasonable consumer would not necessarily see that, but would see, thinking about abortion, we’re your first step. They might think, oh, I need an abortion, this is my first step. I will call these people. So, I think it depends on all of those factors. And I also, again, want to say as the Representative said earlier today, the Representative was saying before, this is not regulating anybody’s speech, it’s not being
deceptive. So, if someone would view that, view a particular website and it’s quite clear, the disclaimer is quite clear, we don’t refer for abortions here. We only refer you for adoption or prenatal care, but we will talk to you about all your options. That’s not deceptive and it wouldn’t rise to the level of deception.

SENATOR SOMERS (18TH): Thank you.

JORDAN GOLDBERG: Thank you.

REP. STEINBERG (136TH): Are there -- yes, Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman Steinberg. Thank you for coming to testify today. I, just by curiosity, I Googled Connecticut abortion center, and the first proposal that I get from Google is abortion alternatives. And you go on the website, and then just bear with me, I’m just gonna quote, referrals for medical support, financial resources, housing, legal, social assistance, professional counseling. It’s, to me, I tend to agree with you. This is kind of misdirecting, I believe, so I’m really thankful for your testimony and for the details in your testimony and thank you, Representative. Thank you.

JORDAN GOLDBERG: Thank you.

REP. STEINBERG (136TH): Other comments or questions? If not, thank you for your testimony today, we really appreciate it.

JORDAN GOLDBERG: Thank you.
REP. STEINBERG (136TH): We will now move on to the last person testifying on Senate Bill 380, that would be Caleb Lopez.

REP. DELNICKI (14TH): With the Chairs indulgence, I’d like to make a couple of comments before Caleb gives his testimony.

REP. STEINBERG (136TH): For you, Representative Delnicki, we’ll make that exception.

REP. DELNICKI (14TH): Thank you, Representative Steinberg, Chair Steinberg, Chair Abrams, Ranking Member Somers and Petit. It is an honor to be here with a member of the South Windsor Police Services, Officer Caleb Lopez. You know, on our worst days, we look for the men and women of law enforcement to be there for us, to provide us with the help and the assistance that we need, when we have a time of trouble. And it seems just plain wrong that when one of these men or women of the police forces that protect us, reaches out to seek medical help, they find themselves in a situation where they could very well lose their job. They’re voluntarily seeking help. And that says, that says it all from my perspective.

As a former Mayor of the community of South Windsor, I’ve gotten to know the men and women of law enforcement, their dedication, their commitment to the community and the value that they bring. Now, I don’t want to each too much of Caleb’s time up, so I’m gonna turn it over to him to make his comments. But again, I want to thank Senator Somers for this proposed bill, Senate Bill 380, because it goes a long ways to providing that kind of help without a fear of being penalized for asking for help. Caleb.
CALEB LOPEZ: Thank you, sir. Thank you, committee members for allowing me to speak today in favor of S.B. 380. I have submitted testimony in writing, but I wanted to speak to you in person on behalf of my brothers and sisters in blue. There seems to be a lot of want for statistics and numbers. As of seven hours ago, there have been 28 confirmed law enforcement suicides in the nation. These are the ones that we know of. These are the ones that have been disclosed. I fear that there are others that we will never know of.

I have to wonder if any of those 28 officers were afraid to get the help they needed because of the stigma around mental health, that they were afraid that their careers would be over the moment they asked for help. I wonder who could have been saved with a bill like S.B. 380 in place to protect them and give them peace of mind.

I am here today because four years ago I took a chance and got help when I needed it most, when my crisis had affected my job and my family. When at my darkest I could have lost it all. I’ll rush it right through. I got help and though it always, it’s always gonna be a work in progress, I am better for it as a father, a husband and a police officer. But as I’ve advocated for my brothers and sisters in blue to get help to take care of themselves by talking about my story, I worry that it might be used against me. I am part of peer support, but yet I continue to be fearful because old mentality still exists. I have seen my brothers and sisters struggle as they respond to tragedies, they are expected to go to, and then go about their normal duties. Officers who responded to the two worst
shootings in the State of Connecticut, in 2010, 2012, still struggle with what they saw and experienced. Many were expected to return to normal duties, sometimes the same day, without processing what they had gone through.

After all, that’s what we signed up for. That’s what the pundits will tell you. But quietly, we do suffer, knowing we won’t be punished or lose our chosen careers, the calling that we have as law enforcement officers, when we do reach out for help. It will save lives.

I ask that you support S.B. 380, please. I don’t want to go to anymore police funerals. I want to be able to one day say, the statistic is zero suicides this year.

Thank you.

REP. STEINBERG (136TH): Thank you for your testimony today. Even though we haven’t heard necessarily a lot of testimony, it has all been extremely pointed and extremely well-reasoned, giving us reason to believe that the bill that we have before us is very important. And I hope we’ll have your ongoing involvement as we try to get the language just right so that, as you said, we can avoid even one more suicide among our first responders.

Thank you again.

CALEB LOPEZ: Thank you.

REP. STEINBERG (136TH): Other comments or questions? Senator Somers.
SENATOR SOMERS (18TH): Good afternoon, and thank you for sharing your personnel testimony, it goes a long way for us to hear personally how current legislation or potentially changes in the legislation can affect somebody individually. I was wondering if you could speak to if this law is to pass, obviously, when the language is crafted more specifically, as Chairman Steinberg has indicated, how do you think this will affect our policemen working on the municipal level, potentially on the state level, how will this transform their lives? How do we, how will it make it better? How will it change the work environment that they’re in now? Can you speak to that? And how would it have changed what you’ve gone through?

CALEB LOPEZ: I believe it will be a game changer. I believe that obviously we have a lot, a lot of work to do in terms of mental health overall, not just in law enforcement, but overall in terms of stigma, in terms of assumptions, in terms of all the things that for generations have been associated with it. And only recently have we started to make positive changes in that, 2019, and sometimes it still feels like the dark ages. In terms of law enforcement, I think that basically if one person, one brother or sister in blue, can suddenly feel safe enough, supported enough to reach for help, to come forward, to know that their department by law, even if they wanted to support them; in other words, right now, even if the department wants to support them they are, they may be restricted in what they can do for them. But if that restriction is off, now that law enforcement is able to seek help, is able to come forward and say, so, I can be a better person, so I can be there for my family and my
community, I need to take care of myself first. And I don’t have to worry that when I come back, I’m gonna be told, you don’t have a job or you’re gonna be stuck in this desk for a while. I think that will go a long way. I know that there are officers right now who are just really waiting for that chance that they want to come forward, but that, that one hesitation is still there. And if we could get rid of that cause of hesitation, I think lives will be saved.

SENATOR SOMERS (18TH): Thank you for that.

CALEB LOPEZ: Thank you.

REP. STEINBERG (136TH): Representative Arnone.

REP. ARNONE (58TH): Thank you, Chairman. I also think on a local level we really need to start training too, also mental health training to the officers too to break that stigma.

CALEB LOPEZ: Yes.

REP. ARNONE (58TH): So I think it’s time to step up after, if this should go through, the local, each department should encourage their departments to train their officers, also, using even social services, local social services that are already in behavioral health, so.

CALEB LOPEZ: Absolutely.

REP. ARNONE (58TH): Thank you for your testimony. Appreciate it.

REP. STEINBERG (136TH): Representative Comey.

REP. COMEY (102ND): Yes, thank you. Thank you for your, your heartfelt testimony. I think also, I
know in my community, first responders in general go under, you know, have a lot of trauma in their jobs and, you know, I don’t think we should set up here with just, with just the, the police officers, law enforcement officers, but also fire, first responders on fire and first, you know, other emergency personnel. I think it’s important that we can take that into consideration in my community it’s been an issue.

CALEB LOPEZ: Absolutely.

REP. COMEY (102ND): And we want to save lives.

CALEB LOPEZ: Absolutely.

REP. COMEY (102ND): Thank you.

REP. STEINBERG (136TH): Other comments or questions? If not, again, thank you for taking the time to be here today. It’s really very important and hopefully this is the year we will get this fixed.

CALEB LOPEZ: Thank you.

REP. STEINBERG (136TH): All right. We still have a couple of more elected officials. Is Senator Looney in the room? I don’t see him. So, there’s one more person on the list that, and I’m having problems reading it, Mairead Painter, is that correct? Okay. And my apologies for any mispronunciation based upon limited ability to read.

MAIREAD PAINTER: Good afternoon, Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit and distinguished members of the Public Health Committee. My name is Mairead Painter, and I am the state Long-Term Care
Ombudsman. The Long-Term Care Ombudsman Program is mandated by the Older American’s Act and Connecticut General Statutes to provide services to protect the health, safety, welfare, and rights of long-term care residents in nursing homes, residential care homes, and continuing care communities.

I am the State Ombudsman, it’s my responsibility to facilitate public comment and recommend changes to laws, regulations and policies. This afternoon, I’m here to speak to you regarding Bill 5276, AN ACT CONCERNING THE SAFETY OF NURSING HOME RESIDENTS AT RISK OF FALLING, that is before you today.

My office very much appreciates the concern of the safety of nursing home residents, the Long-Term Care Ombudsman Program is equally concerned about the risk of falls in nursing homes and identifies the need for protection. Although this bill is very well intended, we have some concerns related to the specific recommendations in the bill.

It is proposed that nursing homes allow the use of personnel alarms and a sitter to reduce falls. Please allow me the opportunity to tell why we have some concerns. Bed and chair alarms became more popular in the 1990s when physical restraints began to be phased out. Bed and chair alarms are used to alert staff when someone is repositioning themselves or maybe trying to exit their bed or a chair.

Unfortunately, outcomes have shown that alarms and other measures like floormats or lower beds do not always prevent falls and sometimes can cause falls. Alarms can create a false, a false sense of security for staff and sometimes cause staff to check on
residents less often that may be at risk for falls because they’re listening for the alarm.

Residents have reported also feeling trapped or afraid to move because if they adjust themselves, the alarms go off. This is disruptive to them while they’re sleeping or going about their day and may also be disruptive to peers or roommates. It can startle a resident. If they hear an alarm, they may not have the capacity to understand why the alarm is sounding and they may actually try to retreat or exit more quickly because they’re afraid there’s something wrong, which we’re all taught, when you hear an alarm, you exit, you might try to exit your bed. You try to exit your room. Moving in this hurried capacity could cause an individual to become injured more severely.

The second option, a personnel sitter, although very necessary at times, can make individuals feel like they’re in prison, like they’ve done something wrong, like someone’s watching them 24/7. They may not have the capacity to understand why someone’s watching them. And this can cause increased anxiety and increased agitation, which also can increase falls.

To reduce the risk of falls, the Long-Term Care Ombudsman Program would endorse individualized person-centered care plans. These plans should include a time study and ask the question, why is the person exiting their chair or bed? Are they having pain? Are they seeking to use the bathroom? Do they need to get up and exercise? And by doing these time studies and allowing for individualized planning, we’re better able to meet the person’s needs and to reduce the risk of falls.
I will add that this method does require adequate staffing and that individuals’ needs are able to be met. And there really is no way to totally prevent falls, but we want to make sure that we’re doing the best by the person and not using electronics as a way to get around providing them with the highest level of care.

I thank you for your time and attention and I look forward to working with you on an ongoing basis. I’m happy to answer any questions you might have.

REP. STEINBERG (136TH): Thank you for your testimony and particularly your last comment, working with us on this. I’m sure you understand that our desire is to find the most effective and efficient way to address the risk of falls in that environment. The representative who brought it forward I think was sensitive to the fact that there might be concerns about staffing and that’s why the electronic alternative was being considered as perhaps more cost effective. But I think you’ve given us a good insight about how that could also have, as everything else we seem to do around here, consequences that we had not intended. I think that the concept of an individualized review is very sensible, if the particular facility has the resources to do that. And I would imagine there might even be some limited instances where an electronic sensor might be appropriate, but only after that review has taken place and better, the use, or the people at the facility were trained to do so, do that analysis rather than the legislature impose that one size fits all, topped absolution which we do all the time. So, I thank you for your very thoughtful and sensitive response. We’re gonna
work with you and others to see if we can come up with an answer to address this problem that is reasonable and cost effective. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. I wonder if you’ve spoken with the nursing supervisors in facilities you work with and whether or not this is something as a matter of standard of care they’re doing already on a regular basis, number one. And number two, obviously a daily sitter, one-on-one, I think is clearly going to be far more expensive than an alarm. And I don’t know if you have any idea what the cost of an alarm is in general?

MAIREAD PAINTER: Well, there are kinds of alarms. The personal alarms that alert and would alert staff to go to the rooms, I believe most nursing homes, although many began using them as a best practice. Many are phasing them out because of injuries and because of standards that we’ve seen where there’s contradicting information about them. When you’re speaking of sitters, that is very expensive. A one-to-one sitter, in some cases, it is absolutely necessary of the safety of the individual and that is determined by the nursing home, by the care plan team, and the assessment done with the physicians.

The only other type of alarms that they have, there are some personal alarms where it remotely beeps like a beeper function to a caregiver on the unit. But if that caregiver is with someone else, if there’s something else going on, they may not be able to get to the person because you could exit a chair or a bed fairly quickly. So, that it wouldn’t 100 percent reduce falls. But if it was sounding directly where the person was, there would be less
of a risk of that person responding to the sound and trying to move.

REP. PETIT (22ND): I guess I would just say, thank you, Representative, Chairman Steinberg, it’s a thought. It’s sort of really in the weeds of the nitty gritty of day-to-day patient care and hopefully we don’t do something that makes it worse for everybody because, you know, the people on the front lines caring for these folks every day have a better insight as to what works, what doesn’t work and what may be affected. But thank you for your advocacy for these folks and hopefully we can continue the conversation and come to an appropriate decision. Thank you.

MAIREAD PAINTER: Thank you.

SENATOR ABRAMS (13TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman Abrams. Thank you for your testimony today. I’m not really familiar with the, the bed alarm. Can you maybe more in detail how they work, like because there was mention that if the patient would move or go to the other side of the bed and then and then it would prompt the alarm. Can you just --

MAIREAD PAINTER: Sure.

REP. MICHEL (146TH): -- give some --

MAIREAD PAINTER: There’s a couple of types of alarms and there may be more than I’m even aware of. One of the pads that goes underneath the sheets on the bed, where if someone moves or the pressure changes to a certain degree, the alarm goes off. There’s another type of alarm that has a sensor under the bed, a motion detector, where if the
person’s legs were to swing over the side of the bed, it would alert them that an individual was sitting up and their legs were swinging. The sensors that also go in wheelchairs, so if someone is sitting in their wheelchair and they attempt to release pressure, the sensor can go off.

One of the difficulties is over time, the sensors wear down and with subtle movements the alarms go off, which can be very disruptive where a person feels like they’re afraid to move or when they’re sleeping it wakes them up repeatedly, which causes a poor night’s sleep, which can cause agitation the next day.

REP. MICHEL (146TH): Thank you very much for the testimony. I’m pleased to introduce you to my grandfather who passed away a couple of years ago, but we had the problem with constantly falling. We were not sure if it was drinking too much red wine at night or anything else, but pretty sensitive, so thank you very much for the details and appreciate also working together as well. Thank you.

MAIREAD PAINTER: Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.

MAIREAD PAINTER: Thank you very much.

SENATOR ABRAMS (13TH): Have a great day. So, next it’s my understanding that Representative Dathan is here. Hi.

REP. DATHAN (142ND): Thank you, Senator Abrams, Representative Steinberg, who just stepped out, and everyone else on, the distinguished members of the Public Health Committee. Thank you very much for
hearing me today. My name is Lucy Dathan. I represent the 142nd District, which comprises Norwalk and New Canaan. And I’m here today to testify in support of House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

I looked at this bill as a consumer protection bill. And I feel that this bill would not affect people and businesses that are good-faith actors. I believe that all medical clinics should be honest and the types of services that they provide. And whenever a clinic starts to engage in deceptive practices, this is a serious problem. This bill does not infringe on First Amendment. We routinely force medical professionals to disclose the side effects of the procedures and medications they provide. You see this on websites of side effects, you see this in terms of pretty much any drug or something that you would buy. And I feel that this is part of it.

I support the clinics that don’t provide abortion services that are honest in their advertising about the services that they do and don’t provide. Just like the other people who have testified, I have done some Google searches and I was pretty surprised to see when searching, you know, abortion services Connecticut, you know, limited service pregnancy centers were coming up and crisis centers. And I felt that that just wasn’t fair that they were coming up, acting like they were providing those services, but when indeed when you looked at their website, it didn’t seem like they, they did, or they didn’t. So, I felt that that was the problem.
That’s one reason why I decided to come out today and testify.

So, just in conclusion, I just wanted to reinforce that I strongly support the House Bill 7070 to limit the deceptive advertising practices of limited service pregnancy centers in our state.

Thank you very much.

SENATOR ABRAMS (13TH): Thank you, Representative. Any questions or comments? Representative.

REP. CANDELORA (86TH): Thank you and thank you for your testimony. I just, you made a comment I just want to flush out. If, if a Google search is done for abortion clinics and these limited life centers come up, you wouldn’t suggest that we should have a law that sort of makes them culpable for search engines --

REP. DATHAN (142ND): No, not --

REP. CANDELORA (86TH): -- on these websites?

REP. DATHAN (142ND): No, no. It’s more of, it was more looking up something, finding a service and then going and looking at their website and seeing that they may include variety of the services they do provide. But in some of the cases, with two examples, Hopeline and ABC Women’s Center, it was, it looked like it was clear that they provided abortion services as part of their list of services. So, it was on their website. But my more point was I was trying to get to see if this was one way to determine if they were part of the, you know, crisis prevention centers or pregnancy centers.
REP. CANDELORA (86TH): I appreciate that. And I just asked it because one of my concerns with the way this bill is written, it’s giving the Attorney General the ability to bring a cause of action against private businesses, which is something that we don’t do under Connecticut law, it’s very rare. And so, one of the things that I’m still trying to get my arms around is what is the scope of this authority that’s going to be given and that’s sort of why I had asked that.

REP. DATHAN (142ND): Okay. Again, in my looking at this, I don’t feel that this bill infringes good faith actors. So, as long as, you know, somebody does what they say, then I don’t feel that this bill infringes that.

REP. CANDELORA (86TH): Well, would you be, I guess I wouldn’t disagree. I, I would agree that the bill itself doesn’t seek to infringe upon people that might be bad actors, but again, as it’s drafted, it would give the Attorney General the ability to go into court and sue and cause, you know, litigation and somebody else would have to make that determination. I think that’s sort of where the issue is. Would you be okay if the bill had sort of clearly and public policy prohibited this type of behavior, so prohibited the deception, but maybe didn’t allow for a cause of action to be brought?

REP. DATHAN (142ND): I’m gonna let the lawyers talk about that. That’s not my specialty.

REP. CANDELORA (86TH): Okay. Thank you, I appreciate that.

SENATOR ABRAMS (13TH): Thank you. Representative Michel.
REP. MICHEL (146TH): Thank you, Chair Abrams. Thank you for testifying today. I think when we’re talking about making a Google search, the search engine uses the wording used by the website that advertises the center itself.

REP. DATHAN (142ND): It comes in the logarithm, you’re right. So, if you have somewhere on your page, the way Google works, is it picks up the syntax and that’s how Google works.

REP. MICHEL (146TH): And, you know, I did a couple of searches myself and it does appear that you get somewhat types, some of those centers that actually don’t really do the services that you would expect them to do when you’re doing the search. And that’s all I wanted to add. Thank you for your testimony.

REP. DATHAN (142ND): Thank you.

SENATOR ABRAMS (13TH): Representative.

REP. ZUPKUS (89TH): Thank you. I just want to make one comment about Google searches. I am certainly no pro at the computer or Google searches but, you know, I’ve searched for things and things that are similar related come up and it may not be what I’m looking for. So, how you tackle that, I don’t know. But I don’t see a problem personally, when you Google search something and a pregnancy center comes up or whatever, that’s just the nature of the internet.

REP. DATHAN (142ND): I understand, my more point was I saw that and when I started digging into the website that actually were resulting in that search and looking at what they were advertising that they do, but when, in fact, they don’t do that. And
that’s, you know, again going back to my phrase about, I see this as a consumer protection bill. And we offer consumer protection in so many other spaces, I would see that this would cover the same thing.

SENATOR ABRAMS (13TH): Any other questions or comments to the Representative? If not, thank you very much for your time. We’re going to be moving on to bill, Senate Bill 46, and Dr. Jonathan Martin. Okay. Thank you.

JONATHAN MARTIN: So, Senator Abrams and members of the Public Health Committee, Dr. Petit. Thank you for giving me the opportunity to share my thoughts about S.B. 46, AN ACT PROHIBITING HOSPITALS FROM CHARGING FEES FOR TRAUMA ACTIVATION.

My name is Jonathan Martin, I’m the Chief of Neurosurgery and Associate Director of the Trauma Program at Connecticut Children’s Medical Center, here in Hartford. Our facility submitted written testimony in opposition of the proposed legislation. I’d appreciate if you’d review the details that are provided there. Rather than speak to these details, I wanted to use the remainder of my three minutes to illustrate the value of trauma activation for the average citizens of Connecticut and convince you that payment for trauma activation should be protected.

All the photos that you’ll see here today pertain to this one child. There’s nothing staged. Everything that’s here relates to the care of a child that we saw in the early evening hours of Friday, June 2nd of 2017. We received this 8-year-old male following a motor vehicle accident. The child met criteria
for an activated trauma and our trauma system mobilized. Technicians, nurses, anesthesiologists and surgeons answered the call.

The child had an injury to his aorta, which is a large blood vessel in his chest. I don’t think you need to be a radiologist to look at this and see there’s a big difference between the two sides of the chest of this photograph. It filled his chest cavity with blood. Three surgeons worked on his chest; four anesthesiologists resuscitated him.

This is a transport from the ER to where he received further care, fresh out of another operating room. I transported blood from the blood bank to lend a hand. The system worked. And against all odds, this child survived.

Make no mistake. This child would not be alive today, had he presented to a facility without he infrastructure present at a trauma center. Accreditation by the American College of Surgeons is not window dressing. It’s one through investment, organization and commitment of considerable resources, both time and money. Without adequate financial support, it cannot be sustained. Each provider testifying here today has invested similarly in their facility to provide a safety net for you, your families and all citizens of the State of Connecticut.

I implore you to support the Connecticut Trauma System and vote no on S.B. 46. Thank you for your time and consideration.

REP. STEINBERG (136TH): Thank you, Doctor, for your testimony, particularly how well you put it together in a way that is very easy for us to see the true
benefits of having this important care available as needed. And we’re very pleased that the story ended as well as it did because I’m sure there are other instances which don’t end so well, when that’s not available.

I’m sure you understand the intention of the legislator who brought this forward. There are obviously costs that need to be borne by someone. And I’m not sure there is a perfect solution to this. But I don’t think anyone argues the importance of having the activation of the trauma capability available for, for whatever is in need. We’re struggling to figure out the best way to address the financial implications of that.

JONATHAN MARTIN: Certainly understood, you know, as a recipient of a high deductible healthcare plan, I certainly am well aware that the costs for my own family in terms of healthcare. What I can tell you to just put it in perspective, last year, Connecticut Children’s Medical Center, we had a total of 38 activated traumas, 38, out of well over 50,000 emergency room visits. A child like this, there’s no question, if he didn’t receive care literally within minutes at the level that he did, if this entire, flip it back over for me, if we didn’t have this type of robust response, he dies. The only way we can do that is to make sure that those resources are available and that that cost has to be borne and it is a difficult decision. I understand your position, it’s a difficult one.

I can tell you that the American College of Surgeons and certainly folks more senior than me in terms of organized medicine within the state and nationally have looked at this. Certainly our hospital is very
supportive of this course of action because there are no easy answers, but we feel this is a good one.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for that testimony. A couple of basic questions for all of us, including myself, an endocrinologist who tried to stay away from trauma as much as possible. Who can activate the trauma system, if my dad falls off the ladder at home, can I call up and get the system activated or is there a specific protocol for activation?

JONATHAN MARTIN: There is an activation protocol. It has to be activated, and again, I’ll certainly make sure that some of my trauma colleagues again, as a neurosurgeon who spent some time in the military downrange, I have a vested interest in trauma. I’m not involved to the same level as everyone else that’s here, I think you’ll see they’re general surgeons, not neurosurgeons. I have our activation criteria here, I’m happy to submit to you. You can’t walk through the door and activate a trauma on yourself. This is typically activated by the paramedics and/or folks in the field meeting specific criteria, either based on mechanism of injury or severity injury in terms of specific physiologic criteria, low blood pressure or a neurologic exam that is, that’s impaired to a specific, but it’s very specific criteria, sir, to your point.

REP. PETIT (22ND): Okay. And, and to go the other direction, you had 30 out of 50,000 visits, do you recall or is there any data on how many were false alarms you activated and didn’t need the team, is
that a 1 percent occurrence, a 5 percent, a 30 percent occurrence?

JONATHAN MARTIN: Yeah, so, you know, we do have over-triage rates that are tracked by our trauma program. I apologize, I don’t have the numbers here in front of me. What I can tell you is typically we like to keep that over triage-rate less than 5 percent at our facility.

REP. PETIT (22ND): I’m sure me and the committee would love to see the raw data to look at.

JONATHAN MARTIN: We’d be happy to provide that to you. I can get that to you later today.

REP. PETIT (22ND): And finally, just in terms of general information, when you say this, can you sort of enumerate the types and number of people that you activate; who comes from where and what do they bring, what does it really mean in terms of real resources?

JONATHAN MARTIN: Absolutely. Within the emergency room, there’s obviously a technician, a bedside nurse, and the emergency room physician. If a trauma activation occurs, there are certain folks who are automatically going to show up. So, for us, it is one of the trauma surgeons, they may have a backup surgeon that’s pulled into this and various subspecialists, neurosurgery, orthopedic surgery. We have specific criteria response times. So, if my input is requested, I have 30 minutes to respond to the bedside for any requests that are made by the trauma team. So, it really requires, you know, a full complement of subspecialty providers. And again, our testimony that’s submitted to you, there’s a more comprehensive list, obviously, I
missed radiologists, there are intensive care providers that are involved as well, cardiothoracic surgery may be involved, craniofacial surgery, orthopedic surgery, urology, it really takes a full complement. And to have them available to drop everything, that can’t happen unless you have a system in place. It doesn’t happen out of good hearts or good will.

REP. PETIT (22ND): All right. And I appreciate that. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Just a quick follow up and then we’re going to have Representative Arnone, Representative Michel, Representative Zupkus. You mentioned a protocol. In your opinion, is there any upside, any refinement one might make to that protocol to reduce the number of unneeded activations?

JONATHAN MARTIN: My answer to that is no. We have, we have a committee that meets very regularly, so we have a trauma committee. We do that in partnership with Hartford Hospital that studies all of our policies and protocols. Many of these are driven in the national level by the American College of Surgeons. Things such as advanced trauma life support. These were systems that were built based on bad outcomes. I believe the ATLS and someone can comment on this, was developed in the ‘60s and ‘70s by an orthopedic surgeon, who’s family was in a car accident somewhere in the Midwest and the trauma system just was not available. These are built from experience, that’s a partnership between civilian trauma, military trauma, these are really robust protocols that have been refined, not locally but nationally and internationally, sir.
REP. STEINBERG (136TH): Representative Arnone.

REP. ARNONE (58TH): Thank you, Mr. Chairman. So, on activation, do you know what the percentage of personnel that are actually in the hospital that respond to these or are, are, there’s a large percentage that have to come in or do you have staff already in the hospital and what the percentage or numbers of that would be?

JONATHAN MARTIN: It’s an excellent question, sir, and it really depends on the time of day. What I will tell you is we have a requirement for in-house attendings for the trauma surgery program. From the standpoint of neurosurgery, orthopedics, et cetera, these are folks who are outside of house, and that’s why there are timed criteria for response to bedside.

REP. ARNONE (58TH): Okay. Thank you very much. One last question. So, the range of costs on this can go from $1,000 to $50,000 and is that too also, of course, a type of care, but and also there’s a change with it, who’s on duty?

JONATHAN MARTIN: Sir, I’m probably not the best person to speak to cost. You know, I sort of am more involved in the delivery of care and the building of systems. But in terms of billing and coding, I apologize, I don’t have that information in front of me. My guess is that some of my colleagues here today do.

REP. ARNONE (58TH): A lot of nodding heads. Thank you very much.

JONATHAN MARTIN: You’re welcome, sir.

REP. STEINBERG (136TH): Representative Michel.
REP. MICHEL (146TH): Thank you, Chairman, and thank you for testifying today. I visited the children’s hospital during our training. I’m one of the new representatives. And it’s an amazing operation. Not to repeat what Representative Arnone said, but are we including in the cost, the number of staff or the action of paging? I’m reading the bill and I’m trying to --

JONATHAN MARTIN: So, when a trauma activation occurs, and again, sir, I apologize, I’m not involved in billing and coding, so I don’t want to speak outside of my area of expertise. But my understanding is that there’s a cost generated when a trauma activation happens. And again, much of this is based on the resources that we need to have at the point of care immediately to achieve outcomes like what we’re discussing here. This is not something in a very severely injured patient that can wait. Seconds matter. Seconds matter.

REP. ARNONE (58TH): I know you’re saying you’re saying your not very familiar with the cost, but is it depending on the number of, of responders to that activation?

JONATHAN MARTIN: Again, sir, I don’t think I’m equipped to answer that question for you.

REP. ARNONE (58TH): Okay. Thank you. And then, that’s another question about costs. And then if this would be passed, this bill, would this mean that the activation would then not be available, the trauma activation?

JONATHAN MARTIN: If this, would it, would it be available? What I would say is for every action that I’m aware of there are consequences. When we
have to make decisions, there are, I will tell you
that at our facility, we have huge volumes of unpaid
care in a given year. 50-plus percent of my
practice is Medicaid and so there are plenty of
things that I do that I receive no reimbursement for
them. At some point, the lack of reimbursement has
consequences. I’m not sure exactly where that
happens, sir, but I certainly have concerns. We
have a robust trauma system that we’re very proud
of. And where exactly those lines get drawn, are
above my paygrade. I will continue to comment about
that.

REP. ARNONE (58TH): Sir, it would be very
interesting, I think, for members of the committee
to get the cost to the hospital and cost to
patients.

JONATHAN MARTIN: I think there will be people
testifying here today that are more senior than I am
within organized trauma within the state.

REP. ARNONE (58TH): Okay.

JONATHAN MARTIN: I’m the graphics guy.

REP. ARNONE (58TH): And I see a lot of people
nodding their heads, so we’ll probably get answers a
little later. Thank you. Thank you for testifying.

REP. STEINBERG (136TH): Thank you, Representative.
Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, cost was my
question, but since I have the floor to ask you a
question. Could you tell me how it’s activated and
what happens?
JONATHAN MARTIN: Absolutely. So, typically if we have a trauma that’s arriving, such as this child did from the field, we get a call from the scene, from EMTs and/or paramedics who are assessing the patient and the mechanism. And so the trauma activation, that decision is made by the ER provider typically. Again, based on specific criteria. Again, I’m happy to provide you with our activated trauma criteria, which are here on this sheet of paper.

REP. ZUPKUS (89TH): So, you don’t actually call the trauma team in, that’s done by the ambulance people or who?

JONATHAN MARTIN: No, ma’am, I apologize if I’m not being clear on that. So, the determination is made by the emergency room physician, who then activates, it’s a trauma activation. So, they call at our facility, and every facility is different, they notify the paging operator who then activates the appropriate code for that to happen and pages go out to individuals who start to mobilize and move towards the point of care.

REP. ZUPKUS (89TH): Thank you. I worked in a hospital at one point and saw people, they would do a code, and everybody ran, and I was very thankful, actually, when I heard that code and saw people running because that meant trouble. So, thank you.

JONATHAN MARTIN: Yes, ma’am. Yes, sir.

REP. STEINBERG (136TH): Representative Michel for the second time.
REP. MICHEL (146TH): Thank you, Chairman. Do you know what the criteria is for the paging operator to actually initiate the, the activation?

JONATHAN MARTIN: Again, sir, they’re told what to do. There’s no decision that’s made on the part of the paging operator. The emergency room provider activates that and uses the paging operator to disseminate the information. But again, our criteria for activating, and I can read them if you would like, if that would be useful to you. I can at least start down the list. So, shock, hypotension, tachycardia, bradycardia, respiratory distress, airway compromise intubation, penetrating or significant crush injury with the following, head, neck, shoulders, chest, abdomen, groin or pelvis. Penetrating injury to an extremity with neurovascular deficit, the list goes on. So, there are very specific criteria for these.

REP. MICHEL (146TH): I might not have been, I also have a French accent, which I apologize for, but --

JONATHAN MARTIN: It’s an excellent accent, everyone in the room is enjoying it.

REP. MICHEL (146TH): I meant the criteria, meaning, I guess you know automatically when a patient comes in if they’re insured or not insured?

JONATHAN MARTIN: Oh, no, that, that absolutely no bearing, no bearing.

REP. MICHEL (146TH): Because it’s an emergency?

JONATHAN MARTIN: Correct.

REP. STEINBERG (136TH): All right. Anybody else for the second time? If not, thank you for your testimony. We may call you back because of your excellent presentation skills, I think more people - -

JONATHAN MARTIN: I’ve been asked actually by some of the other members to leave these; is that a bad thing from your perspective or the photographs? If you want to take them away, I will, but I’ve been asked to leave them.

REP. STEINBERG (136TH): Take them away at this moment in that we have other people testifying. We don’t want to obscure anybody’s visit, but they are really handy. I like the way that you’ve handled the framing and everything. But we’ll take that up later. And now we are, I believe, Senator Looney is present and available to testify.

SENATOR LOONEY (11TH): Good afternoon, Senator Abrams and Representative Steinberg and members of the Public Health Committee. I’m Martin Looney, State Senator from the 11th District, representing parts of New Haven, Hamden, and North Haven. And would like to express my support for two bills on the committee agenda today. First, Senate Bill 46, AN ACT PROHIBITING HOSPITALS FROM CHARGING FEES FOR TRAUMA ACTIVATION. And also House Bill 7070 AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

First, on Senate Bill 46, a trauma activation fee is a fee charged when a hospital or a trauma center activates and assembles a team of medical professionals to meet a patient in the emergency department. It is billed separately and in addition
to the hospital’s charges for emergency department physicians, procedures, equipment and facility fees. A report by Vox and Kaiser Health News found that the fee can vary from about $1,000 to over $50,000. And these fees are fairly new. The National Uniform Billing Committee, first allowed these charges in 2002 in response to a trend of center closures.

Trauma Activation fees are unregulated; any trauma center or hospital can just decide to charge this fee and then decide how high the fee will be.

Connie Potter, an executive who was involved in the creation of these fees, has asserted that some hospitals began abusing the fee by charging an exorbitant amount that seemed to be based on the sole discretion of hospital executives rather than actual costs. She said, “To a degree, I feel like I created a monster. Some hospitals are turning this into a cash cow on the backs of patients.”

According to an article in Physician Weekly, nearly all, “nearly all of the personnel involved in a trauma activation are already in the hospital and receive their salaries whether trauma activations occur or not.” If this is true, there would appear to be little justification for large trauma activation fees.

It would seem that a hospital’s billing fees for physicians, equipment, procedures, and facilities should be sufficient. It’s unclear why there should be a large additional charge for paging medical staff to attend to a patient. It wasn’t necessary before 2002, so why is it necessary now?

If the hospitals can prove that these fees are necessary and are appropriate, then the fees should
at least be regulated and consistent. As a first step, hospitals should make these fees transparent. Connecticut hospitals should be required to report to the Office of Health Strategy what trauma activation fees are charged and what trauma activation fees are collected. In addition, if hospitals are allowed to continue to charge these fees, the fees should be capped.

Thank you for hearing this important consumer protection legislation.

Also, on House Bill 7070, this proposed legislation is rooted in the basic principle that predatory entities should not be frustrating the purpose of consumers through the use of false advertising.

The bill would protect clients from false, misleading, or deceptive advertising from facilities that provide services to pregnant women. These facilities, often referred to as “crisis pregnancy centers,” are organizations that attempt to look like legitimate family planning clinics, while actually providing medically inaccurate information. Under the guise of being a comprehensive reproductive healthcare provider, these crisis pregnancy centers routinely use delay tactics and medically inaccurate information to steer people away from choosing time-sensitive reproductive healthcare. They frequently target urban neighborhoods and other medically underserved communities where people do not have access to regular gynecological services.

Irrespective of one’s views on access to abortion, I hope that we can agree that using dishonesty to manipulate health care consumers is something that
we cannot tolerate in Connecticut. Just as we aggressively pursue other kinds of false advertising issues. We must protect our residents seeking real reproductive healthcare from the calculated misinformation of some in crisis pregnancy centers.

Thank you, Madam Chair, Mr. Chair, and I wanted to commend this committee for raising these important bills and also to commend all of the important work that this Committee on Public Health has done for so many years in making us a leader in many ways in terms of consumer protection, health-related legislation.

REP. STEINBERG (136TH): Thank you, Senator, for taking the time to testify today. And thank you for all your work that you’ve done within the public health arena. There are many things that we will continue to consider that were initiated from your office. And we look forward to talking to you more as the session continues.

With reference to Senate Bill 46, in your testimony, I don’t know how much of the testimony you heard of the previous testifier with regard to that, but I made a point to ask him about the existing protocol by which they determine whether an activation is appropriate. I got the sense from him that it is based upon long experience, not merely at one hospital or in the State of Connecticut, but nationally, so it is far from a trivial decision on their part. Certainly based upon your testimony today, we will ask subsequent testifiers whether or not they’re aware of the instances where hospital CEOs may interfere, if not in the process of activation, but in the determination of what the
appropriate recompense would be from the individuals involved.

I guess the question I have is, your testimony seems to relate more to the compensation than it does to the need to activate in the first place, which is, I think, what would be the ramification if this bill were to pass would be to end the ability to bill the individual involved rather than having a conversation about the amount of that billing.

So, I just want to highlight that if there’s a separate issue that relates to unfair billing practices, that might be a separate issue which may or may not be the purview of this committee, but if you can give us additional information with regard to any instances where you know that occurred, that would be very helpful for us to move forward with addressing that problem as well.

SENATOR LOONEY (11TH): Well, thank you, Thank you, Mr. Chairman. As I stated at the beginning, the bill states that more aggressive position of abandoning the fees all together, but it would certainly be possible if further information is developed to show that there is a logical and reasonable basis for imposing these fees. The key thing is that the fees should be transparent and justified in every case. But it is not about in any way denying care to a patient, it’s about whether or not a separate fee for activating a trauma group should be authorized in a given case, when the personnel involved are generally in the hospital and prepared to take action in emergency cases any way. And it is troubling that these fees were not allowed at all before 2002 and now all of a sudden are. And
it seems to me to be duplicative and of other fees that are already charged.

So, it would seem to me at the very least, there ought to be transparency in the process and a sort of scale of fees based upon perhaps the seriousness of the, of the reason for which the team is being convened. But it just seems to me that right now, it is an unregulated profit center.

REP. STEINBERG (136TH): Thank you for highlighting the issue and you can be assured that others who testify, we will ask them with regard to the presence of the relevant personnel at the time an activation occurs so we can verify that. And thank you for bringing up the issue of transparency as you do with so many issues related to healthcare because I think we’re all in agreement, we need much greater transparency across the board. Senator Abrams.

SENATOR LOONEY (11TH): Thank you, Mr. Chairman.

SENATOR ABRAMS (13TH): Senator Looney, I just want to thank you for bringing this issue to our attention. I think that people are frustrated with healthcare and with the cost of healthcare. And I think being ever vigilant about that is doing the best we can for the citizens of Connecticut, so I thank you very much.

SENATOR LOONEY (11TH): Thank you, Madam Chair, very much.

REP. STEINBERG (136TH): Other comments or questions? Representative Arnone.

REP. ARNONE (58TH): Thank you, Mr. Chair, just one also, Senator Looney on the, a part of the fees and the regulation, I think that’s when we crafted
something we should look at. Again the transparency for managing the service data collection, stuff like that, it should be more transparent. So, thank you for your testimony.

SENATOR LOONEY (11TH): Thank you, Representative.

REP. ARNONE (58TH): Thank you.

REP. STEINBERG (136TH): Other comments or questions? If not, thank you again for taking the time to testify today. Your presence underscores the importance of these bills.

SENATOR LOONEY (11TH): Thank you so much.

REP. STEINBERG (136TH): We move back now to Senate Bill 46, well, actually, we’re talking about Senate Bill 46. Next up is Dr. Shea Gregg.

SHEA GREGG: So, good afternoon. My name is Dr. Shea Gregg, I’m the Section Chief for Trauma Burns and Surgical Critical Care at Yale New Haven Health, Bridgeport Hospital. To the Co-Chairs, Vice Chair and Ranking Members and Members, I thank you you. It’s my privilege to be here in front of you today testifying on this issue that is important to the trauma hospitals for all of Connecticut.

I am testifying on behalf of the Yale New Haven Health System, Bridgeport, which opposes S.B. 46. My written testimony has been submitted and is available for you to review and I will summarize.

My major goal today is actually to answer three questions. One, why are trauma centers important? You heard partly from my colleague why this is important, but trauma center verification was built on the acknowledgement that trauma is an epidemic
and can disable or kill anyone, regardless of age, race, ethnicity or cultural background.

In 1976, the book, Optimal Hospital Resources for the Injured Patient was published, which provided guidelines of what resources an ideal trauma center should possess. As a result of the verification process and the immediate availability of resources, that are trauma focused, studies have demonstrated that access to designated trauma center care saves lives. In fact, there are reductions up to 25 percent of mortality for those people treated in trauma centers. Given the necessary resources required to care for trauma victims, the decision to become a designated trauma center is deeply embedded in the mission of the hospital. In addition to providing acute trauma care, we provide community outreach, where we try to actually reduce the incidents of associated with gun violence, falls in the elder population, and safe behavior campaigns for those who drive motor vehicles. Such activities demonstrate our commitment to community service.

So, additionally, what, what are trauma activations and why are they important? This was touched on with the example that was given initially. One of the central tenants of trauma center is that appropriate resources are immediately available to trauma victims. Trauma centers are required to maintain and monitor tiered activation criteria for trauma victims. These strict criteria outline evidence-based life or limb threatening conditions that have been associated with poor outcomes if not immediately addressed. The tiered activation system ensures that the right level of care is provided 24/7.
The personnel that immediately responds to lower level activation does in less severely injured patients, include one to four emergency trauma positions, one to two nurses, emergency technicians, radiology techs and other staff. For higher level or higher emergency acuity patients, 2 to 6 emergency and trauma physicians respond, surgical subspecialists, multiple nurses, et cetera will respond. The majority of patients actually, and this is a key point, do not present to the emergency department requiring emergency activation. So, medical professionals who have been trained in triaging these, like physicians and nurses, actually will activate accordingly. And the other key point is that over-activations and under-activations are part of the quality assurance process. We watch these constantly. We adjust our criteria accordingly. And we try to actually only activate when we need to.

Is the final question, which is the key question regarding financing, why is it important to financially support the trauma activation process? We police ourselves continuously regarding the activation process. We make sure that the evidence-based guidelines are up to date, that we are very critical in our activation process and should a patient need these things as in meet criteria such as we receive pre-notification via ambulance that the patient is coming, and that we will charge a critical care fee; namely, the person has a life-threatening injury. It’s only under those circumstances where we can actually charge the trauma activation fee.
So, in closing, gun violence, elder falls and motor vehicle crashes have been on the rise since 2017. And we want to be here for you. And I ask that you support, or you oppose S.B. 46. Thank you.

REP. STEINBERG (136TH): Thank you for taking the time, Doctor, to share this really critical background with us. You heard from Senator Looney who testified previously that he believes that all the members of the activation team are routinely available at the facility to simply come on over when an activation occurs. Is that your experience?

SHEA GREGG: It is not my experience. And again, I think it was accurately answered by the first presenter, Dr. Martin. It depends on the time of day, for one thing. And if something happens in the middle of the night, we might have to call in subspecialty services. It’s not like all trauma centers, again, we have level 1 or level 1 trauma centers, level 2 trauma centers, level 3 trauma centers within the state. And depending on your level of activation, you have a required response time, okay. So, I myself spend 72 days away from my home and taking house call, that’s my choice. All right. Other trauma centers require that of their trauma surgeons as well. But other subspecialty services might not necessarily be available during that time period.

So, to answer the question, yes, those services are available based on the criteria of the American College of Surgeons. But the reason why they’re available is because we are able to support the trauma centers through such fees, through billings, et cetera, where we are actually treating a 50 percent Medicaid population, a 20 percent Medicare
population. This is in our example, actually, this does not speak for all trauma centers. But and then the other are either private pays or other insurance companies.

So, we will treat anyone who comes through the door. And the reason why we are able to do so, is we are able to staff accordingly during whatever times. Thank you for the question.


SENATOR ABRAMS (13TH): I was wondering if you could speak to Senator Looney’s point that things changed in 2002?

SHEA GREGG: Sure. So, actually I’ll say a couple of comments about that. Healthcare is changing. Let’s be realistic. I think that everyone has seen the evolution of healthcare reimbursements, Medicare reimbursements, Medicaid reimbursements and budgets, et cetera change and evolve as soon as, you know, this year, or as recently as this year. Was there something that happened in 2002, I can’t historically comment on something, on that, other than the fact that if there was an increased closure in trauma centers, which provide resources to the population that they’re serving, that is concerning, given that we can potentially offer 25 percent reduction in mortality.

So, in terms of the trauma fee, just to speak on transparency, what do we know? We know that the Medicare and the Medicaid fees within the State of Connecticut actually carry a cap in terms of reimbursements, which is the real question; what’s the payment that Medicare and Medicare, Medicaid, actually bring to the trauma centers when we charge
for 50 percent of our Medicaid patients and 20 percent of our Medicare, it’s about $1,000 each. So, the other fees are not put with patient necessarily, it’s actually about $1,000 in terms of reimbursement. So, regardless of what your activation fee is, you’re going to be receiving 70 percent of your activation fees is about $1,000.

SENATOR ABRAMS (13TH): Okay. So, if I understood your answer correctly, in 2002, the change was more about healthcare costs than it was the process of treating trauma patients?

SHEA GREGG: I would say historically, I can’t comment if there was something that happened in 2002. That, that’s my testimony today. So, I can’t say if there was something historically that happened. However, based on Dr. Looney’s comments, if there was an increase or a time period where we were seeing more trauma centers being shut down because of un, inability to support themselves, if that was truly the case, then the concern is, was there something happening in the healthcare system that actually lead to these closures of these trauma centers.

SENATOR ABRAMS (13TH): And my second question was, you mentioned something about a process that you go through to review these internally.

SHEA GREGG: Yes.

SENATOR ABRAMS (13TH): Is there any external review of it and particularly about, you know, to make sure when this was activated, was it activated at the correct level so to speak and, you know, and any additional charges that were, that were levied against the patient because of this?
SHEA GREGG: So, I will answer that two ways. The verification process, when they come, when the American College of Surgeons or the accrediting body because it is, for the State of Connecticut it is the American College of Surgeons, when they come in and they actually review our QI and our QA, they look at our over-triage and under-triage rates, okay. That is actually part of the quality assurance process. So, they make sure that we’re within national norms, that’s an important aspect. They do that for two reasons. One, because they want to make sure that the trauma center is not over-activating. Two, that we’re not under-activating and there’s possible mortalities that are going on so, or that are happening.

So, to answer the question, yes. An external body does check that as part of our verification process in addition to the internal review process where, if we have someone that does not meet criteria for an activation or is under-activated, then so there are two committees where it goes. It goes to a physician peer review committee or an operations committee. This is typically how many trauma centers may be set up. And we will review that case in particular and dive into a wide, under or over-activations did happen.

SENATOR ABRAMS (13TH): Okay. So, they wouldn’t necessarily look though at the cost of it and whether or not additional costs were put on it that may not really be about trauma, they’re looking at the process so?

SHEA GREGG: They’re looking at the process and they’re also looking that we are meeting national norms in terms of the over and under-triage.
SENATOR ABRAMS (13TH): Thank you very much.

SHEA GREGG: Thank you.

REP. STEINBERG (136TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman. Thank you for testifying. Just trying to understand, somebody is brought into the emergency and they might be, they might not need the activation, or they could need the activation, is the personnel, you said earlier that you don’t have consistent presence of the personnel for traumatic vision, or you do?

SHEA GREGG: No, so, a point of clarification is that we have criteria by which that we have requirements in order for, let’s say, let’s actually take it a step back. To explain the activation process, it’s tiered. One is, and it’s actually, you have a trauma consult where the patient will be evaluated at a relatively soon time period because of A., something that was found during the workup. And you have the trauma activation, which is, we’ll say, a partial activation or a trauma alert, depending on which trauma system you’re in. And then you have a trauma code or a full activation, which requires the entire team. There are personnel that are designated for each level of response. And there are also time criteria that is also designated for each level of response as well.

So, say, for example, so for the highest level of activation, a trauma surgeon if they’re not spending the 72 days or how many days they might stay in house, where they might be out in the community at the time, they have to be within that trauma surgeon within 15 minutes. And again, this is a collegial,
this is a collaborative and collegial world that we live in where you have the emergency physician that will be in house because they’re gonna be running the emergency department and they’re gonna initially be starting the resuscitation. There’s resident staff and anesthesia staff, et cetera and trauma surgeons in general that will be back within that 15 minutes, that’s another quality assurance endpoint that we also follow that they have to be back within that trauma surgeon within 15 minutes.

So, bottom line is the staff is available as per national guidelines. And it’s not necessarily that they are in the hospital, say at 2 in the morning, but they have to be within that hospital for the highest level of activation within 15 minutes or a half hour for neurosurgery, per se.

REP. MICHEL (146TH): Thank you for that. And second question, are you familiar with the costs or is it somebody else in the, behind you that would know about the costs?

SHEA GREGG: You can ask, I am familiar with the costs. I actually did a dive with our financial folks regarding the cost and that’s how I got the Medicaid and the Medicare data.

REP. MICHEL (146TH): So, what would be, so is the difference between the lowest tier and the top tier from $1 to $50,000 or, I mean --

SHEA GREGG: I can only comment on our health system. And basically, our activation fee is $3100, roughly $3100 dollars.

REP. MICHEL (146TH): Your activation fee is $3100 for everybody?
SHEA GREGG: And that’s for both tiers.

REP. MICHEL (146TH): Okay.

SHEA GREGG: Okay. So, again, if we look at all our trauma population, that is our activation fee. That’s nowhere near $50,000. I was surprised to read actually Dr. Looney’s testimony beforehand and see that it ranged so high. But again, the way I, the way that we came up with that number, I can’t actually comment on, other than where the fee actually went towards. It goes towards back filling, it goes back filling staff and showing appropriate staffing that the activation staff are available, equipment needs. We actually hold radiology assets and OR assets at the time of activation as well. These are all things that go into calculating that cost.

REP. MICHEL (146TH): And same tier activation but with a different type of, a different response, meaning maybe less staff because of time of day?

SHEA GREGG: Well, the other key point too, and I sort of, and I want to make sure that this is not lost because of the buzzer that went off. The only way to actually be able to charge an activation fee is if you get a prenotification, the patient arrives via ambulance and you can actually bill a critical care code. So, if you have a patient that does not meet critical care billing or does not have a critical care need, then you cannot bill the activation code. So, this actually speaks to the over-triage component of things, where if, when how critical we are in terms of our decision entry when it comes to coming up with the different types of criteria, we are there to treat all types of
injuries, but life or limb threatening injuries are the ones that we want to be able to find immediately and treat because we know the morbidity associated and mortality associated with them.

So, if they meet criteria, but don’t have that life threatening injury and we don’t bill a critical care code, then we no longer can bill the activation fee.

REP. MICHEL (146TH): So, I’m gonna try and rephrase my question. If two people at different days, different times of the day come in with the same tier and with the same criteria that you were just explaining, are they automatically charged the same amount?

SHEA GREGG: Again, it depends on, it all depends on their severity of illness. Let’s say I have someone who came in and they have a, they fell and they’re on a blood thinner. We work them up and we realize that they don’t have, their blood thinner isn’t therapeutic by their blood test. They have no bleeding in their head. We do their, their evaluation. They don’t necessarily have a critical care need in that case; therefore, we cannot charge an activation fee in that situation.

REP. MICHEL (146TH): I’m just trying to compare if the same scenario on two different days at different times with different staff available, I’m trying to find out if you would charge, if the patient would be charged the same amount?

SHEA GREGG: Are you asking, I want to make sure that I understand the question. No matter what time of day is the activation fee going to be the same in terms of what’s the potential billing level and will every patient receive that, no.
REP. MICHEL (146TH): More in terms of, say you would have four people involved in the trauma activation --

SHEA GREGG: Yes.

REP. MICHEL (146TH): -- and another day, you’d have one more person available that would show up and be there. I know it’s very hard to have exactly the same case and the same patient, but just for in theory, if they would be exactly the same case, but you have one more physician for another day at another time, would the price of the charge be the same?

SHEA GREGG: The charge will be the same in terms of the activation fee in our health system; namely, if we had a trauma alert versus a trauma code, the charge is the exact same. However, what I will say, and I want to make this abundantly clear, is that if the patient is critically ill enough for the physician to provide critical care, then we, and they had the prenotification, arrived by ambulance, then we can bill the activation fee. If someone did not require critical care; namely, it was a classic case of over-triage, all right, then we could not actually charge the activation fee.

REP. MICHEL (146TH): So, it’s more about the activation versus the amount of personnel responding to it?

SHEA GREGG: That is, that is accurate.

REP. MICHEL (146TH): Thank you.

SHEA GREGG: That is accurate.

REP. MICHEL (146TH): Thank you.
REP. STEINBERG (136TH): Other comments or questions? Again, thank you for your testimony today. I think it helps clarify some of the facts that are related to it. We’re still wrestling with the best answer, but it does sound like this is such a critical service for people and their circumstance. We have to find a way to preserve its availability when needed. Thank you again.

SHEA GREGG: Thank you.

REP. STEINBERG (136TH): Let’s see. I think we’re gonna continue right along with Senate Bill 46. Next up is Dr. Kevin Dwyer.

KEVIN DWYER: Good afternoon, Representative Steinberg, Senators and Representatives. I am presenting for Stamford Hospital. I’m the Trauma Medical Director at Stamford Hospital. We are against Senate Bill 46. Stamford Hospital represents 650,000 people, patients, potential patients. We employ 3500 people. We’re the largest employer in the City of Stamford and also one of the largest in Fairfield County. We have about $90-million dollars in uncompensated care. We’ve already heard a lot of testimony why we would be against this bill. I can give you a couple of examples.

Recently we had a 6-year-old that had a brick, was hit in the head with a brick and that patient came to our hospital. If we were not a trauma center, we could not have a pediatric neurosurgeon come in and attend that child. Operating on a non-pediatric hospital because we’re a trauma center and then later on transfer that child to a pediatric hospital
for critical care. That would not happen if we were not a trauma center.

Recently we had two patients that came in very critical with multiple injuries, particularly lower extremity injuries, near amputations. If those two patients showed up in any non-trauma center, the chances of their survival is very slim. And certainly they would end up with amputations. But because we had the response of multiple residents, trauma surgeons, anesthesiologists, and orthopedic trauma specialist, which you would only find at a trauma center, we were able to save, not only save the lives of those patients, but save their extremities.

So, these are examples of the kind of personnel that we have to supply funding for to be on call in the middle of the night. Trauma surgeons, orthopedic trauma surgeons, neurosurgeons, they are not necessarily in house, the trauma surgeon is directly saying, we have to have a trauma surgeon in the house, we have to have an anesthesiologist in the house. We need extra nursing personnel in the emergency department and in the ICU. We have to keep a 24/7 OR open and ready for these trauma patients. These are the things that would not be needed for non-trauma hospitals and they are needed in the middle of the night.

That’s what the activation fee goes to. We also have to have these specialists on call. Other hospitals would not need these specialists and, and we need to have them available and compensated so that they can come in within 30 minutes to take care of these trauma patients. This does not happen in non-trauma centers and that’s where our activation
fee is part of that support along with the multiple amount of training and nurses and therapists that go to take care of the trauma patients along their journey through their, after their injury.

REP. STEINBERG (136TH): Thank you for your testimony, Doctor. To the best of your ability to say, what percentage of activations at your hospital turn out to be unnecessary?

KEVIN DWYER: We, we have a, we had, if we delve down to let’s say, what’s an activation, we looked at the activation and see that criteria. Last year we only had one that was unnecessary.

REP. STEINBERG (136TH): And we heard the previous doctor talk about the average activation cost at his hospital. Could you roughly state what it is at Stamford?

KEVIN DWYER: I think, I think at Stamford, I’m not exactly sure of the activation cost, but I think that I wasn’t given that information. However, I know it’s not $50,000, that’s for sure. And I’m pretty sure it’s, you know, and it is below $10,000, but I don’t know exact costs.

REP. STEINBERG (136TH): Well, I think we’re gonna be here to see, to collect that information from as many hospitals as possible to understand the range. But it is at least somewhat reassuring to hear that there don’t seem to be a large number of incidences where the activation proves to have been unnecessary, at least in the context of your facility. Any other questions or comments? If not, Doctor, thank you for your patience and for your testimony today. Next up Dr. Phil Corvo. I’m getting the signal from the back of the room. All
right. We’ll continue with the parade of physicians. Dr. Kathy LaVorgna, LaVorgna it looks like, excuse me.

KATHY LAVORGNA: Thank you Chair Steinberg and members of the Committee. I probably have more gray hair amongst my trauma colleagues than the others. And I do have institutional memory in that I ran the trauma service for 22 years at Norwalk Hospital. Do, I’d like to, I gave my testimony. I brought it in this morning. So, you have my testimony. I’m not gonna read that to you. I’d like to address some of the questions that is see the committee grappling with.

Number one, is the activation team. The reason for an activation is prescribed by the American College of Surgeons based on the scientific evidence of what causes death in the injured patient. What causes death or severe disability. That is the same for every hospital.

The team that we have is, as everyone else has mentioned, and the team is the same regardless of the day or night, regardless of whether it’s Christmas Eve or New Year’s Eve, it is always the same team. In my community hospital, all my trauma surgeons are private doctors. So, they are not employed by the hospital. They choose to come one 24-hour stretch one day a week to provide trauma care and we rotate, the eight of us rotate. There’s always somebody on first call, which means they’re in-house for 24 hours and there’s one on backup call, in case they’re overwhelmed with a bus load of trauma patients.
Now, what else causes us to need to pay for the trauma service? It’s not just all the people who work in the hospital because as you say they work there, they’re getting paid anyway, they’re just doing their job. It is when a trauma patient comes in, the hospital stops. It freezes for a moment and it stands ready. The OR stops. They don’t let another patient into the OR. They keep a room ready and waiting to go. The cat scan machine stops imaging patients because we may need to push the trauma patient to the head of the line. Our blood bank stops and assesses all the product that they have in their refrigerator to make sure we have enough for a mass transfusion, and we have to keep extra blood in our hospital because we’re a trauma center. And that blood only lasts for a few days and then it goes bad and it’s wasted if it’s not used. So, it’s a cost.

In addition, the care of the trauma patient is monitored on a day to day basis to make sure that we are complying with best practice and standards in caring for those patients. All that data is put together. It is put into a National Trauma Databank, a registry which is also run by the Trauma Quality Improvement Project of the American College of Surgeons. We pay for that data to be looked at to be risk adjusted and compared with other trauma centers across the United States. And that information comes back to us and tells us whether we’re doing a good job or whether we have some challenges that we have to work on.

All of these things go together for the costs of a trauma activation. Now, we at my hospital have a three tiered activation. We’ve been a level 2
trauma center since 1993. We have a three tiered activation which ranges in cost from $3,000 to $5,000 to $7,000. Now, what we charge isn’t what we get because 65 percent of our trauma patients are Medicare patients. And Medicare pays $1,000 for an activation. Medicaid pays less than that. Five percent of our patients are self pays, they don’t pay at all.

What changed in 2002, what happened in 2002 is that as people say, the amount of money that was available before healthcare started to change, the population started to age, HMOs came in, there were less people on private insurance and trauma centers were closing. And every day from 1993 on, my hospital said, can we afford to be a trauma program? And I did the work. I did the work and I’ve done it every year for the board. It costs about $3-million dollars to run the trauma program at my hospital.

And with trauma activation fees, my hospital just breaks even. We don’t make a fee; we don’t make a profit. 26 other states in the United States fund their trauma hospitals. Connecticut does not. The only money we have is to put in reasonable activation fees to recoup the money that we’re spending to assure quality and safety care for every citizens in Connecticut. Every Connecticut citizen is within 30 minutes of a designated trauma center. That is a safety net that you don’t want to take away from the people of the state.

Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. It really, I think, puts a lot of this into a different perspective. Particularly, you
know, a single hospital with the responsibilities to be able to respond to having an annual budget of $3-million dollars, I think that the potential loss of being able to recover that would have great implications for your ability to provide those services. And I take your point that if we should lose trauma centers within the state, that would put many, many people at risk. Even in a small state, that would create the need to travel distances that could make the difference between life and death and a good outcome and a bad outcome. Are there any questions or comments? Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman. Thank you for testifying today.

KATHY LAVORGNA: Nodding my head back there.

REP. MICHEL (146TH): Yes. And I’m sorry, I have to bring my computer up here, but my TV was on so I could hear what was going at the same time, then rush back down. So, you said that you have three tiers, $3,000, $5,000, $7,000 charges to the patients when it’s appropriate. And then you said, you mentioned Medicare and Medicaid. I don’t think it’s as bad, but what is your cost because we, we found out earlier that it’s not depending on the number of physicians, but more of an activation fee. So, I’m trying to grasp your, your cost on your side, just to understand because it’s one thing to mention the three tiers and what you charge the patients. And then, I’ll let you talk, I’m sorry.

KATHY LAVORGNA: I tried to express that, but maybe I’ll express it again. So, the costs are having a surgeon, a trauma-trained surgeon in-house 24 hours a day, holidays, weekends, et cetera; having a
backup surgeon also for it to be available. The cost is having extra blood products available. The cost is having equipment in our emergency department, in our operating room for care of the trauma patient. And the cost is the time we lose when the hospital is on hold. We’re not doing book a business, when the hospital is on hold to treat a trauma patient, the other facilities, like our operating room or our cat scanner and our MRI machine are on hold until they found out whether the trauma patient is going to the head of the line for those things. And the cost of verifications every three years. Connecticut is a state that designates trauma centers based on American College of Surgeons verification process. They come and do a deep dive, a two-day dive every three years on your program and they go through records and processes and overcalling activations, et cetera. And, and that costs money. It costs money to belong to the data repository. The National Trauma Databank and the TQIP, the Trauma Quality Improvement Project costs money. And it costs money to train your people. And it costs money to hire your data registrar who has to pull up 400 datapoints out of each patient’s chart to put into the registry. So, all of this is a functional process that costs money.

REP. MICHEL (146TH): But to have a trauma physician 24 hours, is that something that you would not have, if you didn’t have the activation system?

KATHY LAVORGINA: I can’t ask a private surgeon to give up 20 percent of their work week for free because when they’re on call for trauma, they’re not seeing patients in their office, their not doing complex surgeries in the operating room. They are
waiting to care for a trauma patient and there are minor, you know, minor traumas too that they care for. But they’re there in-house away from their families for 24 hours at a stretch. So, they do get a small stipend for taking call.

REP. MICHEL (146TH): I see, I mean --

KATHY LAVORGNA: Which is fair to cover the cost, it doesn’t even cover the cost of their lost business for that day, but it gives them some incentive.

REP. MICHEL (146TH): And I’ll ask a question I asked earlier when everybody was nodding their head in the back, but if there is no activation and activation fee, there wouldn’t be a trauma center in the hospital?

KATHY LAVORGNA: Correct. Correct, because we couldn’t afford to give away all that service for free.

REP. MICHEL (146TH): Okay. Thank you.

KATHY LAVORGNA: And in Connecticut, the law is that if you are severely injured, you must be transported to a trauma center. You can, you can make a pit stop at a non-trauma center, but that patient then must move up the line to a center that can handle that trauma.

REP. MICHEL (146TH): Again, don’t get me wrong. I’m thankful for physicians and trauma centers and I was in the emergency a couple of weeks ago. I don’t remember when, but, so thank you.

KATHY LAVORGNA: You’re welcome.

REP. STEINBERG (136TH): Anybody else who would like to comment or ask a question? If not, thank you for
your testimony. We’re filling in the puzzle here very nicely. Next up is Dr. Alan Meinke, I believe.

ALAN MEINKE: It’s always hard to testify after Dr. LaVorgna, in an effort to save the committee some time, I was asked to speak in congregate. Thank you for the time to allow us to speak. Especially, with regards to input with this S.B. 43, AN ACT PROHIBITING HOSPITALS FROM CHARGING FEES FOR TRAUMA ACTIVATION. On behalf of the American College of Surgeons here in Connecticut, the Connecticut Quality Collaborative and the State Medical Society, and the leadership, physicians and healthcare providers of the Western Connecticut Medical Group practicing surgeons, we oppose this bill, of course.

There are only 12 designated trauma centers in the state of Connecticut, all that treat injured patients, 24 hours a day, 7 days a week, 365 days a year, regardless of their ability to pay. On a yearly basis, trauma teams led by Connecticut physicians and surgeons treat thousands of patients with severe and life threatening injuries.

We are write today for you, to urge your oppose this S.B. 46 legislation, which would prohibit hospitals from charging fees for trauma activation.

Our state’s trauma activation system provides critical services for the injured, when those services are needed, using evidence-based criteria that you just heard. When calling a trauma activation during times of extraordinary need. Not relying on this bill would be a, significantly impact the provisions of those services and make it more difficult to get those correct resources to the
patient’s bedside in order to prevent unnecessary death.

The trauma system in our state performs a critical function, providing the right level of care to an injured patient at the right time that care is needed most. The system makes sure a full range of highly-skilled emergency healthcare providers are available 24 hours a day, ready to care for those badly-injured patients.

The trauma activation fee helps provide resources required to make sure that the trauma service has the correct number and composition of healthcare providers, facilities, equipment in order to save lives.

When the Trauma Alert Program was started, over 20 years ago, I personally didn’t appreciate the impact it would have on the lives that we were going to save in the next 20 years. Those patients that rolled their car on a patch of ice on trauma night, I’m sorry, on date night, those awakening to find themselves trapped in a fire when warming their apartment with a space heater, are victims of penetrating knife and gun trauma, and farmers and laborers who suffer on the job from traumatic injuries.

Over 20 years, countless lives have been saved. So many Connecticut families have benefitted from not losing a spouse, a parent, a loved one or a breadwinner. We have seen deaths, complications, suffering, greatly reduced, which benefits all of us and also reduced long-term costs.

As organizations and surgeons focus on the continuing improvement of the quality of care in
Connecticut for our patients and the sake of all who utilize these comprehensive medical services for a trauma service, I please urge you to seriously consider voting no on this S.B. 46.

REP. STEINBERG (136TH): Thank you for your testimony, Doctor. I think we hear; we’ve heard a pretty consistent refrain here today and I don’t think there’s anyone in the room who doesn’t believe strongly the importance of having these trauma centers available for those in need. It’s conceivable that this particular approach is not going to address the problems that some people see, but we appreciate your testimony. Are there any questions or comments from other members of the committee? If not, again, thank you for your time, for your patience in waiting today, we appreciate it. Dr. Gary Kaml, I believe it is.

GARY KAML: That’s correct. And Chairman Steinberg and to the rest of the committee, I thank you all for the ability to speak and present my testimony today. I have submitted it online and that’s available to you.

I appreciate the opportunity to represent Saint Francis Hospital and Medical Center as well as Trinity Health in New England to testify in opposition to S.B. 46.

Saint Francis Hospital and Medical Center is one of only 12 verified and designated trauma centers and one of only three adult level 1 trauma centers in the State of Connecticut. As a trauma center, we treat all injured patients. As Dr. Meinke said, 24 hours a day, 7 days a week without regard for the patient’s ability to pay.
Every year our trauma center treats patients injured in motor vehicles, motor vehicle crashes. Victims of assault with gunshot and stab wounds, victims of intimate partner violence, elderly patients who fall at home, drownings, burn victims, and workers injured on the job.

In Connecticut, as in many states, the Department of Public Health utilizes the American College of Surgeons Committee of Trauma Verification Process as the sole condition of becoming designated as a trauma center in our state. In order to become verified, trauma centers must satisfy a tremendous number of requirements. We are required to maintain not only an expert level of care, but also maintain a state of readiness at all times. We must staff call schedules, and even backup schedules with specialists of every stripe. We must maintain staffing in the operating rooms, radiology suites and blood banks. And we must have registrars and performance improvement coordinators to collect data and ensure that we are delivering the highest level of care, as Dr. LaVorgna was testifying to earlier. The list goes on and on. So, even our reverification visits, which we must undergo every three years, are costly. This labor-intensive process costs hospitals on the average of $18 to $20,000 just for the site visit alone, not to mention all of the labor that goes into preparing for the visit.

Trauma centers create good paying jobs, jobs with benefits that attract the best and brightest healthcare professionals to our state. That enriches the tax basis as well as our health system.
Our injury prevention and quality assurance programs actually work to decrease healthcare expenditures.

S.B. 46 would prohibit hospitals from charging a fee for trauma activations. These fees provide us with the ability to offer essential trauma services to the residents of Connecticut and to help defray the cost of maintaining verification status required by the state. Allowing hospitals to charge these fees is a widely accepted practice that has been in place for many years and is recognized by insurance payers and the centers for Medicare and Medicaid services across our nation.

I know of no other state legislature in our country which is seeking to abolish these payments, nor do I know of any blockbuster payments, $50,000, $35,000 payments that have ever occurred in our state.

Prohibiting hospitals from charging these fees would catastrophically jeopardize our ability to provide this essential care, which is just literally a matter of life and death for our patients.

Finally, I’d like to proudly tell this committee that if the roof above our heads were to collapse right now, all of us would be cared for in verified trauma centers, which would be ready and able to provide the very best care at a moments notice.

Thank you for your time and consideration. I strongly urge the rejection of this bill and I would be happy to take any questions.

REP. STEINBERG (136TH): Thank you, Doctor, for your testimony. I think that the mere fact that virtually every trauma center hospital in the state is, is important enough to be here today to testify
and wait long hours, is an indication of how strongly you oppose it. And I think we’re getting much greater appreciation for the important work that these trauma centers do for us in the State of Connecticut, the protection they provide, the important role that they play. It’s invaluable in that sense alone.

I will ask you one question. Are you wearing that white lab coat as a physician or as a meat packer?

GARY KAML: I actually, if I could show you my notes, I actually wrote in, I’m wearing this white coat as a proud physician, not as a meat packing plant worker or as a stagehand. But I’m glad that our passion shows and all of these people here that are behind me, I would gladly put my life into their hands. And we built something in Connecticut that’s really great, that’s really beautiful. We have a trauma network that works to take care of patients. Dr. LaVorgna is right, no one in this state is more than 30 minutes away from a verified trauma center that maintains a constant level of readiness.

I think that it’s easy to misconstrue that these fees are payments just for the activation, just to simply, you know, pay for something that you’re already paying for, they’re already in the hospital. But these payments were designed and implemented in 2002; number one, is a response to hospital’s saying, you know what, this isn’t paying, we can’t financially support this. So, we’re not gonna be trauma centers any more, and they walk away. And that was alarming to the people 15 years ago. And it should be alarming to us now. The other thing is, is that, that payment was devised as a way to
somehow compensate hospitals to keep them in the game so that they could pay for not the actual response, not the actual presence of the person coming, but to make sure that all of those specialists are, are there, to make sure that we have the staff available to do the quality control, the self-policing that we do every day. And the report out to the national bodies like TQUIP and the National Trauma Databank, all of that’s a requirement for us to be a trauma center and it ensures great care. The citizens of the state get great care. Please, please oppose this bill.

REP. STEINBERG (136TH): Thank you. And I think even if we may have read articles or heard about abuses by CEOs at other hospitals, I’ve yet to hear a representative of any of the hospitals in the State of Connecticut who have used this as a profit center or have abused it in the fashion that has been alleged. So, I think that testimony is also very important.

GARY KAML: Yeah. And our, our trauma activation fees in our facility are indeed tiered to, you know, from three separate tiers, low, middle and high. And those are far below $10,000. They range from, let’s say, in a range of $4 to $7,000. And by no means is that what we get paid. We get paid far less than that.

REP. STEINBERG (136TH): Thank you. Representative Betts.

REP. BETTS (78TH): Thank you, Mr. Chairman, and thank you very much, Doctor. I just want to be on the record, you know, as a consumer, on prices, whatever you charge is fine by me, I want to live.
I repeat, I want to live, okay, go for it. But on the serious note, I’m really kind of stunned because I feel like this is one of the strengths of Connecticut. We’re very lucky to have people so dedicated and committed to this mission and clearly all of us in this state benefit from it. Hopefully we don’t need to use it. But every life is worth saving, no matter how, what our age is. And it was interesting when you said that no other state had introduced a proposal like this to eliminate. I think that’s pretty self-evident. If there’s abuse going on, that’s different. But trauma centers are something that I think are, are incredibly important to differentiate ourselves from a lot of other states and we’re blessed to have that.

If this were to happen, and I don’t really envision this, but if this were to happen, what do you think the response would be from hospitals or to the trauma centers that currently exist? And I know it’s somewhat speculative, but it certainly raises a question and cloud about the value of a trauma center, the need for it if we’re going to be doing this?

GARY KAML: And I think that’s an excellent question because at the bottom of this is the question of, of care versus dollars. And if you’re the one lying on the gurney, then as you say, spend anything you want. Please save me. But I think that the predicted outcome is tough to have that kind of crystal ball in front of you. But if you were to have that, that, you know, if you were to take that look forward, I think that you would see a number of hospitals that cease to become trauma centers, that cease to be trauma centers. There is no mandate
form the state that you have to be a trauma center. There is a mandate saying that critically ill patients have to, you know, have to go to trauma centers. But what happens when all the trauma centers go away? And I think that there are hospitals, I think that most hospitals view running a trauma center as a zero-sum gain. They’re not looking to, you know, make a mint, they’re looking to break even because, you know, we’re, we view ourselves as a resource to the community, not just in the treatment of trauma patients, but in the prevention of trauma, okay.

All of our trauma programs have to have, as part of their conditions of verification, have to have trauma prevention programs within them that reach out to the community. We spend our time, which isn’t compensated, we spend our time training EMS, okay, going to ambulance providers and paramedics and such and doing education with them. And we train elderly folks, you know, of fall prevention techniques, drunk driving, gun violence, all of that.

And so, I think that if you take away that funding, which was designed to support trauma centers as trauma centers, then you’re looking at folks saying, we can, we can take a zero sum, we can take a no profit proposition, but we can’t take a center that loses money and continue to support it.

So, that I think a lot of the trauma centers would cease to be trauma centers.

SENATOR LESSER (9TH): Representative Betts.

REP. BETTS (78TH): Thank you, Senator. Actually, you said two things that stood out in my mind. One
is that there’s no state money involved, that makes me very excited. And the second this is, you said it was not mandated. I’m not sure I’ve ever heard that before, but I think that shows you the value of letting people work absolutions themselves and for both those reasons, I would definitely oppose this. And I thank you for your comments and thank you, Senator.

SENATOR LESSER (9TH): Thank you, Representative. Are there other questions from members of the committee? If not, thank you very much, Doctor, for your testimony. Moving on, next we have Kimberly Barre from Yale New Haven Health. Following Kimberly, we’ll be hearing from Dr. Jonathan Gates. Good afternoon.

KIMBERLY BARRE: good afternoon, members of the committee. I am Kimberly Barre, I am not a doctor. I am actually an ICU nurse and have been for over 20 years. And currently I am the Trauma Program Manager for Yale New Haven Hospital and Yale New Haven Children’s Hospital. Yale New Haven Hospital is one of the three adult level 1 trauma centers and Yale New Haven Children’s Hospital is one of two pediatric level 1 trauma centers. So, we provide the highest level of care, that makes us a safety net. We receive patients from all over the state, helping patients that need the highest level of care.

You have my testimony, I had already had it sent in, so I’m not really gonna repeat it because much of this has already been said before, so in order to not be redundant. One of the things I would like to just point out is that we do a lot of background administrative work with our registrars, Dr.
LaVorgna alluded to the registry team. We have seven registrars that collect data. And that data is used as a repository for research. So, we have ongoing research as a level 1 trauma center that supports best practices and looks at the best way to care for our patients.

We also use that information to guide our injury prevention efforts because we don’t just want to treat the problem, we want to prevent them all together. And so those are just some of the additional things that we do as a trauma center. And this is my counterpart, Dr. Adrian Maung, he’s our Trauma Medical Director.

ADRIAN MAUNG: So, good afternoon and thank you for allowing us to express our opposition to this bill. And you have heard how much of value our trauma centers are to our communities. And I just want to highlight a couple of other things that I think were said as well, is that we don’t just take care take of the injured patients, we also help them rebuild their lives afterwards. And we also work with our communities to help prevent or at least mitigate injuries. So, for example, through a collaboration through Yale New Haven Hospital and New Haven police department, we have provided police officers and trained them in the use of tourniquets. And even just last week, there was a police officer that used a tourniquet to save the life of a young gunshot victim. That is things we’re not being compensated for by part of our mission of our trauma center. We also prepare for the unexpected, you know, unfortunately the mass casualty events that we now know, like the Las Vegas shooting, can occur any time, anywhere and don’t have any kind of warning.
And that’s part of what we train for as trauma centers. And these fees help us support all of these missions. And eliminating them, we really jeopardize our ability to help our patients and our communities.

Thank you.

SENATOR LESSER (9TH): Thank you. I’m gonna turn it over to the actual Chair of this committee, Senator Abrams.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Dr. Petit?

REP. PETIT (22ND): Just, as Dr. Martin who spoke first, I just wondered since you worked with administration what you think your false activation rate is? You get calls and you activate the team and you find out you don’t need them; does that end up being a couple of percent, 5 percent, 10 percent, where do you fall?

KIMBERLY BARRE: The American College of Surgeons considers sort of 35 to 40 percent a threshold. And we review our over-activation monthly and our rate is about 20 percent. And some of that means then that we look at our established triage criteria and we, every couple of years we look at it and we will reevaluate whether that criteria still belongs there at that level or on the tiers all together. So, we do reevaluate.

REP. PETIT (22ND): And I realize it’s a lot less time, but when it’s activated and then not utilized, is it sort of a de minimis cost to you or is there, is a significant real cost when it’s activated, and
the usual ER team takes care of the patient and you’re all set?

KIMBERLY BARRE: Go ahead.

ADRIAN MAUNG: So, significantly, the costs of this system are very hard to sort of quantitate, I mean, because it’s not just the fact that you get a bunch of doctors and nurses in the emergency room. It’s having the availability of the whole system. So, it’s hard to, you know, it’s hard to say how much that actually costs. I mean, if we were using all of those resources constantly and the operating would stop operating and this would be a cost to the hospital that their losing money by not providing care to other, other patients. So, but it’s hard to sort of quantitate and say how much it costs.

SENATOR ABRAMS (13TH): Any other questions or comments? No. Thank you very much for your testimony --

ADRIAN MAUNG: Thank you.

SENATOR ABRAMS (13TH): -- and thank you for being here today. Next we have Dr. Jonathan Gates. Mr. Gates.

JONATHAN GATES: Thank you very much for the opportunity to speak on the activation fee. My name is Jonathan Gates and I’m the physician and Chief for the Trauma Network for Hartford HealthCare, which is the seven hospitals within the Hartford HealthCare. Ed Robinson is joining me as well.

ED ROBINSON: I’m the Chief of Emergency Medicine at Hartford Hospital.
JONATHAN GATES: I have submitted a written testimony, and I’m not gonna repeat that. It’s available for you to read. And I wanted to address some of the questions that I’ve heard. And please, I would welcome any questions you might have as well. I can tell you from a business standpoint, it’s nice to know what your costs are. You like to have good cashflow and you want to give the customer what they really want. But the challenge is try to determine what the costs are for the trauma center. They’re obviously indirect and direct costs. But one of the things I think we sometimes don’t think about is we clearly have a trauma network in the State of Connecticut, it’s critically important.

But a hospital, like Hartford Hospital, which has 2,000 trauma admissions a year, many activations as you can imagine, and many of those patients are then sent home as well. Our over-triage is probably 20 percent as well. There’s a tremendous amount of work behind the scenes that goes into creating a trauma center.

You’ve heard about the American College of Surgeons who comes to visit. You’ve got a number of ACS representatives behind who go to various hospitals and visit them. And that cost to the trauma center every three years is $15,000 at a minimum.

There are requirements that we all have to meet to be a trauma center, level 1, level 2, level 3 trauma center, and they are expensive.

You can imagine there are things we haven’t talked about, about the research that’s required of a level 1 trauma center and that is costly to have people who do that, who support it or grant writers who are
research assistants. The injury prevention program might have a budget of well over $200,000 just to decide how do we develop the full helmet law, which we think is required in the State of Connecticut. We have surgical residents, we have ED residents, we have radiology residents, all who need to be well versed in trauma care. The education of these residents is expensive, and we have to offset that in some way. We have fellowships at Hartford Hospital and acute care surgery and surgical critical care and vascular surgery, all of which were required to learn how to take care of trauma patients.

And when you think about it, the quality program is a huge part of what we do in many of the surgical services, but certainly in trauma it is as well. It is absolutely required by the American College of Surgeons, things like morbidity and mortality meeting, which is not what we would consider a patient facing event in which you can place a bill but is absolutely required for our quality to do a better job at every patient that we have that comes into the trauma center.

So, if those costs are very hard to document, but they’re real, they’re recurrent, they occur every month, the performance improvement committee every month required. We have a registrar, you heard that Yale has seven registrars, we have about three. But these are people that are collecting the data. We need that good clean data to be able to make decisions about how well we take care of patients.

ADRIAN MAUNG: If I may just make one comment, and I’ll, a number of the comments that our colleagues from around the state have said this. I just want
to emphasize that this is not a frivolous charge. At Hartford Hospital, we also have a three-tiered approach as has been described by a number of our colleagues. We only charge an activation fee of the highest. Our activation fee is $2200. If someone comes in and we decide that it’s not, it shouldn’t be that level, they get downgraded to the middle. They don’t get the charge. What was also said, which may not have been appreciated, is if the patient, there needs to be prearrival information from EMS.

So, for instance, if someone gets dropped off at our doorstep down the street, their friend drops them off, we can’t charge the trauma activation fee because EMS wasn’t involved, they didn’t let us know. But that patient may be just as critically ill as any other. I think that’s it. And I have never, I’ve been at Hartford Hospital 24 years and I’ve never been aware of the CEO ever being involved in these conversations.

SENATOR ABRAMS (13TH): Thank you very much. That was some very valuable information. I’m glad that you shared that. Is there any consistency among hospitals to, is that seems particular to your hospital and I’m wondering if it’s consistent to all hospitals, the kind of charge, hearing that you described?

ADRIAN MAUNG: Quite honestly, today was the first time that we heard how other hospitals managed this.

SENATOR ABRAMS (13TH): Okay. And so, my other question is, is there anything you think you could be doing better when it comes to this, given the
concerns that have been brought up to this committee?

ADRIAN MAUNG: Better in what way?

SENATOR ABRAMS (13TH): I think some of the issues that have been, I don’t know how long you were here, I apologize if you haven’t been here for some of it. But concerns about inconsistency in charges, concerns about transparency, concerns about being charged when the services aren’t used, which doesn’t seem to necessarily be the case for you. But, you know, just any of those kind of things that are the concerns that brought up this issue to our attention to begin with?

ADRIAN MAUNG: I mean, I think it’s a good idea to pay attention to it, but I’ve not heard anything at any point regarding the State of Connecticut in outrageous fees and, and, you know, large profits. I think that’s more in the southern part of our nation.

SENATOR ABRAMS (13TH): Thank you. Were there other questions? Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair. I guess a question would be throughout Hartford, Hartford Health obviously owns a number of facilities around the state. And I was wondering if you had thoughts about the difference in practices between level 1 and other levels of trauma centers; is that something we should be considering as well?

JONATHAN GATES: Well, not really. There are obviously difference in the care that’s delivered, depending on the level of the hospital. And in Hartford HealthCare, we will have, there are
actually 1’s, 2’s, and 3’s, and still there needs to be a response by the hospital at their level. If it’s a level 3, we will bring a trauma surgeon to the bedside, we’ll bring an ED physician, nurses, radiologists perhaps, reading a film maybe from home. But at least the patient will be recognized as having a problem and might be decided, the triage might then be to send the patient to a higher level of care. But it’s that ability to finetune that decision making that is expected and required by the ACS when they come to visit at a level 3 trauma center. And certainly the level 1 trauma centers, as you know, were the highest level of care and really a level 2 is equally high level of care, but no research requirement and no real cardiac surgery or replantation of digits is required as well.

SENATOR LESSER (9TH): And I was interested in hearing you discuss the cap that you have on fees in Hartford Health, is that consistent across trauma levels or is that specific to one category?

JONATHAN GATES: I think that it’s probably a little inconsistent across the network and that’s something we will be taking a look at as time goes on, so that we can be consistent. There are a lot of things that we want to look at in terms of guidelines and practice guidelines. And I think, you know, the activation fees are one of them. But my impression is from what I understand so far, they’re all pretty much within range as to what I would expect as an acceptable fee.

SENATOR LESSER (9TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative.
REP. MICHEL (146TH): Thank you, Madam Chairman. I’m sorry, I forgot both or your names, but the gentleman on my right.

JONATHAN GATES: We’re used to it.

REP. MICHEL (146TH): You did mention that you had three tiers, but you only charge for the highest tier, which is a fee of $2200; is that, did I understand correctly?

JONATHAN GATES: You understood correctly.

REP. MICHEL (146TH): Okay. Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? No. Thank you very much for your testimony and your time today. Appreciate it. We need to jump ahead first. Is Dr. Salner here? Dr. Salner, you’re going to be testifying on House Bill 5442, correct?

ANDREW SALNER: Yes.

SENATOR ABRAMS (13TH): Thank you very much.

ANDREW SALNER: Thank you, and good afternoon to the members of the Public Health Committee. My name is Andrew L. Salner, M.D., and I’m the Director of the Hartford HealthCare Cancer Institute at Hartford Hospital, there’s a team of Hartford HealthCare here for a moment.

As a practicing radiation oncologist, I’m involved with treating cancer patients with pain associated with their cancer condition, where it’s treatment each and every day. Of course, my patients also present with a whole variety of pain syndromes associated with other medical conditions as well. I’m also privileged to serve on the Connecticut
Department of Consumer Protection Medical Marijuana Program Board of Physicians and have actively participated in helping to support the evidence-based use of medical marijuana for a rapidly growing host of medical conditions.

I do believe the board along with the superb staff at DCP has helped to encourage this growing list of qualifying medical conditions based on the science and evidence we review at each of our meetings. This process, as originally designed by the legislature, is the most thoughtful one designed to ensure that appropriate patients will have access to the use of medical cannabis for their condition.

As one of the earliest certifying physicians in Connecticut, I’ve certified hundreds of cancer patients into the program and it seemed to benefit for those whose symptoms such as pain or nausea, sleeplessness, schedules, cachexia, did not respond to conventional medications for who had severe side effects from their regular medications. Pain is a very complex topic and there are many types of pain. We know from still what is relatively new scientific research into cannabinoids and the endocannabinoid receptor system interest the human body. That certain pain syndromes may respond better than others to the use of medical cannabis. In particular, certain types of neuropathic pain may be most responsive. And hence, the Board of Physicians has recommended approval of multiple qualifying conditions in this realm where true evidence exists, including migraines, facial pain syndromes, post-herpetic neuralgia, spinal disorders, spasticity syndromes and the like. Opening up the eligibility to the medical marijuana program to all chronic pain
syndromes risks the inclusion of patients with syndromes which might not respond and benefit. The terminology, chronic pain, is not a definitive diagnosis and means too many things to too many providers and patients.

Also, the subject of description of any pain of any chronicity whatsoever to a certifying physician would place that individual in a situation where the patient should be certified. They may not be guided to ensure that the use of medical cannabis would be more beneficial than harmful. Rather, I would recommend that we continue to expand the qualifying conditions as we are asked to review a host of conditions, review the evidence so that those who become eligible may be more likely to benefit and less likely to be harmed.

We’ve taken this responsibility seriously and will continue to do so. We’ve always been willing to consider any proposed condition and review the data comprehensively. The risk of utilizing chronic pain as a condition is that many patients, some even without pain, might qualify for use of medical cannabis and would open up to many with vague and unsubstantiated pain syndromes.

Thank you.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments?

REP. STEINBERG (136TH): Thank you for taking the time to testify today, Doctor.

ANDREW SALNER: My pleasure.

REP. STEINBERG (136TH): As we said with a previous bill that also related to the existing medical
marijuana program, I wanted to stress this committee takes very seriously the good work that the Department of Consumer Protection and the Board of Physicians has done in determining which conditions are appropriate for our medical marijuana model. And we do not introduce the concept of chronic pain trivially, but we share your concerns about it being perhaps the broadest category of condition that we could possibly add to the list of those conditions and perhaps the most prone to be, I don’t want to use the word abused, but taken beyond limits and could be problematic for us.

We are not necessarily advocating on behalf of adding that condition as much as exploring it because it does affect so many people in the State of Connecticut. And it’s also a reflection of how confident we are of our existing medical marijuana program, how well it’s been working that we are sufficiently confident to even contemplate adding this condition to the list.

But thank you for your testimony. And my guess is this is not the end of the conversation.

ANDREW SALNER: Thanks, I appreciate that.

REP. STEINBERG (136TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman, Mr. Chairman. Thank you for coming to testify. I actually had the privilege of visiting a medicinal cannabis growing facility and I found out how elaborating the system is, which is great. Are you aware of any other state that have chronic pain as a certifying condition?

ANDREW SALNER: I am not.
REP. MICHEL (146TH): Okay. I know for a fact, I believe, New York, Rhode Island, Maine, and Massachusetts have it. So, my question would be, you must have conducted some studies; are you familiar at all with any of this research?

ANDREW SALNER: I know we, our group has looked at various conditions that have been proposed to us. Any condition that’s proposed to us, we’ll sit and discuss, we’ll do the research on. We’ll get back together and discuss. And I am not aware of any literature using, medical science literature, looking at the use of medical cannabis in the sort of the wastebasket term of chronic pain. And I don’t mean that in any pejorative way, I’m just saying that chronic pain is just not a medical description that describes a particular pain syndrome.

So, you know, we’ve opened up many, many, many pain syndromes in the last year because we felt that patients with fibromyalgia, severe fibromyalgia for example or rheumatoid arthritis should have the benefit of medical cannabis. And we would be open to looking at any condition. But utilizing chronic pain as a syndrome, simply would be such a wide open term that I think it would be open for abuse potentially.

REP. MICHEL (146TH): So, by the way, outside of the four states, I’m looking it up now, there’s 16 other states across the country that have this as a condition. If pain is a symptom that can be treated safely with the, with the cannabis for these other conditions, why would it not be able to be applied to chronic pain patients?
ANDREW SALNER: It certainly could be used for different types of pain, but not all types of pain, according to the available evidence and literature. And again, the research into medical cannabis is still relatively new and limited because of the Schedule I status at the federal level. But, but our board has generally attempted to apply evidence basis for every ultimate action we take. And I’m not aware of chronic pain literature with medical cannabis as a, as a, you know, an open condition with studying different types of pain.

REP. MICHEL (146TH): Thank you. And, but we have pharmacists, they are to help guide the patients, because I know --

ANDREW SALNER: Yes. But once the patient is certified, the patient has access to purpose whatever they would like. So, as much as the pharmacists are excellent in the program at the dispensing pharmacies and really have committed their career to this, I think once the patient has gotten their medical marijuana card and has gotten through the door off the pharmacy, it’s likely that they’re gonna leave the pharmacy with a product. I’m fine with that, if they’re certified and they qualify, they actually, they absolutely should. But I’m just trying to make sure that we apply evidence to a decision about whether a patient would qualify or not.

REP. MICHEL (146TH): And, and this is not meant in a negative way at all, but there are 20 states that have included pain as a condition of chronic pain, sorry. Actually, I shouldn’t say that because I’m not sure exactly of the terminology. And that’s we are here for today as well, is to work with you and
other people to make sure that we are accurate in our wording. But with the states utilizing around our state, I think these kind of studies would be, would be sort of, of a timely, you know, there would be needed in a more timely manner. I’m not saying that you should have done that or but considering that states that are adjacent to our state are legalizing it, and there’s 20 other states in the country that have agreed to put pain as a condition for medicinal cannabis, that maybe we’re a little bit behind. Not, again, I’m not a critic, but I’m just gathering sort of some facts. And I’m just trying to --

ANDREW SALNER: Yeah, I think a substantial number of the conditions that we have listed in Connecticut are pain related. So, I’m not saying that we don’t have pain. I think, you think about the number of patients who have, for example, neuropathic pain related to spine injuries, we include those patients. So, we’ve included a lot of pain syndromes on our list, where there’s evidence to suggest that cannabis really does help them and helps them more than hurts them. I think it’s just the use of chronic pain as a diagnosis is the thing that makes me concerned that it might include patients who either don’t have pain, but they walk into a certifying condition and say I’ve got long term backache, I want cannabis. Or patients who’s pain syndrome may not potentially respond. So, that’s my concern. I’m happy to look at the data from the other states, if there are any.

I know that a lot of other states may make some decisions about qualification without using exactly
the same kind of rigor that we do. But I’d be happy to try and explore that.

REP. MICHEL (146TH): Yeah, and again we value your work, I value your work. But I’m not a physician and chronic sounds worse than, I mean, chronic pain sounds more alarming than just pain.

ANDREW SALNER: Agreed.

REP. MICHEL (146TH): Thank you.

ANDREW SALNER: Thank you.

REP. STEINBERG (136TH): Other comments? Thank you, Doctor, you’re the first to broach this subject today, but you will not be the last.

ANDREW SALNER: Thank you, I appreciate it.

REP. STEINBERG (136TH): But we seem to be really on a really excellent run of physicians here. You’ve got to wonder, who’s minding the store. But thank you very much for your testimony.

ANDREW SALNER: Thank you.

SENATOR ABRAMS (13TH): Monika Nelson. We’re back to Senate Bill 46.

MONIKA NELSON: Thank you for allowing us to testify today. My name is Monika Nelson, I’m here with Dr. Riccardi. I’m the Trauma Program Coordinator at Waterbury Hospital. I’m also an Emergency Department Nurse. And I want to talk about the nursing standpoint of this bill.

One thing that, I’m not gonna reiterate everything that my colleagues have said throughout the day, but we do want to say that along with everything else that happens when a trauma team gets activated, we
also do a lot of injury prevention and also a lot of nursing and physician education that come with trauma. In order to care for a trauma patient, you can’t just have the regular knowledge of anyone, of any nurse in the emergency department. You need specific trauma education to be able to look at vital signs and trend them and do appropriate interventions that come with this job. So, we are opposed to this bill and we hope that our trauma centers prosper and sustain with this trauma activation fee.

DANIEL RICAURTE: Thank you to the committee for the opportunity. My name is Daniel Ricaurte. I’m one of the physicians at Waterbury Hospital. I’m one of the Chief Surgical Residents and my goal here is not to talk about what the charges are at Waterbury Hospital, unfortunately that is beyond my pay grade. I think some of our colleagues here, who are a part of administration have talked about that.

What I wanted to talk about was the misconception of what happens behind this picture because we’ve all see it. The trauma team is at the disposition of the patient. Trauma activation happens and we see the picture, everybody’s around. But not many people understand what happens before this, before this and I could well be one of the people in the picture taking care of a critically ill or critically injured patient. Before that all of the people in there are taking care of other patients around the hospital. I could well be having a conversation with one of my critically injured patients somewhere else in the hospital. I could be dealing with one of my other colleagues. I could be taking care of a sick patient somewhere else. And
at a second or an instance, the pager goes off and I have to take care of that patient immediately because we know it’s life or death.

We talked about over-triage and the cost. I think what we’ve not talked about is under-triage and how that can kill patients. So, I think we are a little bit misguided at the fact that we’re not just waiting around as physicians or staff, just waiting for a trauma activation to occur. We are taking care of patients elsewhere.

I’m happy to take any questions of this point.

REP. STEINBERG (136TH): Thank you for your testimony. Any questions or comments? I think you’ve made a good point. We really are trying to strike the right balance to protect the ability to provide effective trauma treatment and we certainly don’t want to under-activate any more than we are eager to over-activate. So, thank you for your testimony. We appreciate you taking the time.

MONIKA NELSON: Thank you.

REP. STEINBERG (136TH): And if you wouldn’t mind taking your visual aid, thank you. So, you seem to have coordinated with the other hospital. Again, we’re gonna ask everyone’s indulgence. We have a couple of people here who need to catch a flight. This happens on occasion. We do only make exceptions rarely. But we are going to allow Renee Lani and Dr. Stephen Korzeniowski to testify on House Bill 5910, so they can still catch their flight.

RENEE LANI: Thank you Chairs and members of the Committee and good afternoon. My name is Renee
Lani, and I’m here on behalf of the FluoroCouncil. FluoroCouncil represents major manufacturers products based on today’s per- and polyfluoroalkyl substances or PFAS. Today’s PFAS provide unique performance benefits to enable industries and products which are critical to modern life.

For this and the following reasons, we respectfully oppose House Bill 5910.

First and foremost, it is inappropriate to regulate PFAS as a Class. PFAS make up a family of chemistry encompassing a broad range of chemicals and products with widely varying physical and chemical properties, health and environmental profiles, uses, and benefits. Importantly, because of this diversity, it is inaccurate to associate safety concerns that have been raised regarding a few PFAS with other PFAS in the family.

Industry voluntarily started working with EPA in the early 2000s to phase out long-chain PFAS substances, this included virtually eliminating facility emissions and long-chain PFAS product content. Those long-chains are no longer produced in the U.S., Europe, or Japan. These efforts have led to substantial declines in the blood levels of PFOA and PFOS in the general U.S. population.

Furthermore, today’s PFAS are supported by a robust body of data. They are generally short-chains, and they have significantly improved hazard profiles compared to the legacy long-chain products. Today’s PFAS are critical to enable a myriad of applications vital to the U.S. economy.

The manufacture and commercial use of today’s PFAS are subject to review by regulatory bodies around
the world. They are well-studied, and the evidence shows these chemistries meet relevant regulatory standards for the protection of human health and the environment. For food packaging and food contact applications, many governments require additional data.

My colleague, Dr. Adamsky will expound further during his testimony.

Importantly, today’s PFAS are critical to modern life. PFAS are essential to thousands of products and applications throughout the economy, including everyday items such as cell phones. Today’s PFAS provide for first responders. For instance, clothing utilizing PFAS offers life-saving protections to first responders. Whether it’s helping to the deflect bullets or by maintaining performance of protective gear in the extreme environment of a fire. They are also crucial to Class B firefighting foams, which my colleague, Dr. Korzeniowski will discuss in his testimony. Healthcare settings rely on today’s PFAS in medical garments, which provide protection from the transmission of diseases in bodily fluids during medical procedures; and high dielectric insulators, which are critical to defibrillators, pacemakers and imaging devices, such as MRI.

In the building and construction industry, today’s PFAS are widely employed in paints and coatings with the properties such as durability, UV resistance, and anti-corrosive properties lengthen the lifetime of infrastructure, facades, and surfaces.
Products that rely on today’s PFAS are beneficial to a wide range of industries that are major industries that are major job creators.

And so, in conclusion, we’d like to, we’d like to ask you to oppose House Bill 5910.

Thank you.

REP. STEINBERG (136TH): Thank you. Very timely remarks. I don’t think anybody here disputes that that these products as originally introduced have provided a lot of benefits that we’ve come to rely on. I would also submit that there are literally thousands of chemicals that we introduce with good intentions, we now realize may have long-term health impacts. It’s very hard to correlate, but the rise in the incidents of autism, food allergies and the like may be directly related to the number of chemicals that we think have helped simplify our lives in many ways, but it may have complicated them in order ways that we never intended.

I take your point that perhaps we should not be attacking the PFAS as a class, as opposed to individual ones that we have in the past eliminated those that have been proven to be particularly deleterious. I will argue that the FDA, as currently structured, is not a reliable protector of, EPA, excuse me, of, of our rights as citizens to protect our healthcare. If anything, it seems to be going the other direction, which I believe gives states reasons to seriously consider enabling its own protections until such time as the EPA returns to its original mission.

So, you can understand why we’re taking this very seriously here today. If we were to be a little bit
more narrow in terms of the PFAS that we would be focused on, would you be prepared to help us? Are there some PFAS’s that you would agree need further limitation at this point in the game?

MONIKA NELSON: The FluoroCouncil, as I mentioned, has voluntarily phased out the long-chain legacy PFAS. The two most commonly cited PFAS you’ll hear in the news are gonna be PFAS and PFOA or PFOS and PFOA, those are no longer manufactured in the U.S., Europe or Japan. And FluoroCouncil has been an advocate for EPA to finalize the SNUR, so that they cannot be imported from a couple of countries that continue to do that. So, in short, yes, we would be willing to work with the state to help, you know, identify chemicals but, you know, there have been a lot that have been voluntarily phased out already and would not be present in products that are being, that are in commerce in the State of Connecticut.

REP. STEINBERG (136TH): Thank you for that. Many of us are probably not familiar with PFOS and SNURs. It sounds like a children’s storybook. Would you mind clarifying those points a little bit, please?

MONIKA NELSON: So, PFAS, P-F-A-S, are per- and polyfluoroalkyl substances. That’s the family of chemistries. PFOS and PFOA, and some people will say PFOS, PFOA, those are two specific individual chemicals, just like chlorine is a chemical. So, those are two families of the class of chemistries. Those are the ones that are typically in the news these days. SNUR, I apologize, for you, it’s just a rule making from EPA that would limit imports of any of the substances that have been voluntarily phased out in the U.S. I would limit the imports from them coming into the U.S.
REP. STEINBERG (136TH): So, if I understand you correctly, it’s your point of view that the concern currently about PFAS is, is not necessary because the dangerous ones have already been dealt with and the ones that remain on the market are safe?

MONIKA NELSON: Yes. The ones that are on the market were reviewed by EPA and pre-Trump EPA, and they have been on the market since the current administration. And they, you know, there’s a lot of literature out there and we’d be happy to provide the members of the committee with those studies showing that, for instance, the main breakdown product of the PFAS of today is not carcinogenic, it’s not mutagenic, it’s not an endocrine disruptor by weight of evidence. There really is a lot of information out there on those PFAS that are utilized and on the market today in products that, you know, demonstrates the safety of those products.

REP. STEINBERG (136TH): Thank you. We very much appreciate all the information you’re prepared to provide us, maybe with some sort of glossary to help us with some of the acronyms and terms. If the Doctor, are there questions? Yes, Representative Arnone.

REP. ARNONE (58TH): Well, thank you, Chairman. So, the PFAS and the PFOS, the long-chain, is that the best --

MONIKA NELSON: That’s correct.

REP. ARNONE (58TH): Sure. So, now the long-chain, the forever chemicals, so these are very, they don’t break down. And they’re still imported. So, you did, could you clarify what you were saying about
the EPA is trying to stop the importation of them, but they are still coming into the country?

MONIKA NELSON: In certain instances. I would not say, I can’t, you know, speak to import/outports, I’m not an expert on that by any means. But there are a handful of countries, China, I believe, India that still make it. But like I said, the major manufacturers of it do, most of which are members of FluoroCouncil have phased it out, like they don’t make it in their production facilities globally. So, those FluoroCouncil members are, you know, dedicated to the stewardship and phased it out all over the world. But that doesn’t prevent others from still making it in countries in which the phase-out was not. And so, that’s kind of one of the reasons why FluoroCouncil has supported the finalization of that new rule that has been proposed by EPA, but proposed a few years ago, but it’s still sitting there right now.

REP. ARNONE (58TH): So, what is the Council doing for the future and trying to clean up what we have today? And we’re seeing it move through ground, move through soil, particularly quick. We’re picking up in our wastewater treatment plant and it’s just a cycle because they don’t go away until they actually get into your ground water. So, what is the Council’s plan in the future to help us clean up the mess that we have now?

MONIKA NELSON: So, I wouldn’t say that the Council that’s necessarily within the Council’s rule. But we do support the education of the methods of cleanup. For instance, granulated activated carbon, it is a cleanup method that’s effective at removing PFOS and PFOA. There are also other technologies
such as reverse osmosis. So, we’ve been working with regulators across the state and federally to let them know that there are solutions to the PFAS, most of which are legacy issues and the groundwater, which you pointed out, and, you know, pointing them in the right direction as to where they find solutions, treatment techniques because they do exist. But the member companies do not manufacture those treatment techniques.

REP. ARNONE (58TH): Thank you.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. So, I missed the beginning part of your testimony. Just a question that may come up later with some other folks that are here to testify. The fire retardants, the foam that’s used, does it all contain PFOA or does it contain families of PFAS chemicals?

MONIKA NELSON: So, PFOA is no longer utilized. If they, foam being, and Dr. Korzeniowski can testify to this question a little bit more. But I don’t know the exact cut-off year, but PFOA is not utilized in a firefighting foam. It was, yes, that’s not going to be found in foams that are manufactured today. It’s not, yeah.

REP. PETIT (22ND): Thank you.

REP. STEINBERG (136TH): Other comments? Yes, Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chairman. So, does this debate involve the foam that the firefighters at airports use?
MONIKA NELSON: Yes. So, airports, you know, depending which they are, a lot of airports may be under FAA regulations current, so they have to follow whatever the FAA says. Current FAA regulations state that airports have, the ones that have to follow the regulations have to have on site what is called aqueous film forming foam or AFFF. You’ll hear people call it. It’s the fluorinated foam. And that is because that is the only foam on the market that currently meets military specifications or mil-spec. Now, there was a law that was just passed in the last year that I think in 2020 or 2021 and again, Dr. Korzeniowski can confirm, you know, the date that those airports will have the choice of whether or not to utilize fluorinated foam or not fluorinated foams as opposed to being required to use fluorinated foams. As Dr. Korzeniowski will raise some concerns with that just because there are fires, fuel-based fires which is what AFFF is used for that cannot be put out or not put out quick out. So, in a life or death situation, AFFF is the foam of choice.

REP. HENNESSY (127TH): Thank you. So, I read an article saying that maybe in training they don’t have to use this kind of toxic material and also that there are other products available. But I think what you’re saying is that as far as the efficacy, unfortunately, the more detrimental is the preferred choice.

MONIKA NELSON: Yes, so, as you said, there are alternatives. And as far as training and testing, FluoroCouncil has taken the position that the best practice is to not utilize the fluorinated foam for that. So, for instance, there is a bill in Virginia
that has received support from local MGOs that NGOs that bans the, bans the testing and training with fluorinated foam and the FluoroCouncil has been supportive of that bill. And as it maintains, it allows the use of the foam in the situations that require it, but it cuts down on what was a large route of exposure historically during training of firefighters, making sure their equipment was working. That was the majority of exposures to the environment from foam was from those activities, not from actually putting out fires, so. Virginia’s law allows for or the bill going through Virginia’s legislature allows for the foam to be utilized in necessary situations but cuts down on the unnecessary exposures when needed.

REP. HENNESSY (127TH): Yes, thank you. The article referred to Greenwich experiencing groundwater that is now contaminated. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, I think we better bring up Dr. Korzeniowski before you miss this flight.

MONIKA NELSON: Thank you.

STEPHEN KORZENIOWSKI: Thank you again for allowing us to testify. I really appreciate it, and as well as changing the time. I am Dr. Stephen Korzeniowski. I am representing the Firefighting Foam Coalition, which is a global organization that represents the manufacturers of firefighting foams and the chemical components on issues related to efficacy and environmental impact.

With regard to the proposed legislation, the House Bill 5910, we respectfully oppose the bill for the
following reasons: AFFF foams are the most effective foams currently available to fight high hazard Class B fires in military, industrial, chemical, fuel depot, aviation and other applications. AFFF have proven effective in large-scale fires, fuel in depth fires and other high-hazard fires. They are unique film forming and fuel repellency properties by rapid extinguishment, critical burn back resistance and protection against vapor release, which helps prevent reignition and protects firefighters working as part of rescue and recovery operations.

Fluorine-free foams can and do work. And they do provide an alternative to fluorinated foams in some applications such as still fires and smaller tank fires. However, they are not currently able to provide the same level of fire suppression capability, efficiency, flexibility and scope of usage. Fire test results presented at international fire protection conferences including some performed by the Naval Research Lab, all show that fluorinated foams are significantly more effective at extinguishing flammable liquid fires in fluorine-free foams. In a recent trade publication from last month, an NRL scientist said that fluorinated foams outperformed fluorine-free foams by a factor of 4 to 5, by containing the fire and suppressing vapors that can reignite.

While concerns have been raised regarding environmental contamination issues related to certain PFAS’s, as Renee said, PFOA and PFAS, these chemicals are neither used to manufacture, nor used in the formulation of the Fluorotelomer C6-based
fluorosurfactants used in current-day, Class B foams.

These C6-based products have been available and used since the '70s with full conversion to all C6 products by the end of 2015. Legacy contamination from the use of firefighting foams is largely the result of past practices where foam was discharged to the environment during training, testing and calibration of foam equipment. Current best practices calls for the containment and treatment of foam discharges and the use of non-fluorinated fluids for testing, training and calibration. As large-scale high hazard Class B fires are actually rare, requiring best practice management for all foam users has the potential to significantly reduce discharges of PFAS to the environment.

The Firefighting Foam Coalition is supporting legislation in other states that bans the use of PFAS base foams for testing and training, but not of the emergency use to fight fires. We believe that this is a responsible and sound approach that protects society from catastrophic fires, while at the same time minimizing the environmental impact from foam use. Banning the use of PFAS based foams in high hazard fire applications could leave important facilities in Connecticut without adequate life safety and fire protection.

For these reasons, we oppose House Bill 5910. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony, Doctor. As you get the sense because you’re testifying really early, we haven’t gotten into the --
STEPHEN KORZENIOWSKI: No, you haven’t.
REP. STEINBERG (136TH): -- details yet --
STEPHEN KORZENIOWSKI: I thank you.
REP. STEINBERG (136TH): -- of this bill. And I’m sure there will be those who will testify about the problems that they are aware of relating to this.

You understand what we’re trying to accomplish here. We’re trying to eliminate contaminants, if you will, in the, in the environment and particularly in the healthcare context. It concerned people, obviously in the past there have been problems with PFAS. We’ve heard the previous testimony that to a large degree, the worst of those have already been eliminated form production here in the states.

I guess the question I have for you is, are you effectively disputing that there is a problem in the United States currently with the PFAS that are currently being produced or is there opportunity for us to focus on some specific ones and further limit their production and use?

STEPHEN KORZENIOWSKI: I mean, I’d like to answer your question this way, you know, really a couple of things that have happened, one in particular is when EPA changed the health advisory from 400 to 70. And the analytical technology to go measure these became dramatically better. So, we can find things. The fact is, as you will hear later, I am sure, that what happened, when that happened, when the analytical technology got better and we went from 400 to 70, they’ll tell you the United States lit up and that is true. I can’t dispute that. And where it lit up mostly was at the military bases. So, I’m
not gonna sit here and dispute that that isn’t the case. It is the case.

What I will say is what’s happened is that as a result of these, all of these things that have happened over the past four or five years, and the recognition that training and calibration of equipment and testing must change. We and others, as well as the military clearly understand past practices have to be changed and eliminated.

What the industry has also done over the past several years is changed to a chemistry that Renee described that we have a significant body of data on that indicates that it is very different than the technology of the past. It still has the firefighting capability.

So, yes, I’m not gonna dispute what you’re gonna hear later. I won’t be here to hear it, but I can’t argue that when you look at the map of the United States and elsewhere, where this was used and people did train and that foam went uncontrolled into the ground and into the aquifers, it lit it up, no question.

REP. STEINBERG (136TH): Thank you for that clarification. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Doctor, if I heard you right, so you testified that the fluorine-free foams are significantly less active against Class B fires?

STEPHEN KORZENIOWSKI: What I, what I, I’m gonna give you the short answer is that they do work. And there is a significant amount of activity going on in, in the private industry, our members in the
Firefighting Foam Coalition, and as you’re well aware, probably the military. The military has been very vocal about the fact that they are funding a significant number of research projects to create fluorine-free foams that have no fluorine whatsoever, but still meet the military specifications, the performance standards. So, the fact of the matter is that if you do the comparison testing, these, the fluorine-free foams will work on smaller fires, not fuel in depth fires, where you’re squirting a nozzle at a long distance and that foam goes underneath, underneath, let’s say it’s oil or crude, what happens when that, the flame gets contaminated, it burns itself. Whereas, the fluorinated foams will pop back on the surface and put the fire out.

Small fires, that’s not the case. They work perfectly well. Your municipal fire departments likely don’t need fluorinated foams except for special occasions. I think you’ve heard this morning that there were trucks available to deploy in the state so that if there’s an emergency, those trucks can be deployed and used with the AFFF concentrate. That’s, that’s, that’s a good option. So, you not have it on hand, you only deploy it when you really need it.

REP. PETIT (22ND): Now, this question may be too wide ranging, but in Connecticut, where we have things like Electric Boat, the Coast Guard Academy, Sikorsky Aircraft, United Technology, will this put these large companies that deal with jet engines, helicopters, nuclear submarines, et cetera, put them at a significant disadvantage in terms of their higher, or risk in terms of these issues?
STEPHEN KORZENIOWSKI: I think, I think the debate is, is that will the, will the folks that are funding research, and there’s a lot of companies funding research, will those companies be able to develop a product that meets the, the high standards that the military set. They set those standards to protect the property, say an aircraft carrier, the jets with, with armament bombs underneath and our, our military. Now, will they relax those standards, I can’t say. But the standards that are set today were developed to protect our service people, the equipment, the Forrestal disaster in ’67, where several hundred people got killed, things of that sort.

And so, the military is actively working at creating a product that has no fluorine, yet still meets those same standards. Every company, every, every major member in the Firefighting Foam Coalition sells both. They sell both fluorinated and non-fluorinated because they recognize, in some cases, the fluorinated product may be overkill, you don’t need it. And you’re gonna hear that later on, also. Use it only if you need it. And we would agree.

REP. PETIT (22ND): Thank you, thank you, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Other questions or comments? I’m only sorry that you won’t be here to hear some of the other testimony. But I thank you for making the effort to be here today and I encourage you to review the further testimony we will have here today and to continue to be part of the conversation as we struggle to figure out what to do about this problem.
STEPHEN KORZENIOWSKI: Thank you. And as Renee said, we’ll help, if you have further questions. Thank you.

REP. STEINBERG (136TH): You may hear from us. Thank you again. And with that, we’ll return to Senate Bill 46. I believe, is it Jeffrey Nicastro is next on the Western Connecticut Health Network.

JEFFREY NICASTRO: Good evening. Senator Abrams, Representative Steinberg. Thank you for letting me speak. For full transparency, I joined Western Connecticut Health Network as the Network Chair of Surgery about 30 days ago. But I’ve been a lifelong trauma surgeon, starting downrange, like my neurosurgical colleague years ago in the Navy, and have been involved in the care of trauma patients throughout a 25-year history. And I’m honored actually to be speaking with the august group behind me that’s already spoken.

I submitted my testimony, but I would like to make a few additional comments. Number one is about the significant sub-trauma as a life-threatening illness. You probably already know this, but trauma and traumatic injury is the most common cause of death in the age group of 1 to 44 in the United States of America. And Connecticut enjoys a mature and quality trauma system, of course the individual hospitals with their ASCOT designations, are part and parcel of that; however, interestingly as a system, this state functions exceedingly well. And it’s because it’s been following the ACS-COT guidelines, which actually inform the activation process for a long time.
Having been a Network Chief of Trauma across the system, much like Dr. Gates in the neighboring state, which we won’t mention, we could have learned a lot from how Connecticut’s approached trauma.

Two real quick, one real clarification issue, we’ve been focusing a bit too much, I think, on over-activation. ACS-COT guidelines are clear and yes, we follow our over and under-triage numbers very, very carefully as the residents said, we’re particularly concerned with under-triage. However, activations can only be billed if A., they’re initiated through EMS, the patient’s brought in through EMS and B., if the patient actually demonstrates a certain level of seriousness of injury. So, it’s, it’s regulated really from outside the system. So, there’s no intrinsic self-referral or upside to over-triage.

On the other hand, the last thing we want to do is not mobilize the resources that we have, when somebody really needs it. So, again, testimony submitted and with the understanding, I’ve only been in Connecticut for a brief period of time, I’m exceedingly happy and honored that I get to work with your group of physicians, nurses, techs, EMT personnel and everyone that contributes to trauma in this state.

REP. STEINBERG (136TH): Doctor, thank you for your testimony. Welcome to the State of Connecticut. You will see that we often have a testy relationship with our hospitals and that I’m sure you may have occasion to testify before us again. But I would hope that you would spend most of your time practicing your specialty on behalf of the people in the western part of the state.
To your point, we’ve heard a lot of testimony already from your colleagues here in the State of Connecticut. It’s, I think we’re gonna take attendance here shortly to make sure that every trauma center has had a chance to testify here today.

JEFFREY NICASTRO: I’m representing Danbury as well.

REP. STEINBERG (136TH): Thank you for covering more than one hospital, we really appreciate that. Does anybody else have any questions or comments for the Doctor? I note that you neither indicated you were a doctor on the sign-in sheet, nor wore a white lab coat, so we were not sure exactly how to address you. I apologize for not doing so initially. Any other, okay, we’re good.

JEFFREY NICASTRO: Thank you.

REP. STEINBERG (136TH): Thank you for your time. Next up we have Dr. Peter Zdankiewicz, if I have that correct, probably close; not here, okay. We’re okay with that. Dr. Ronald Gross.

RONALD GROSS: Good afternoon, Representative and Senator, Chairs and distinguished members of this committee. I’m going to address S.B. 46 from a different viewpoint, and I appreciate your indulgence.

I have been practicing trauma surgery for 37 years, 27 of those in the State of Connecticut. I have been either running or the Associate Director of two level 1 trauma centers in this state. And for the last 10 years, I had been the Trauma Director at a hospital just north of the state in Springfield.
The importance of being a trauma center is very simple, it is to care for the sickest and the most severely injured patients you can imagine. The staffing of a trauma center is interesting in that trauma centers are staffed by people who are committed to being trauma physicians, nurses, techs and such. Hospitals that are not trauma centers fail to attract the best and the brightest in the field. I’ve previously submitted my testimony. But I will tell you that I have been a member of the American College of Surgeons Committee on Trauma, first as the Vice Chair and then Chair of the COT here in Connecticut. And then a member of the Central Committee for 11 years, and I do review trauma centers across the country, and I’ve done so for 15 years.

What you can see as you review trauma centers, is that they are staffed by people who’s only goal is to work at a trauma center. In 2002, the reimbursement was encouraged, these activation fees were allowed because trauma centers were failing. They could not afford to stay in existence. And the people who staff those trauma centers moved on to other hospitals.

As you’ve just heard, trauma is a leading cause of death in our young and most productive part of the society. Trauma is worldwide the largest burden in the medical field. We, as a state, have one of the finest trauma systems in the United States and it’s been recognized by the college. And we have that because we have verified and; therefore, designated trauma centers. Should we lose our trauma centers, we will lose the people who staff them.

I would be happy to take any questions.
REP. STEINBERG (136TH): Well, thank you, Doctor for that perspective. And it’s certainly, I think you’ve heard here today that we’re all very proud of the system we have in place in Connecticut and are certainly not inclined to do anything to endanger the ability of people to receive appropriate trauma care as needed. I take your point that it also helps us attract the best and the brightest in the field, which should give us all great confidence and reassurance.

Would anybody like to address any comments or questions? You know, we may be a little bit less inclined to ask you questions only because of the amazing testimony of those who proceeded you. It’s not by any means any less interest.

RONALD GROSS: For the record, I am older than LaVorgnia and unlike her silver hair, I don’t have any. Thank you very much.

REP. STEINBERG (136TH): We tend to avoid age on questions here. All right. There you go. So, last on this bill we have Dr. David Shapiro, you’ve been very patient.

DAVID SHAPIRO: Thank you, everyone. Chairwoman and Chairman, thank you for your time. Thank you to my colleagues here today who are an esteemed group of people for whom I’ve learned a lot. They are mentors. They are colleagues and they are peers. I’m a trauma surgeon, I’m also the Vice Chair of surgery at St. Francis, the Chief of the ICU and I’m also the Chief Quality officer for St. Francis’ Hartford network.

You’ve heard that trauma centers treat injured patients and that’s everyone, 24 hours a day, 7 days
a week, 365 a year. You’ve been told that this service is provided to patients regardless of their ability to pay, independent of their status as a citizen and without pause to their social or ethnic background. And for those of you concerned, it’s also independent of their party association. You can laugh at that.

As we heard also, according to the CDC, trauma is the number one cause of death of patients in the first half of their lives. And while it’s only the seventh on the list for patients older than 65, it still affects them a ton. They are our parents, they are our aunts and uncles, they are our grandparents, they are also our children, our siblings, they are our colleagues and they are our teenagers, who we see both at the children’s hospital systems in Connecticut as well as all the trauma centers, crashing cars, falling down, doing stupid things and making bad decisions. Trauma systems in Connecticut have supported injury prevention efforts around the state and that includes efforts with the police departments, departments of motor vehicles, the state attorney’s office, the Department of Public Health. My colleagues and I even came to the Department of Public Health and taught them how to put on tourniquets in the Stop the Bleed Campaign a few months ago.

One thing I’ll mention that hasn’t been mentioned, is if you think about the way trauma systems work, and some of you have heard is that when a trauma patient is brought to the hospital without an ambulance service providing their care first, we can’t charge an activation fee. So, think for a
moment about Orlando and the Pulse Nightclub events a couple of years ago. Those patients were mostly brought to the hospital by private vehicles, pickup trucks, carried, dragged down the street. None of those patients warranted or have gotten any activation fees charged to them. And the hospital costs about $1.5-million dollars just in the care of those patients on that day. Never mind the subsequent care of those patients who had mental health problems, adjustment disorders or any of the complicated issues that come afterwards.

We have to be ready at the full range of our armamentarium at the hospital at any given time to take care of everyone who comes in. And that can include anyone in this room. It can include me when I drive home today. I was on call yesterday. I’ve been up since yesterday morning taking care of patients until last night, until this morning I should say and took an Uber here from home, so I didn’t have to drive my car and be tired because that’s a good example.

I’ll add kind of a pertinent but rather dark thing to talk about at the end of this testimony, and that’s that I serve this community as an organ procurement advocate as well. And it may be something unknown to you or something that’s foreign, but trauma systems also contribute to the organ procurement world in that about half the donors of organs out there, especially in Connecticut are from traumatic injuries and they’re not from living donors, their not from people who have had strokes.

So, if half the donors went away because we couldn’t manage them at hospitals and we couldn’t run the
programs that support their care and critical care in the trauma programs, we wouldn’t have that resource either.

So, think about us as a resource. And I mean the trauma surgeons and trauma programs as a resource to you, to the public of Connecticut, because that’s what we do and that’s what we’re here to stand for. So, I appreciate your time.

REP. STEINBERG (136TH): Thank you, Doctor, I would have thought perhaps we had heard everything we needed to hear with regard to this issue, but --

DAVID SHAPIRO: There’s always one more --

REP. STEINBERG (136TH): -- you shed some more light on the situation. We really do appreciate that. It’s easy to isolate it in the context of one specific trauma, one person, and yet there are broader ramifications that we need to keep in mind. I hope you get the sense, having heard everybody else’s testimony, that we take this issue very seriously and we are not inclined to settle with something that has been working very well, unless we can improve upon it and serve the people better in that regard. Questions or comments? If not, thank you for your testimony. Thank you for taking an Uber and not putting anybody else at risk. You’re right, it could happen to any of us at any time. So, let us all drive safe. Thank you.

All right. We’re gonna move on to a different bill just for a little while, House Bill 5910. And I want to start by saying, all of you who are still here, you have this committee’s admiration. It is a marathon for many of us and we appreciate how passionate you are about the subjects that you’ve
chosen to remain here for hours and hours. And this, unfortunately, a fairly common experience with the Public Health Committee. We have a lot of long hearings. So, again, thank you for your patience.

For those who might be facing conflicts in their personnel lives, if you should have to leave, I would encourage you to make sure that you leave us with your written testimony, either online or through other ways. We want to really hear from all of you in one fashion or another.

So, in moving on to House Bill 5910, Frank Adamsky, I believe is next up.

FRANK ADMASKY: Good afternoon. My name is Dr., or I’m Dr. Frank Adamsky, and I’m the Regulatory Affairs Manager for Daikin America, a member of FluoroCouncil. PFAS are vital to many industrial and consumer applications. They are also used in paper, paperboard, molded, and molded fiber food packaging to prevent oil and grease from leaking through the package on to clothing, furniture or car interiors, for example.

With regards to H.B. 5910, we respectfully ask you to oppose this bill because it is unnecessary. This an application that is already thoroughly regulated at the federal level, and a close look at the science will show that PFAS used in food packaging pose no appreciable risk.

It is important to understand that only a limited subset of PFAS are permitted for use in food packaging. These do not include PFOA, PFOS or any of the similar long-chain PFAS’s nor do they include chemical referred to as GenX. Any discussion of these long-chain substances or their potential
health effects in food packaging is irrelevant, inappropriate, and contributing to unnecessary fear about the safety of our food supply. The use of PFAS in food packaging is already thoroughly regulated at the federal level by FDA because of the safety of our food supply is not a state-specific issue.

Based on substantial upfront data requirements, FDA determined that PFAS currently used in food packaging under the Obama era FDA, are safe for their intended use. Importantly, any non-PFAS identified by an alternative assessment process would be subject to the same FDA regulatory scrutiny under the current administration.

Any argument that the PFAS currently approved by FDA for use in food packaging presents some significant risk to consumers is neither risk based nor supported by the robust body of scientific data on these substances. Our industries member companies publicly post volumes of scientific documents regarding another substance PFHxA, which another of my colleagues mentioned, the primary substance by which hazard of the PFAS used in food packaging is characterized. Claims that these new PFAS’s, including PFHxA are not well studied, are unfounded. The substantial body of data shows PFHxA is not carcinogenic, mutagenic, genotoxic and not an endocrine disruptor. PFHxA is also not a reproductive of developmental toxicant. It is also not bio-cumulative. I recognize the buzzer, I’m wrapping up. Further detections of PFHxA in the environment in humans are extremely low. Some environmental and biomonitoring programs stopped testing for PFHxA because it was not being detected.
This includes CDC’s national biomonitoring program - NHANES. Using FDA’s and ANSES’s, which is a French agency dealing with similar topics, methodologies for calculating estimating dietary intake, the maximum exposure to PFHxA from food packaging is 13,000 times lower than the safe level determined by these agencies. What this tells us is that PFAS used in food packaging pose no appreciable risk to human health or the environment.

In conclusion, we ask you to oppose H.B. 5910. Thank you.

SENATOR ABRAMS (13TH): Thank you, are there any questions or comments? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. A couple of questions. What are the alternatives if this type of packaging wasn’t available, are there other alternatives that might be safer or less or more expensive; where can we go?

FRANK ADAMSKY: The short answer is that there are not alternatives available now that perform to the same level at the same price point; otherwise, they’d be in use already. Our company and other companies on FluoroCouncil, we are barrier solution providers, that’s what we do. We’re not invested just in having fluoro compounds, we’re always looking for all the compounds that can work in these applications safely and at an economical point.

REP. PETIT (22ND): And at the risk of muddying the waters, this may be more for my own interest, if I microwave my leftovers in this, do I create a risk by microwaving, does it change any of the chemical structure or does it change the exposure if I microwave one of these products?
FRANK ADAMSKY: Thank you very much for that question because it’s excellent. And so, what FDA requires and what, and it’s not just FDA, we work, these products are approved on a global basis. So, it’s in Europe, it’s in China and Japan, Mercosur, in South America. All these, all these agencies, all these global nations, agencies, require testing not just for oven-able food service, but also for microwaves. My company was actually instrumental in helping FDA develop their microwave tests and they are extremely safe. And if I may, may I actually address one or two of the comments that were stated earlier? Is it okay?

As a scientist that passionately believes in my mission to provide safe products for food packaging, I’d like to clarify a couple of points or two from Senator Bergstein’s testimony this morning. PFOA has never been used in food packaging. FDA does strongly regulate food packaging applications, not just food. Our products were approved under Obama era FDA. They’ve been in use for many years. Migration testing is the keystone for food packaging testing globally, not just in FDA.

FDA and all national agencies globally require upfront testing for toxicology and migration for any food packaging products. It typically takes about two years and several hundred thousand to over a million dollars in testing and time to get a product approved on a global level. And as Chairman Steinberg so correctly pointed out, getting the bad stuff out is an activity, should FDA devote significant resources to. Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Senator Lesser.
SENATOR LESSER (9TH): Thank you, Madam Chair. You mentioned a French study on the presence of contamination in food products. Could you discuss the state of your opinion in regulation and monitoring of, of chemical contamination right now?

FRANK ADAMSKY: Wow, how long do you guys have?

SENATOR LESSER (9TH): I’ll defer to the Chair on that one.

FRANK ADAMSKY: There, there --

SENATOR ABRAMS (13TH): Not long.

FRANK ADAMSKY: I live my life in this area, it’s actually, Europe uses two primary sets of regulations, one is through the global EU, but most companies and most European Union members defer to Germany and it’s a process called or it’s a group called the BFR, and that is the overriding regulation for food packaging in Europe.

SENATOR LESSER (9TH): And are their regulations generally about the same as we have right here, or they are stricter in any respect?

FRANK ADAMSKY: They’re the same, but different. They’re roughly the same sets, the same view because it’s food service packaging. You’re looking at the same types of things, ovenable, microwave, things like that. They’re similar but a little different.

SENATOR LESSER (9TH): Thank you.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your time and testimony.

REP. STEINBERG (136TH): Next up is Anne Hulick.
ANN HULICK: Thank you, Chairman Steinberg, Senator Abrams, ranking members and distinguished members of the Public Health Committee. I’m Anne Hulick, I’m the State Director for Connecticut Clean Water Action, a national nonprofit environmental organization. I also coordinate the coalition for Safe and Healthy Connecticut. We are very much in support of House Bill 5910, although I’d like to suggest a couple of amendments or changes that might be helpful to this committee.

The reason that we’re concerned about these chemicals in firefighting foam and food packaging is that these chemicals, although they haven’t gotten a lot of attention in Connecticut, if you do any Google search, you will, you will be inundated with the impacts not only to public health, but to the environment from exposure to these chemicals. These are highly effective chemicals in that they, the fluorine carbon bond does not breakdown in the environment. They are persistent, they bioaccumulate and they migrate up the food chain. They’re found all over the world. It is estimated by an independent group called the Environmental Working Group that over 40 states and 110-million Americans likely have this in their drinking water. There’s an interactive map that I’ve shared with you in testimony.

But recent research over the past several years has shown these chemicals are linked to kidney cancer, testicular cancer, liver disease, thyroid disruptions, reproductive disorders, even immune resistance to vaccines in children. We are very concerned about not only the health impacts, but the contamination to water sources. Because these
chemicals are so persistent, they do get into the ground water and then they migrate. They, they migrate and there’s been research over the past several years that shows miles and miles long plumes of these chemicals stretching and contaminating water sources all across the U.S.

This is really a huge global crisis and I believe, and the reason why we’re so supportive of this bill is that it’s incumbent upon us in the absence of federal legislation and leadership, frankly, to take action. So, the two things that we are supportive of is reduction of, or restriction of the use of firefighting foam for training purposes. I think that is something that I believe I heard some of the FluoroCouncil people support and we are aware that the FAA is not yet ready to say that the aqueous film-forming foam, AFFF, should be restricted in actual jet fuel fires.

So, we support a restriction for training purposes that will reduce a huge source of exposure. With respect to, oh, I’m sorry, I know I’m out of time. I can finish up.

REP. STEINBERG (136TH): If you wouldn’t mind, Anne.

ANNE HULICK: With respect to the food packaging, I, we do respectfully disagree with the previous testimony. There’s more and more evidence that even a short-chain, there’s a whole debate about long-chain, short-chain for fluorinated chemicals. This is just the chemistry of how they are making these chemicals, whether they’re eight atoms, six atoms, all of that has become confusing for people. And the science is still ongoing. But the fact is that these chemicals are linked to some very serious
diseases and a number of independent studies, not conducted by industry, have shown that the food packaging does contaminate the food or beverages they’re in. So, we are concerned about that.

I would like to suggest that food packaging restrictions of PFAS chemicals be implemented in 2021, because in our national work with manufacturers, we’re very confident that they, recognizing these concerns, are moving in that direction. So, we feel that an implementation date of 2021 is very sufficient and realistic. There are well over 100 products on the market, and I can share a database with you, that are already in place that are fluorine-free and PFAS free. So, the market is already shifting, but by having an implementation date that is reasonable for our manufacturers and our retailers, we believe that that is a commonsense approach.

REP. STEINBERG (136TH): Thank you, Anne, for testifying on this issue. Thank you for showing some willingness to find a common ground and it does sound at least for the firefighting foam that we’re probably very close to something that will work for both industry and for the rest of us.

I admit that I am a little confused, not really by the science, but by the fact that on one hand, you’re talking about carcinogenic endocrine disruptor implications and yet the industry has said that those particular products are no longer produced or made available here in the states. So that it’s important for us to be clear within the, the continuum of different PFAS chemicals, which ones we’re talking about. Perhaps you would choose to comment that they are basically saying that the
problematic ones have been addressed and yet you say their independent study is not done by industry that indicate there are still some versions of PFAS’s out there that are available and problematic?

ANNE HULICK: It is a complicated issue. So, the class of, of per and polyfluoroalkyl substances or PFAS, the earlier ones were PFOS, P-F-O-S, and P-F-O-A, those were taken out of commerce a number of years ago because of the very harms that we have, you know, we have found. Not only health harms, but environmental contamination across the globe.

However, the industry, like with other chemicals, they shift molecules and adjust molecules to achieve the same efficacy in the products, but and then claim that the research shows that those are safe, when, in fact, A., there’s likely not a significant body of research that has been done to demonstrate their safety and B., there’s always new variations of those, of those class of chemicals coming into the market. So, our federal government and regulatory agencies are not able to determine if those products are indeed safe.

I go back to the example of this phenyl A, which I know you all are aware of. So this phenyl A, we knew was an endocrine disruptor. Many states and then subsequently our federal government restricted BTA because of it’s endocrine disrupting compounds. The industry then switched to, switched some molecules so that they now, so that we now have BPS and BPF. The claim was that these were safe, that, but there were no studies done to say that or inadequate studies to conclude that.
The same is happening here. And we do not believe, and early evidence suggests, that switching the molecules so PFHxA likely has the same health impacts as the previous chemicals that had longer chains.

So, I think it is a misrepresentation and an inconclusive statement to say that these short-chain compounds are completely safe. I do believe that, you know, I hear the industry saying that and the industry studies supporting that. We in the advocacy community and we work with the Green Science Policy Institute, who I’d be happy to refer all of you to, Silent Spring, the researchers in Massachusetts that are studying this issue. We work with independent science groups all over the country, who have educated me and my colleagues to bring this information to you. We don’t represent industry; we represent advocates and public health professionals and scientists.

REP. STEINBERG (136TH): Anne, thank you for all the good work you do. I think the other suggestion you made, and I know you’ve submitted some suggested revised language to provide industry an opportunity to make the transition they’re already perhaps on a path on by delaying implementation until 2021, but it will also afford us more opportunity to have studies done that would prove them one way or the other. And the legislature would still have an opportunity before 2021 to review those studies, so I think that’s a reasonable compromise in that context.

ANNE HULICK: And also, we are very aware that, you know, we don’t want to do anything that impacts our businesses, our small businesses, our restaurants,
our takeout, places like Whole Foods, frankly. We want to give them time, now that they’re becoming aware to find safer alternatives and we’re doing a lot of work with those very businesses to help them to shift to safer alternatives as they increasingly come on the market. So, we really are trying to be cognizant and present reasonable approaches.

REP. STEINBERG (136TH): We do appreciate that and particularly your point about aiding businesses to make the transition rather than simply imposing new restrictions on them. Are there comments or questions? This may reflect a little bit of our exhaustion at this point. So, Representative Michel.

REP. MICHEL (146TH): I have a lot of energy. Just a very brief question. If I’m understanding correctly, just those changes on switching molecules or changing the chain, basically is not necessarily changing the impact on public health or the environment, it’s just to get it out of regulatory and positions, okay. Thank you.

ANNE HULICK: You’re welcome.

REP. STEINBERG (136TH): Any questions or comments? If not, Anne, thank you very much.

ANNE HULICK: Thank you.

REP. STEINBERG (136TH): Next up is Louis Birch. Is Louis here? Okay. Chris Phelps? I don’t see Chris, either. Moving right along then, we have Joyce Acebo-Raguskus.

JOYCE ACEBO-RAGUSKUS: Good afternoon or is it evening? Thank you so much for your patience. Yes, my name is Joyce Acebo-Raguskus. I am a strong
advocate with Clean Water Action and forgive my voice. I am in support of 5910, and I echo all that my colleague Anne Hulick, Director of the Clean Water Act presented.

With regards especially to the amendments 1 and 2, to restrict the use of firefighting foam, military, et cetera. I know our time is waning, so I’ll simply say, I support the two amendments that are in Clean Water Action presented.

And I would like to focus on the threat of, don’t drink the water type of a threat. It is definitely a human health and an environmental issue. And it’s very cunning, it’s leaching, and that’s why we’re here today. So, specifically, alerted by Greenwich water situation. And the fact is that the federal projection to regulate has been profoundly unsuccessful. It is a human health hazard, a carcinogen, hormone disruptor affecting infertility, kidney, liver, thyroid of all ages. And I’d like to say that with regard to the gentlemen in this room, it’s also been a known testicular cancer health issue. 10,000 new cases of testicular cancer have been diagnosed. This is American Cancer Society. The average age at time of diagnosis of testicular cancer is about 33 years young. Largely a disease of the young and our middle-aged men, but about 6 percent occur in our children and our teenagers. They present over the age of 55. That is not something that needs to be pushed aside. It’s serious, it’s cunning, it’s leaching, and I absolutely support the two amendments to begin that process of cleaning up our water supply. It’s our lifeline. And thank you so much for all you do.
REP. STEINBERG (136TH): Well, Joyce, thank you for what you do. It’s good to see you. I think it’s a testament to your commitment that you’re here today, even voice challenged, to somebody who had laryngitis for a couple of days last week, you have my empathy. Rather than tax your voice further, I have no questions. Anybody else who would like to address a question or a comment? If not, we’re going to strongly recommend as a committee, a Public Health Committee that you rest up and regain your voice.

JOYCE ACEBO-RAGUSKUS: Thank you, it’s a joy to be back and see all the committed, hardworking, conscientious souls.

REP. STEINBERG (136TH): Well, thank you. We’re moving on now to House Bill 5444, and as we often do with this subject, we have Ellie Nicol.

ELLIE NICOL: That was a great introduction. Thank you. Honorable Chairs, Co-Chairs and ranking member, I am very happy to be here to speak in favor of bill, House Bill 5444, AN ACT REQUIRING THE LICENSURE OF ART THERAPISTS. My name is Ellie Nicol and I am nationally Board Certified as an art therapist. I would like also to thank Representative Bolinsky and Senator Logan for their sponsorship in Art Therapy Licensing Bill, and also thank the committee for voting to introduce it as a committee bill.

In reviewing the bill, however, I found language that appears to contradict another part of the bill and also may continue to confuse the public about who is qualified to practice art therapy in a
competent and safe manner. And as regulated by the Department of Public Health.

Let me direct the committee’s attention to subsection 2(c) at the top of page 3, that would allow non-licensed persons to practice art therapy, as long as they don’t represent themselves as art therapists, which clearly contradicts the prohibition in subsection 2(a) against any practice of art therapy without an art therapist license issued by the Department.

I support the definition of art therapy on page 1, line 6, that clearly defines art therapy as a practice done by a professional who has completed a master’s level degree, approved art therapy program. I have submitted amended language in my written testimony to address this.

I work with at-risk adolescents in an alternative high school in Bridgeport and in a practice in Danbury, where I use art therapy with a variety of populations. One young woman left college mid-term last year with symptoms of panic, hallucinations and suicidal ideation all due to a sexual trauma. Talking about the experience only triggered her symptoms. Engaging in art therapy, drawing out her fears, distorted thoughts and injured self-concept, enabled her to deal with her issues and heal and return to college the following fall. Her art will be on display Wednesday at Art Therapy Day, here in the Capitol, Room 310, from 12 to 4. You are all invited. I hope you can come.

Art therapy is more than art and therapy. Art therapy is a distinct clinical and evidence-based use of art. Understanding how art interacts with
the client’s psychological disposition and how to safely manage and interpret the reactions different art processes may evoke, are competencies that must be gained through substantial experiential learning that is unique to art therapy master’s programs.

In closing, I see individuals, groups, couples and families. When I work with couples, I do not say that I am doing marriage and family therapy, I say, I’m doing couples art therapy. When I see a family and I connect them with social services, I don’t say I’m doing social work.

As you look at the written testimony, you will see that we have strong support from the Connecticut Social Work Association as well as New Haven Articles and many other professionals and organizations that you’ll see.

But I want to be very clear that nothing in our licensing bill prohibits or restricts any other person from using art media in their professional practice, as long as they don’t represent themselves as art therapists or otherwise authorized to do art therapy. Thank you.

REP. STEINBERG (136TH): Thank you, Ellie for your testimony today and for the testimony last year and the year before and the year before that.

ELLIE NICOL: Actually, we won’t here last year.

REP. STEINBERG (136TH): Oh, that’s true. We took a year off. But we really do appreciate your perseverance and commitment to this task, and we recognize that you have been patient, while DPH pursued its piece of the puzzle. And hopefully that makes a sufficient difference this year and --
ELLIE NICOL: Yeah.

REP. STEINBERG (136TH): -- and we will give it consideration. I don’t have anything more to add because I think that I’ve heard some version of this a number of times. And we’re very appreciative of how your profession has evolved over the years, too, to provide really tremendous assistance to a lot of people. So, thank you for that. Comments, questions? Members of the committee? If not, thank you, once again for your testimony.

ELLIE NICOL: Thank you.

REP. STEINBERG (136TH): Aimee Jette, please.

AIMEE JETTE: Hello. Hi, good evening, Co-Chairs, Vice Chair. I’m a representative of the Public Health Committee. Thank you for the opportunity to speak today in support of House Bill 5444, AN ACT REQUIRING THE LICENSURE OF ART THERAPISTS. My name is Aimee Jette and I am a master’s candidate in Hofstra University’s Creative Arts Therapy Program. I’m also Ridgefield, Connecticut resident. And I am the President of Art in Common, it’s a 501c3 based in Ridgefield. So, I’m very grateful to be here today.

Art Therapy is a unique mental health occupation that incorporates the disciplines of psychology and art-creation. When a client cannot find the words to express a thought or feeling, the act of art making can provide access to a new system of communication. It is a form of creative expression that engages symbolism and metaphor through visual imagery. Art therapy allows the therapist and the client to use art to process information in a way that can surpass talk-therapy alone.
Often, unanticipated images arise during the creative process that surprise both the creator and therapist and create an opening for valuable discussion and self-awareness. When a symbol arises in the therapeutic process, which exhibits a dysfunction, it can demonstrate problems ranging from early attachment issues to certain types of pathology.

Sometimes, the client feels a rush of emotional impulses and has trouble expressing them by talking alone. Art therapists are specifically trained to help the client understand what is happening and guide them in the healing process. As you’re well aware, our gun violence is on the rise, traumatic events can be processed and visualize in a secure manner through the creation of artwork. Often, when clients are asked to verbally describe a traumatic experience, there is a risk of re-traumatization. Through art, trauma can be reintegrated into enduring memories in a sustained way. This facilitates memory reorganization and recovery.

Helping a child convey these intense feelings using imagery encourages the construction of a new narrative for them. I work with at-risk children, families and teachers who reside in high-risk towns. I recently worked with two public schools to introduce art therapy to 1300 elementary and high school students. The children each had the opportunity to create a piece of art to be delivered to Marjorie Stoneman High School, in Parkland, Florida, with personal messages of empathy and resilience. The community of Parkland plans to respond in kind. Through dialog and discussion, the students learned new methods to use art to decrease
stress, increase emotional regulation and increase compassion, even in their own lives.

This is an opportunity to engender hope and strength among these communities, increasing bonds and rendering healing.

In closing, art therapists undergo rigorous training resulting in a specialized master’s education and preparation for a national board examination. While I applaud other professionals for using art in their practice, I would like to propose they use terms such as creative expression or group art, reserving art therapy for registered art therapists. It seems to be a reasonable solution where the benefits clearly outweigh any potential downside.

In addition to protecting the consumer from misrepresentation of services, it will attract art therapists and recent graduates like myself to bring services and revenue to Connecticut.

Thank you for this opportunity to testify.

REP. STEINBERG (136TH): Thank you for your testimony and for really being very serious about entering the profession, hopefully at a very good time, where we’ll be placed to bring back the change that have been long sought in the state. Does anybody have any comments or questions? You sort of get the sense that, you know, we’re pretty clear on this one.

AIMEE JETTE: I do.

REP. STEINBERG (136TH): Thank you. Next up is Briana Benn-Mirandi, I believe. Feel free to correct me.
BRIANA BENN-MIRANDI: Briana Benn-Mirandi, hello.

REP. STEINBERG (136TH): There you go.

BRIANA BENN-MIRANDI: So, I’ve submitted a written testimony, which outlines just a few of the many client cases I’ve worked with within just the last year. A child on the autism spectrum, a teenager, who was selectively mute, an angry disgusting teenage girl, all cases where talk therapy was not the go-to solution.

I was going to share these stories, but you have them on paper. And in sitting here today, and more important for art therapy licensure occurred to me, so I’ve amended my testimony. I began my private practice in September of last year. I am currently full to overflowing with clients, good news for my practice, bad news for potential clients.

I’ve begun trying to refer clients out, emphasis on trying. Most clinicians I know do not work with children who require more for the same, if not less, pay, for services beyond the therapy hours, such as communicating with parents and schools, the requirement of bigger spaces, and the provision of toys and art materials for communication.

Children and teens also usually have to work around schedules for school, mom and dad’s jobs, and extracurricular activities other than therapy, which allows for limited hours that a treating clinician such as myself can even fit children in.

I have a maximum of eight or nine sessions a week that I can accept a school-going child. I often attempt to find a creative marriage and family therapist or a creative social worker to refer to
when I come up short on finding a good fit with an art therapist. Unfortunately, even when I find what I feel is a perfect match or as close as I can get, it’s often not good enough.

I was told by a mother last week that instead of going to a referral, she would prefer to be put on an indefinite waiting list for her son to see me, flattering as this may feel to me, this is not helping her son. Just in sitting here today, I have followed up on three additional clients, referrals who I cannot see due to my full schedule that I need to refer out to.

And if this is the case for an affluential shoreline town like Madison, can you imagine the need for the bigger cities? As art therapists we have the same level of education as marriage and family therapists, master’s level social workers and professional counselors. We’re not trying to take anything away from other therapists, such as using art work in session, far from it. The world needs more emotional healing through art. Rather, we wish to provide a clear understanding of what art therapy is and what it is not as well as exemplify it’s effectiveness. And we wish to be counted among the other hardworking, long studying clinicians who we work side-by-side with in the helping profession.

There’s a definite need for more mental health workers that not only work with but specialize in the language of children. Many, if not most art therapists are just that. And we need them licensed not serving this need for people of Connecticut. Just as art therapists are doing in the 12 states that already have licensure, and hopefully soon in
the 20 additional states currently seeking this licensure, including ours. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. I was particularly taken by the struggles that many of your patients have to find somebody with the appropriate background. And if anything, we’d want to encourage more people to get into the profession. So, thank you for that. Yes, Senator Cohen.

SENATOR COHEN (12TH): Hi, I just wanted to welcome Briana because she’s from the 12th District, from Madison, and I was pleased to see on the testimony list how many licensed art therapists there are in actually the 12th District. I’m sure there all over the state, but I was particularly pleased about that. And you’ve done such a good job at explaining this to me and for the benefit of some of the newer legislators here who have not been through a couple of years of testimony on this, could you just explain a little bit. I know there’s dual licensure. Could you explain a little bit about why the need for this bill? I know we’re talking a lot about the benefits of art therapy, but not, not so much about why there’s a need for the licensure?

BRIANA BENN-MIRANDI: So, I am dually licensed as a licensed professional counselor. But that is an additional 2,000 hours and an additional exam, above and beyond what, say, my husband, who’s also a licensed professional counselor needed to do to get licensed and go out into working in the field. So, a lot of people, a lot can happen in that time it takes to do another 2,000 hours. And to be honest, I’ve just come back to art therapy after being away for 10 years. So, a lot of people may not see it
through, as I did, until just recently. And this is one of the problems leading, because there’s not as direct a path to licensure as there are for social workers, LMFT’s, and licensed professional counselors that a lot of art therapists are being told or are not seeing it through to go that extra mile.

There’s also the question of, well, it’s really hard to market yourself as an art therapist because a lot of people don’t understand what art therapy is and it doesn’t help that many other people who are not master’s level educated psychoanalysts are saying that they also do art therapy. So, it’s, it’s a much more up-hill battle to get where I currently am in my practice for most art therapists.

REP. STEINBERG (136TH): Thank you for that. I was, I was perhaps not helpful to my new members of the committee to assume that everybody was as familiar as those who have been on the committee for a while were. So, thank you, Senator Cohen, for giving her the opportunity to provide a more clarification. Any other questions or comments? If not, thank you, welcome back to the, to the profession.

BRIANA BENN-MIRANDI: Thank you.

REP. STEINBERG (136TH): And hopefully we’ll have something to talk about soon.

BRIANA BENN-MIRANDI: Thank you.

REP. STEINBERG (136TH): Next up is Tess Hannafin.

MARY TESS HANNAFIN: Hello. Mr. Chairman, Madam Chairman, members of the committee, thank you of this opportunity to testify. My name is Tess Hannafin and I am a new art therapist from New
Haven, Connecticut, and I am here in support of the House Bill 5444, AN ACT REQUIRING THE LICENSURE OF ART THERAPISTS.

So, a little bit about art therapy, not to be redundant, but it’s always an honor to advocate for my profession. So, as different as all of us humans are, we all have the commonality to want to be seen, heard and understood, and could all use the benefit of mental health counseling. But what if you were unable to be accurately seen or heard? What if you were unable to access these truths that may be shameful to discuss? And what if talking is not enough?

We are all different learners, such as auditory, visual, kinesthetic, tactile, so wouldn’t that make us all different expressors? Creating art is another form of communication. It is a different angle of analyzeation, an entirely different language, if you will, that allows us to express things that we are unable to articulate with words alone. It provides a platform to better understand effects of the self that would otherwise not be accessible.

We take in life through seeing, feeling and doing. We literally live visually. If we’re taking in these images through vision that allow us to recall how we felt, then how does solely talking about these past events and feelings seem like enough to get an accurate perspective of our lives?

Whether it’s through the sensory benefit of the tactile artmaking or the satisfaction of creating something that gives the sense of accomplishment, art adds a deeper layer that only the unconscious
can access. I work in a dementia unit, and as was previously mentioned this morning about someone with Alzheimer’s and the difficulty it is to communicate, I can say firsthand how impactful and beneficial creating art with these residents have on their quality of life. It gives them the sense of control and autonomy and they’re able to communicate and they are validated.

With the help of a licensed art therapist, who has the artistic knowledge to help guide those who are not as acquainted with art materials as well as the counseling and psychology education background in order to safely facilitate a deeper understanding of the artwork and reflect affects of the person’s psyche, one can receive the appropriate help to learn this very special creative process. It’s like learning a language, that once learned, can be used to unlock what was previously unable to be expressed.

The committee is aware that many art therapists have been licensed in Connecticut as professional counselors. However, recent legislation approved by the General Assembly and signed by the Governor as Public Act No. 1794, will restrict eligibility for counseling licenses, beginning January 1st of this year, only to person’s holding master’s degrees from counseling programs that had CACREP accreditation or related programs that closely correspond to CACREP standards and curriculum. This will effectively deny the last available option for most art therapists in the state.

Just one more minute, is that okay? Thank you. Without a separate art therapists license, it will be increasingly difficult for graduates of the
Albertus Magnus College Art Therapy Program as well as programs in neighboring states to obtain licenses and practice in Connecticut. There will be fewer qualified and licensed practitioners to meet the state’s urgent need for mental health services, less diversity and innovation in mental health practice and no assurance that residents of our state, who need art therapy services will receive them from appropriately trained, qualified, and licensed art therapy professionals.

Addressing certain things about yourself is hard, but seeking the help is harder and by allowing art therapists to become licensed mental health providers, it will only allow for more people to gain more access to the treatment that they deserve.

Thank you for this opportunity to testify.

REP. STEINBERG (136TH): Thank you for your testimony. I also really like using 3x5 cards or 4x5.

MARY TESS HANNAFIN: A little flimsy.

REP. STEINBERG (136TH): Thank you, particularly for your emphasis on the dementia community, you know, the State of Connecticut is growing at a rapid rate. We know that there will be more and more patients with various forms of dementia and it’s wonderful that this form of therapy is so helpful to them. So, thank you for that. Are there any other comments or questions? If not, thank you very much.

MARY TESS HANNAFIN: Thank you.

REP. STEINBERG (136TH): Last up on this bill is Amanda Vallario.
AMANDA VALLARIO: Good evening. Madam Chair, Mr. Chair and members of the committee. My name is Amanda Vallario. I am here on behalf of House Bill 5444. I graduated from Albertus Magnus College in 2017, with a Master of Art in Art Therapy.

I have provided clinical art therapy at hospice care as well as at a substance abuse clinic. Currently, I provide these services for child and families at a nonprofit company in Southeastern Connecticut.

I am here today to advocate for art therapy licensure and for future, for further recognition in the mental health field. I find frequently justifying art therapy as an evidenced-based practice. Each week, hours that could have been spent with clients, are spent advocating for the use of art therapy in sessions.

My colleagues and supervisors are immensely supportive. However, they struggle to understand the profound effects that art has in therapy. Recently, a 12-year-old female came to me with comorbid symptoms of depression and anxiety. We began our episode of care by treating her symptoms of depression. It became apparent through out conversations and through the artwork that we were making in session that she could benefit from art therapy, focused on treating her anxiety. It was through her artwork that I was able to discern the need for a shift in treatment. In following sessions, I encouraged her, I engaged her, excuse me, in art therapy directives, proven effective in treating anxiety.

In a short period of time, she made significant progress and an increase in ability to identify her
anxiety symptoms as to use art as a coping skill. This is evidenced by an increase in school attendance, an increase in social engagement as well as an interest to join the school’s drama club.

This is just one example of how art therapy has been effective in treatment. I believe that the licensure of art therapists in Connecticut would lead to more time spent meeting client’s needs and less time spent trying to justify why I’m using art therapy in sessions. This would also lead to more effective mental health services in our state.

Thank you for this opportunity to testify.

REP. STEINBERG (136TH): Perfect timing. I think you get an extra award for that. Thank you for your testimony. We all recognize how valuable the therapy is for people with various forms of anxiety. And it was a particularly wonderful story about how well that particular subject turned out, joining the drama club, boy that’s a huge turnaround, I would have to say. So, I think it gives us all a sense about how successful this form of therapy can be.

AMANDA VALLARIO: Thank you.

REP. STEINBERG (136TH): Questions or comments from members of the committee? Thank you for taking the time to be here today. We really appreciate it. We’re gonna move on to another bill, to House Bill 5654, and first up is Dr. Pat Felice.

PATRICK FELICE: Well, good evening, Senator Abrams, Representative Steinberg, Senator Somers, I see is not here, I wish to recognize here as well as Representative Petit and distinguished members of the Public Health Committee.
My name is Patrick Felice, I’m a Board Certified Plastic Surgeon and past President of the Connecticut Society of Plastic Surgeons. I’m here today on behalf of our organization as well as the State Medical Society and the Connecticut Dermatology and Dermatological/Surgical Society, representing thousands of physicians in Connecticut to testify in opposition to H.B. 5654, to allow dentists to administer neurotoxins and dermal fillers under their scope of practice.

The bill before you today poses serious patient risks, given the fact that dentists lack the clinical training to perform surgery outside the oral cavity and, in fact, the practice of dentistry or dental medicine is defined in Connecticut’s General Statute 379-20-123(a) as the diagnosis, evaluation, prevention or treatment by surgical or other means, of an injury, deformity, disease or condition of the oral cavity or its contents, or the jaws or the associated structures of the jaws.

The provision goes on to exclude, 1., the treatment of dermatologic diseases or disorders of the skin or face; 2., the performance of microvascular free tissue transfer; 3., the treatment of diseases or disorders of the eye; 4., ocular procedures; 5., the performance of cosmetic surgery or other cosmetic procedures other than those related to the oral cavity, its contents, or the jaws; or 6., nasal or sinus surgery, other than that treated, related to the oral cavity or its content or the jaws.

Now, I’m sure after hearing many testimonies today, I was here for most of the afternoon, listening to the trauma center testimony of some of the critical things that are going on in your minds, you may find
that treating the aging face is trivial. As, as voiced by many people when they think of cosmetic procedures, well, you know, it’s like going to the beauty shop, you know, it’s like getting your hair cut. What harm could be caused?

It’s important for you to understand that the training we go through is dealing with millimeters. Any deviation from a few millimeters can result in damage to surrounding nerves, blood vessels, structures. You could puncture an eye. You could inject or embolize a filler material into a vessel, cause embolization into the eye, causing blindness. You could embolize vessels and cause skin necrosis of the skin.

Also, it’s important to know that if you don’t recognize whether a lesion on the skin is benign or malignant. You might inject near that and spread cancer. So, it’s not trivial. It’s not trivial. It took over 30 years of research and development to derive clinical uses of botulinum toxins to treat very serious medical conditions, and that’s in my submitted testimony. I won’t go through all the conditions.

REP. STEINBERG (136TH): I’ll ask, Doctor, that you begin to summarize.

PATRICK FELICE: Sure. Sure. I’ve seen the complications from fillers in my own practice and I have testified in the past on that. The training of plastic surgeons is, is clearly a seven to 10 year process in training after completing a medical degree, complete three to six years of full-time experience in a residency training program, accredited by the Council for Graduate Medical
Education and three years of training in the same program for plastic surgery. Dentists, since you have four years of dental school, following graduation from an undergraduate program.

Finally, I would like to mention that in 2011, the Connecticut General Assembly passed Public Act 11209 to create a scope of practice review process within the Connecticut Department of Public Health. I participated in that process over the years. Under this process, organizations submit proposals to the department and committees of interested parties and are organized to review the request, study its implications and make recommendations. The proposal you have before you today has not been submitted to the department for review and consideration. My colleague will testify further on this matter.

On behalf of the patients of the State of Connecticut, we urge your opposition to H.B. 5654. We thank you for your consideration.

REP. STEINBERG (136TH): Thank you, Doctor, for your testimony. I will assure you that the members of this committee do not take this subject by any means trivially. And we are very much aware of the bad outcomes that can occur from inappropriate application of some of the products that are not being actually administered by a trained physician.

You raised the point about education and training and drew the distinction between what you are obliged to do as a plastic surgeon and what a dentist has. The dentists have put forward that they believe they have sufficient training and education in the very limited context of what
they’re proposing to do in this. Would you choose to comment about that?

PATRICK FELICE: I am always in awe of the people that, in our professions that require a limited application to things, but it really hardly ever stays limited, does it? I think, you know, the feeling that you’ve been inside this area of, and when I talk about feel and millimeters, you haven’t really done surgery under the skin or you don’t understand skin or you don’t really, you haven’t dissected out those miniscule blood vessels and nerves in the face and know that anatomy so well from being under there for years of our training, that it’s, it’s a touch. It’s something that we, when I say trivialize, how trivial is it to think that we can just go injecting things under the skin without that touch and knowledge of years of training and experience. And that’s where I draw the distinction.

I don’t think there are limited applications. This is a serious, serious business.

REP. STEINBERG (136TH): Playing devil’s advocate. If we take a specific example of Botox, it seems to be virtually ubiquitous in our society these days, which everybody wants to use it on somebody. You know, it’s almost reached the point where it’s so common, what could go wrong? Has that been your experience?

PATRICK FELICE: No, it’s not. It’s not. Botox is a nerve substance that we’ve certainly had experience for medical uses of. It was originally indicated for treatment of strabismus where a child may have had, you know, so-called cross eyed, and
you can weaken one of the muscles to straighten the eye. It’s been used for paralysis, hyper-spasticity paralysis patients. It’s used in a lot of areas, torticollis, twisted necks. There, there are so many medical uses for it. And through those trials and tribulations, we learned a lot about Botox. Now, you’re absolutely right, Botox is pretty innocuous if placed in the right places. But if you inject it into a nerve, I’ve had patients that have had chronic pain from an injection directly into a nerve because they weren’t aware of where the supraciliary vessels and nerves were when they injected it. You can, you can force any volume into anything and cause injuries, even Botox.

REP. STEINBERG (136TH): Thank you for that. I, I share your concern about how easily, I don’t want to say cavalierly, but how frequently Botox is applied by all sorts of practitioners at this point.

Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Doctor, can you tell us, as far as you know, who has it within their scope of practice to do dermal fillers and neurotoxin injections?

PATRICK FELICE: Well, at the current time the statutes for physicians, they can do dermal fillers and Botox under their licensure statutes. APRN’s can now independently practice and they can do it under their current license. That’s really it. I mean, a nurse has to be, there’s one thing that’s going on with the producers of Botox and fillers is now they have expert injectors, they’re called. And they go to different offices and they teach people how to do injections. And most of them are nurses and PA’s, I mean, I’ve never met one that is a
physician. We don’t tend to take a lot of time away from our practice to go running around, you know, training on how to do injections unless it’s at a formalized meeting or other event. But, but there’s injectors out there that will go out there and train people to do it. You know, under Connecticut law and our licensure, those are the only two I’m aware of that under the statutes of their license can actually do injections. Even PA’s have to be under the direction of a physician.

REP. PETIT (22ND): Would you draw any distinction between the variety of dermal fillers and the neurotoxins, or would you consider them same in terms of potential for complication and adverse events?

PATRICK FELICE: I think neurotoxins are, if you get a bad outcome; in other words, you inject it and somebody has a drooping eyelid and, you know, they look horrible for about three months until it wears off, I mean, it’s not permanent. The, the, the issues of permanency become injecting it too close to a nerve or, you know, an area where you can create a chronic neuritis. Fillers, I think, are a bigger issue. Fillers you can, there’s a lot of different fillers that can be used in the wrong places. You have to know which fillers are used best for what area of the face. They could embolize. You could inject the vessel and embolize it just about anywhere. They are pretty large molecules. So, I think fillers pose a bigger risk, but I wouldn’t discount Botox.

REP. PETIT (22ND): Thank you. Thank you, Mr. Chairman.
REP. STEINBERG (136TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. What is the training, because I do, somebody said to me the other day, you can go to a health party and have Botox. I was like, no, thank you. I’ll keep my wrinkles. What is the training for fillers? I actually thought Botox was fillers, that’s why you got it.

PATRICK FELICE: Right.

REP. ZUPKUS (89TH): But I don’t know. That’s what I know about it. But what is the training for Botox or fillers?

PATRICK FELICE: Well, just to clarify, Botox is to immobilize wrinkles that are caused by muscle action. It’s a neuromodulator to decrease that action. Can it be used too much? Yeah, look at some of the people on TV. You’ll see that they have no expression whatsoever. I mean, it’s pretty scary. The very thought that your whole face is numb now, that’s not true. But they’re pretty expressionless and that’s just lack of knowledge of how much to use in what areas. Not permanent effects, but not great effects.

No, the fillers, you know, I’m sorry getting back to, you’ve never been convinced about --

REP. ZUPKUS (89TH): My question was, what was the training?

PATRICK FELICE: -- the parties and the training. The parties are another thing that really get my goat because they’re really out there drinking wine and it’s contraindicated for Botox. And yet there are wine parties with Botox. An APRN can hold a
party and inject Botox or fillers. A physician can hold a party and inject fillers or Botox. Would I ever do that outside of a medical arena, no. The training is under the statute, physicians and APRNs.

REP. ZUPKUS (89TH): But can you just briefly tell me what is the training, is it seven hours and you go sit in a classroom and somebody shows you how to inject it or is it something you watch online? What is the training to be able to inject fillers or Botox?

PATRICK FELICE: There’s no requirements for how you get trained. Typically you can do a CME course and go on YouTube and see how to train. I mean, you can change an engine to your car that way, why not? So, most of them are done by the distributors of the products, the company that owns the products are sending around expert injectors.

REP. ZUPKUS (89TH): Okay.

PATRICK FELICE: And they’ll spend a few hours in the office, show them how to do it. And they’re then the next expert injectors.

REP. ZUPKUS (89TH): Great. Thank you, you answered my question.

PATRICK FELICE: Sorry, it took me a little while to get there, but I wanted you to truly understand Botox versus fillers.

REP. ZUPKUS (89TH): I do, now I know why I have the 11th here.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.

PATRICK FELICE: Thank you.
SENATOR ABRAMS (13TH): Thanks for being here. Dr. James Williams? Dr. James Williams? Dr. Michael, I can’t read your writing, Ungerleider. Okay. Thank you.

MICHAEL UNGERLEIDER: Don’t worry, everybody does that.

SENATOR ABRAMS (13TH): Sorry about that. Thank you for being here.

MICHAEL UNGERLEIDER: So, I was gonna say, started this at good morning and then good afternoon, it is good evening, I guess, now. Senator Abrams, Representative Steinberg just left and members of the distinguished Public Health Committee that are still here. Thank you.

My name is Dr. Michael Ungerleider. I’m a general dentist in Granby, Connecticut. I’ve been practicing for 30 years and I do, in a small town, I do a lot of things, general dentistry, family dentistry, orthodontics, cosmetic, surgical, implant dentistry for Granby and the surrounded town. I’m past President of the Connecticut State Dental Association and a master in the Academy of General Dentistry. I am rising to support the House Bill in allowing dentists to perform certain facial therapies as part of their dental practice. And I believe there are six questions that really need to be answered. Why are panfacial injectables not a topic in dentistry? What’s the trend in the USA? Why is there resistance and what are the objections? Is there patient demand? What are the patient benefits? And what are the state’s benefits?

I hope to answer all of those in three minutes. Why are panfacial injectables a topic? So, we as
dentists are specialists of the head and neck, specifically the panoral region, including the mouth, the jaws, okay, jaw muscles, smiling muscles. We were trained alongside with physicians in the exact same classes, including full body cadaver dissections. We give the most injections of any healthcare provider, bar none. Not only do we give injections, we give big needle injections, okay, at least when it comes to your face, as opposed to the very small needles that are used for Botox and dermal fillers.

We are very aware of all of the things that can go wrong, okay. We give injections in the very exquisite areas of the eyes and mouth, when we’re going to give injections in the back of the mouth. So, we know how, how, we deal on, we deal on every day in millimeters, so that is our expertise. And even with our antiquated Dental Practice Act, we can still treat associated structures of the jaws and muscles control the jaws.

The trend in the USA is Connecticut currently is only one of 12 states in the country that don’t allow injections of Botox and dermal fillers for cosmetic purposes by dentists. In the past 10 years, they’ve gone from 25 percent of states to 75 percent of states that are allowing it.

And important point is, Boston University School of Dental Medicine in the next couple of months is going to start giving classes to the third and fourth year dental students in Botox and dermal fillers. So, we will have young dentists just coming out of school being able to do that, yet everybody else can’t do it. That seems a little odd to me.
With that said, the resistance, and I will sum up, the resistance is education, safety, scope of practice. We are not talking about dentists that are going to just go buy the stuff and start doing it, even with an expert trainer coming for a few hours. All of our courses are hours, days events. I’ve mentioned I am a master in the Academy of General Dentistry, that means that after I became a fellow, I had --

SENATOR ABRAMS (13TH): I’m sorry, I’m gonna have to ask you to sum up, okay?

MICHAEL UNGERLEIDER: I will sum up. I’m gonna tell you, this is gonna be good for patients, more competitions for price stabilization, more competition, better access to care, okay. And it will be safe, I can guarantee. Dentists are safe and we will continue to be safe. Thank you very much.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments? Representative Comey.

REP. COMEY (102ND): Hi, thank you, Doctor, thank you, Chairman. So, is it because, are you trying to grow the business of dental, the scope of dental providers because of maybe reduced reimbursements from insurance companies, is that trying to grow your model?

MICHAEL UNGERLEIDER: That’s an excellent question. I think that’s part of it as some people in general dentists are learners, we’re CE junkies. We love to just learn more, and this is our field. Currently dentists that are oral surgeons and have the, not only DMD, but the MD part, okay, which there are a lot of dual people, they can do it anyway, okay.
And this is just something that, well, we will also help, you know, you mentioned the economics. There’s a big wait currently if you look nationally and even statewide at waiting for a dermatology appointment or even a family practitioner. The average wait, they’re over 30 days. The average wait for a dentist is five days. And so, again, it’s going to, will it benefit financially and, and overcome some of the insurance things, it might.

REP. COMEY (102ND): I’d just like to say that my dentist was in favor.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Hi, Doctor.

MICHAEL UNGERLEIDER: How are you doing?

REP. ZUPKUS (89TH): Thank you for coming. So, would you give me a couple of examples of why you would need it around your face, like if someone came in. My daughter just got braces, so is it to make her lips bigger or better smile, what are some of the examples?

MICHAEL UNGERLEIDER: Yeah, that’s a great question. Initially, you would probably use it, most people that are dealing with general dentistry or oral surgery are dealing with pain issues, TMJ issues, headaches that involve the jaw muscles, that would instantly take care of that and longer lasting than let’s say a nonsteroidal or something else that would take more time. If we did, you know, I wouldn’t think a teenager would usually need a Botox or a dermal filler, but let’s say somebody that’s older, 50s, 60s, having a full mouth reconstruction
or something and then now they have a great smile, but they still don’t have that lip support and everything that would be somewhere where you would add that in.

REP. ZUPKUS (89TH): And would it be just convinced to this, like your mouth area or would you go up to the forehead?

MICHAEL UNGERLEIDER: Well, that’s a good question. You know, when you go home tonight, look in the mirror and smile.

REP. ZUPKUS (89TH): Oh, boy.

MICHAEL UNGERLEIDER: What muscles are you using? Okay. So, we’re dealing, we’re talking about the smile muscles.

REP. ZUPKUS (89TH): Uh-huh, okay. And you made a comment, I’m not sure if I heard you correctly about newer dentists that are being trained, are able to do, are gonna be able to do this, but --

MICHAEL UNGERLEIDER: Currently, the first school in the country that’s going to be doing that is Boston University this coming April. And one of the instructors, the, that, you know, you mentioned what is the training, okay. The training for a dentist that is going to be doing this has to go through multiple, multiple days of training as opposed to just an expert trainer coming in to tell us, okay. So, that, we are, I mean, in general dentists are, we are over-educated, and we were very careful about safety. I mean, we are mostly, you know, also in private practice, you want to do things that are gonna keep people coming. You don’t want to be doing things that are gonna be --
REP. ZUPKUS (89TH): Right.

MICHAEL UNGERLEIDER: -- scaring people away.

REP. ZUPKUS (89TH): Yes. Because I noticed now when I go to my dentist he checks my tonsils, my glands, takes my blood pressure all of those things, so. Great, thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any other questions or comments? Thank you, Doctor, thanks for your --

MICHAEL UNGERLEIDER: Thank you for your time.

SENATOR ABRAMS (13TH): -- time and testimony.

REP. STEINBERG (136TH): All right. Next up is Dr. Summer Lerch. Thank you. Okay.

NANCY SUMMER LERCH: I used to tease people, yeah, he’s my uncle. Well, good evening, Senator Abrams and Representative Steinberg and people on the Public Health Committee. Thank you for being here and staying this long to hear us too. My name is Nancy Summer Lerch, I have a dental degree, 10 years of education for that degree. A fellowship in the Academy of General Dentistry and I’m accredited by the American Academy of Cosmetic Dentistry. I’ve been practicing dentistry for over 35 years. And 30 years since I got that accreditation. I’m a former examiner with the accreditation process of the American Academy of Cosmetic Dentistry and a past president of the New England Academy of Cosmetic Dentistry.

I am here to testify in support of House Bill 5654. So, a couple of things. I love being a dentist. There are never two teeth that are exactly alike.
Just like a fingerprint, our teeth are just like that. And over the years what I’ve seen is that a natural new smile for somebody changes their life. Some people have come to me with crooked teeth, crowded teeth, broken teeth, missing teeth, stained teeth and just plain worn down teeth. And when they’re done, and they’re able to smile and express themselves and be connected to people again, it changes their lives. And it happens over and over and over and over again. So, one of the questions that came up is why, why are we interested in this bill?

I think there are situations where we can enhance people’s lives and make people happier and more self-aware and self-confident, by being able to add a filler here or there, change a lip size. Take somebody, I think Representative Zupkus you asked where or somebody else did, take somebody who has smokers lips that are thin and full of little cracks and enhance them. Somebody who has a gummy smile, a gummy smile is the upper lip muscles, they work too well, so using a little bit of Botox in this area will numb that lip and then a smile becomes more what we call normal.

People actually have come to me and I’ve had to cut their gums because I had no other ability to affect that gummy smile, since I don’t do what I’m not allowed to do. I would very much love to do, what I’m not allowed to do.

Let me just see, a couple of other things. You’ve already heard that we in the past 10 years, 50 percent of states have enacted training and the ability of dentists to be able to perform fillers and injectables. And I think the thing that, that
when I did my research for that in the State of Washington, they did, did matter to the states. The point is it’s been vetted. This process for dentists has been vetted and has come up that dentists have the training, have the intelligence, have the background to be able to do dermal fillers and injectables, neurotoxins, and not hurt anybody.

One of the pieces my colleague, Dr. Ungerleider didn’t get to say is that that incident rate with fillers and botulinum, neurotoxin, is about 1 to 2 percent, the incident of something negative happening. If you do a dental implant, the incident is 4 to 6 to 10 percent. So, procedures we already do have a consequence that’s higher than the potential consequence of us being trained to do dermal fillers and neurotoxins.

So, in closing, I think you’re here to make the world a better place and so are we dentists. We all want to see people happy. That this bill allows for more happiness at minimal risk. Oh, by the way, guess who’s paying for the training? When I go get my training, I pay for that. The State of Connecticut doesn’t have to do, put any money forth to pay for this bill. So, if I choose to do that in my next 10 years of practice, about what I have left, then that’s on me. And I would really very much like to do that.

So, I urge you to pass House Bill 5654, AN ACT ALLOWING DENTISTS TO PERFORM CERTAIN FACIAL THERAPIES AS PART OF THEIR DENTAL PRACTICE. Thank you.

SENATOR ABRAMS (13TH): Questions for Dr. Lerch. Hi, good to see you.
NANCY SUMMER LERCH: Nice to see you.

SENATOR ABRAMS (13TH): I know how very passionate you are about what you do and that you really mean it when you know and acknowledge that you change people’s lives. So, I, I hear what you’re saying, and I appreciate your testimony. Thank you.

NANCY SUMMER LERCH: Thank you.

REP. STEINBERG (136TH): Doctor, thank you for your testimony. It’s clear that you have copious experience, education, training, which if everyone had that, I think we’d have a great comfort level. Do you know how many dentists in the State of Connecticut have your level of training?

NANCY SUMMER LERCH: Accreditation in Cosmetic Dentistry, three, myself and two others.

REP. STEINBERG (136TH): So, there are only three in the entire state that rise to that level?

NANCY SUMMER LERCH: Yep.

REP. STEINBERG (136TH): Interesting.

NANCY SUMMER LERCH: There’s about 450 in the world.

REP. STEINBERG (136TH): So, if we were just allowing three of you to perform these procedures, I think I would probably be comfortable. But what you’re saying is people who don’t necessarily have your level of expertise would also be allowed to perform these procedures?

NANCY SUMMER LERCH: Yeah, well, the, my accreditation is in the technical work of making the tooth look like a tooth. And that’s an art discipline, that’s a technical discipline, it’s a
physics discipline, it’s a dental materials discipline. There’s so many pieces that go into that. There’s a lot of good dentists in the State of Connecticut, a lot of good dentists, who just haven’t taken the time to put themselves through this kind of arduous process and it is arduous and mentally challenging at times.

So, I think, I think what you’re saying is how could we, I don’t have an answer to that. How could we determine the, the capabilities of a dentist, the commitment of a dentist and maybe the integrity of a dentist to be able to do that; that’s a very good question, I can’t answer it. But I think maybe it’s interest the training.

REP. STEINBERG (136TH): I’m really focused as much on the rigor of the training and the education --

NANCY SUMMER LERCH: Yep.

REP. STEINBERG (136TH): -- to be in a position. You heard the, the plastic surgeon who testified earlier about potentially adverse outcomes.

NANCY SUMMER LERCH: Uh-huh.

REP. STEINBERG (136TH): The question is, would the dentist be sufficiently self-aware of a problem as it was occurring? As you say, it’s only 1, 2 percent bad outcomes; would they know what to do in those 1 to 2 percent? I mean, one could argue, it’s a lot better than 4 or 5 percent, though I could argue that 4 or 5 percent is bad outcomes in the other areas, what we really ought to look at. 1 percent may not sound like a lot, if you know what you’re doing when you see it, however that could be very problematic if that 1 or 2 percent occurs, and
the dentist is not equipped to deal with the situation that results; would you comment on that?

NANCY SUMMER LERCH: Yeah. I’m gonna go back earlier to your question. The physician testified that he’s dealing in millimeters, so do we. We deal in millimeters all the time, if not micro-millimeters in terms of how our crowns fit, in terms of the width of the tooth as we have to prepare it. Keeping that tooth so that the nerve of the tooth is not involved. We’re always dealing with very micro measurements. And that includes how deep we put our needles and how we angle the needles, same kind of issues. And I have had Botox done, Representative Zupkus, and they do, it does go, it goes very shallow and very lightly. And so, I think when I compare the two, what I do in the mouth and what I’ve had done on my face, they’re very similar in terms of the delicacy of the technique.

The second part of your question was, just reframe it so that I remember it?

REP. STEINBERG (136TH): Just, we should, a bad outcome occur, would you be aware of it? Would an average dentist be aware of it and be able to take the appropriate action?

NANCY SUMMER LERCH: Yes, because that comes in the training. Every single training course that I looked up online, and I have not done one, but I’ve looked them up online. I started researching this about five years ago for myself. That is one of the major components of it, the technique, the why, the technique, the where, and then how to manage some bad outcomes. Plus, we all have staff that are trained at least with the level of CPR. Trained to
handle dental and emergencies that come up, so not just dental, but dentally related in our offices.

REP. STEINBERG (136TH): Okay. I’ll hand it off. Would any of the other legislators choose to comment or offer a question? If not, thank you for your time. You’ve given us something to think about. Still working on my comfort level, but thank you very much.

NANCY SUMMER LERCH: Understandable, thank you.

REP. STEINBERG (136TH): Next up is Dr. Kouros Parham, again, penmanship matters.

KOUROSH PARHAM: Thank you, Mr. Chair, thank you, Madam Chair, thank you respected members of the committee for the opportunity to provide testimony on this bill. You have my written testimony. Rather than reading the testimony, I’d like to just offer a couple of comments regarding comments that were made.

As a representative of Connecticut ENT Society, I’m here to oppose this bill. This is not out of disrespect to my dental colleagues; we do deeply respect them. We are well aware of their capabilities. The principle objection is the bypassing of the vetting process that is already established wisely by this very committee and former Chair Jonathan Harris. In order to examine scope of practice in healthcare. The vetting process is a proper venue to pass any expansion of scope of practice in the state. And this is an established protocol, it’s been working well over the past eight years and bypassing it as if signed does not seem to be necessary. I work as an Associate Professor of Department of Surgery at University of Connecticut.
School of Medicine. I train residents. I’m the Program Director of the Residency Program in Otolaryngology. We train our residents to use Botox. To use Botox both in cosmetic context and in medical context.

This training is five years. Not five years of Botox day in and day out, but it’s placed in context of the broader care of head and neck diseases. This five-year program does not involve a few days here and a few days there. It’s a graduated program that gradually prepares our residents for taking on the responsibilities that come with this important, with this important tool.

There are significant consequences to the use of these tools, healthcare consequences that Dr. Felice was very capable, did a great job of outlining, I am sure and comprehends properly trained dentists, it can be utilized appropriately for the indications that they have in mind. But until that process of training has been vetted, until the scope of practice expansion has been vetted, our society, the Connecticut Medical Society would strongly oppose this bill.

Thank you very much.

REP. STEINBERG (136TH): Thank you, Doctor.
Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Thank you for coming today. I just have one quick question on the training. What would make an APRN, because they can do it, what I heard, more qualified than a dentist to do it?
KOUROSH PARHAM: To be honest, I’m not prepared to answer that, simply because I do not know. I would not, if I was part of the vetting process for APRN’s, I would have wanted to learn exactly all of those contents, and I don’t know the answer to that.

REP. ZUPKUS (89TH): Because, you know, a prior speaker was talking about how BU, I think, said that they’re going to be doing a whole training on this. So, to me, just in listening, they would be possibly more qualified than having someone come for a video session for an hour.

KOUROSH PARHAM: Not knowing the details of the training that BU is going to offer or the APRN’s offer, I don’t feel qualified on commenting on who should be doing it and shouldn’t be. What I can tell you is that the training that we offer, our trainees over five years, and this is after medical school, I totally understand what Dr. Ungerleider said, and forgive me if I mispronounced it, yes, in the first year of medical school, I sit in the same classes as our dentist colleagues. We dissect the same cadavers. But then there are three more years of medical school that come after that. And once that’s done, I spent five more years as a resident to train, including Botox applications and medical cosmetic applications. So, that is where we diverge in terms of our background.

REP. ZUPKUS (89TH): How long specifically is, do you get Botox and filler training over three years or is it a class or a session?

KOUROSH PARHAM: It’s recurrent exposures over five years. There are multiple didactic sessions on any given year on the topic, both in cosmetic and
medical applications. And then they experience it in the field seeing attendings use it, seeing the patients that seeing what the outcomes are. These are the elements that are essential to a fundamental education in this realm.

REP. ZUPKUS (89TH): My last comment, so we could agree then that I’m sure an APRN, nothing against APRN’s, but they don’t get all of that training, either?

KOUROSH PARHAM: I don’t think so.

REP. ZUPKUS (89TH): Thank you.

REP. STEINBERG (136TH): Any other questions or comments? Doctor, thank you for your time and for offering that perspective.

KOUROSH PARHAM: Thank you.

REP. STEINBERG (136TH): We’re taking this bill very seriously. Last up on this bill is Dr. Daniel Saunders.

DANIEL SAUNDERS: Good evening, Senator Abrams, Representative Steinberg. My name is Dr. Daniel Saunders. I’m the President of the Connecticut Association of Oral and Maxillofacial Surgeons. I’m a board certified oral and maxillofacial surgeon. Similar to my plastic colleagues, I have additional training, an extra four years, I did an extra year of research, so I did an extra five years. I would say that technically I have informed my dental friends that under the law, they are now currently allowed to use Botox injected in their face for TMD and temporomandibular dysfunction and other treatments now, they’re already allowed to.
But I do find it very, very odd that our representative has pointed out that LPN’s and PA’s and other people have given this with no, little to no training. And that my oral and maxillofacial surgery colleagues that have their MD because you can either have your MD or not have it as a surgeon, and that also includes several members of the American College of Surgeons, they already practice Botox and fillers under their medical license. But there are several people, included myself, that under the current law, I’m not able to use. Yet I’ve done hundreds of clefts, I’ve placed 8,000 implants. I’ve done hundreds of craniofacial cases, including full maxillary cases, maxillectomies, tumors bigger than your fist. And so, I find it very, very odd that something like this, the dentists aren’t asking to do something that they can do now without additional training.

We are proposing that with some additional training they would be able to do this also. I find it very, very odd that a doctor wouldn’t be trusted to do this, but an LPN or a PA is.

As far as the surgical complications that my colleagues have mentioned, just a point of fact, none of these complications have come from dentists. These are all complications that are being done by other plastic surgeons, LPNs, PAs.

So, you know, again, I, we, the dentists I would certainly argue have probably the highest safety rating of almost any group I’ve seen with the number of procedures they do. As far as what is the safety net when a dentist does a procedure like this and something happens, for the most part in almost every state in the US, the oral surgeons bail out all
dentists with anything they do, whether a root canal didn’t go right, an extraction didn’t go right, or a tumor was incompletely removed. We also do work hand in hand with our ENT colleagues for all kinds of head and neck cancer cases all the time. That’s kind of a routine daily thing for me. I, when I look at this bill, although unfortunately, two other board members on my board, who are the training program representatives for both Yale and UConn, would like to testify, but it appeared to me this was kind of rushed and they didn’t have time to fit it in their schedules, but their biggest argument is it’s very difficult to have a dual-degree person want to come into their program and then they can’t practice what they learned in this state. And so, they’re missing out on, on good possible recruits for oral surgeons.

REP. STEINBERG (136TH): Doctor, thank you for your testimony. I was gonna focus on the degree of qualifications you bring and to your point, it seems almost silly that you don’t have the ability to do things that are being done by LPNs and PAs currently. And if it was simply a matter of enabling you to do so, I don’t think any of us here would have a problem with that. It’s the broader subject of all dentists whose, the majority of the time they spend is not necessarily in this area, but on dealing with teeth in the more traditional fashion.

But I find that the argument seems to fall down because so many people are allowed to do it, yes, under the supervision of a physician, but probably in the course of the action, behaving fairly independently until the physician is needed in that
context. As I often find the case here in public health, it makes we want to revisit all of our scope of practice as it --

DANIEL SAUNDERS: Sure.

REP. STEINBERG (136TH): -- relates to who has the right to do what to whom. I’d almost rather go backwards --

DANIEL SAUNDERS: I’d like to --

REP. STEINBERG (136TH): -- than go forward sometimes.

DANIEL SAUNDERS: -- I’d like to bring up one more point that anyone in here over 50 years old, they said they trained with Botox, it wasn’t used 40 years ago. So, you know, I don’t think there was a whole huge level of training with using of Botox and dermal fillers 30, 40 years ago, there just wasn’t.

REP. STEINBERG (136TH): And I would say when Bobby Thomson hit his homerun. I think you raised a good point. We have a lot to consider here. It’s not as straightforward as perhaps it initially seemed. Certainly, we want to attack appropriate training and expertise before we would allow any new category to do so. But I think you made some very valid points.

DANIEL SAUNDERS: Thank you.

REP. STEINBERG (136TH): Other comments or questions? Thank you for your time and for your patience.

DANIEL SAUNDERS: Thank you.

MAG MORELLI: Good evening, Senator Abrams, Representative Steinberg and members of the Public Health Committee.

My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities. I’m joined with by Matt Barrett and today we are pleased to provide testimony on House Bill 5276.

Fall prevention is one of the most challenging and ongoing issues in all of aging services, including in the nursing home setting. Federal nursing home regulations address this issue, while also acknowledging that numerous accident hazards exist in everyday life and can be difficult to avoid.

The fragile nature of most nursing home residents adds to the complexity of preventing falls. This is why it is important for all nursing facility staff to understand the importance of fall prevention and to take part in creating the safest environment possible.

A falls prevention program begins by creating a culture of safety, identifying falls history and risk factors, conducting an assessment and evaluation, and then developing a person-centered care plan. It is an interdisciplinary team effort and it should be part of the facility’s continuous
quality assurance and performance improvement effort.

MATT BARRETT: And for the record, I’m Matt Barrett, CEO of the Connecticut Association of Healthcare Facilities. Manding the offering of bed alarms to those at risk for falls is in direct opposition to both federal regulations and culture and quality initiatives designed to improve nursing home patient care and quality of life.

Federal regulations specifically prohibit the use of restraints, which include position alarms such as bed and chair alarms, absent documentation of an assessment that the restraint is necessary to treat a medical symptom, peer planning by an interdisciplinary team and a physician order.

While federal regulations permit a resident or representative request the use of a restraint, restraints may not be used solely based upon such a request and in the absence of a determination of need as discussed above.

Additionally, there has been little disagreement in the skilled nursing home community among public health regulators of nursing home care and by those that advocate on behalf of nursing home residents that a nursing home should be restraint free, should be a restraint free healthcare environment to the extent possible.

Indeed, a nationwide cultural and health quality transformation has occurred in nursing homes to eliminate the use of restraints over the last decades in favor of more individualized and holistic methods to prevent falls. To that end, when CMS, that’s the Center for Medicaid Services, revised the
nursing home regulations in 2016, it issued revised guidance regarding restraints, specifically noting that there is no evidence that the use of physical restraints, including but not limited to bedrails and position alarms will prevent or reduce falls. I’ve submitted written testimony of the record.

Thank you.

REP. STEINBERG (136TH): Well, technically, since you registered separately, you’re entitled to a three-minute speech, but thank you for getting it done in three minutes together.

Obviously, order in the Court. Obviously, you’re aware of our good intentions to try to address falls and it’s by no means monolithic there are any number of reasons and, and different potential remedies, some of which are more or less effective cost, efficacious or cost effective. Given what we’re trying to accomplish, do you have any specific suggestions on what we should do that you can share with the committee?

MAG MORELLI: I think that nursing homes right now are all working on fall prevention programs. It’s part of, it’s been part of the culture for many, many years. But in the new federal guidelines that have been revised and are being put into place over a four-year period there’s three phases of regulations with a real emphasis on the fall prevention program. And individual person-centered care plan, you know that’s the key, is making sure that each person care plan addresses why they might be a fall risk, what can be done to prevent that fall risk and sometimes, you know, it has to keep. You keep doing the assessment over and over again to
MATT BARRETT: I would simply just add that the federal government is by a few years sort of beat you to the issue in that the consequences for failure to comply with the new rules, regulations regarding participation in the program are pretty significant. And so, I think that on the heels of very significant new requirements under federal law, I don’t think there’s a reason for state-level action at this time.

REP. STEINBERG (136TH): Thank you for that. Representative Cook, followed by Representative --

REP. COOK (65TH): Thank you, Mr. Chairman. Thank you both for being here. We appreciate the not taking of the six minutes. But I do appreciate all of your work that you do with our elderly population. But I do have a couple of questions regarding this bill, obviously, you know, it says the nursing homes have to offer patients an option of having either a bed alarm or a personal sitter. Is that option, and I heard you, I just want to make a clarification. Is that offer not already on the table for nursing home residents to date?

MAG MORELLI: The alarm may not be, there may be an alarm free nursing home, you can make the request and they can investigate and do an assessment, and if there’s a medical reason they can provide the alarm. The sitter, many nursing homes offer the option of the resident hiring a sitter or providing a sitter at the cost, private cost to the resident,
one-on-one sitter. It’s extremely expensive. Sometimes it’s put into place out of necessity. But it’s not sort of a usual practice or an offer made to someone who comes into a nursing home.

REP. COOK (65TH): So, when it comes to billing, we know that nursing homes often struggle to make ends meet. We know that there’s often, you know, you know I have a bill into increase nursing home staff. So, as we know that there are often times when nursing home staff are doing the best that they can, but they are still limited in what they can do, and you’re saying that a sitter can be hired on a personal, individual pay-type basis. Is there not a code that you can have an insurance company cover that if it deems to be medically necessary, do you know?

MATT BARRETT: I would respond by saying that nursing homes are required under the law now to staff to meet the residents needs. And so, on occasion, periodically, they are required under the current code to provide one-on-one care, but not for long periods of time. And so, I don’t believe the code addresses the notion that in addition to the requirements regarding a nursing home’s really essentially having to staff to meet the residents’ needs that, that the provision that providing on top of that a personal sitter is contemplated. That really is kind of a resident choice or a resident’s family choice more often the case, I think.

MAG MORELLI: Most insurances, unless you have long-term care insurance would not be covering your long-term stay in a nursing home. So, and I don’t believe the Medicare, post-acute care, unless there
was a particular reason would necessarily cover the one-on-one.

REP. COOK (65TH): And you touched on the federal changes. So, I would request, and I’m sure that my colleagues would appreciate seeing those federal changes, if you could sent those to us.

MAG MORELLI: Sure. There’s several hundred pages long but --

REP. COOK (65TH): Okay. Don’t --

MAG MORELLI: -- no, we can send you a summary. I can send you a synopsis.

REP. COOK (65TH): A smaller version of that?

MAG MORELLI: Yeah, let you know what the changes were and --

REP. COOK (65TH): And I know that certain hospitals, so we were in St. Mary’s a few weeks ago with my father-in-law, and they have, they have a color coded system. So, he was a fall risk. And, you know, at almost 89 years old, these things do happen. And so they gave him a yellow blanket, very bright yellow by the way with like the yellow slipper socks that everybody in the hospital knew what that color meant. Is that a standard that we could possibly use going, you know, statewide? And I know that we always try to figure out something that works and works best to our ability, but if that’s, you know, if that’s a standard across the board, and I wanted to say blanket statement, but that would have been really bad. If that was a standard across the board and everybody knew that a bright yellow blanket was attached to fall risk, then there would be no room for interpretation or
misrepresentation at staffing changes and from floor-to-floor changes. I’m just trying to figure out a more of a continuity of care and how can we do this in a way where it’s simplistic, universal, and we don’t have to continue to worry about what may or may not happen when we put somebody in a nursing home or a hospital for that matter?

MAG MORELLI: And, you know, we’d be happy to talk to you about what standards might be applied and discuss it further. Sometimes there’s some issues and difference between the nursing home and the hospital, whereas if there’s something in the nursing home that labels someone to be a certain, certain type of patient, sometimes that goes against, it’s against the rules for dignity. But, you know, nursing homes do this all the time and setting up some type of code or some type of something so their staff understands who’s a fall risk and who are, you know, on other issues. So, I’d be happy to talk to you about that, if there’s a universal way we can do that.

REP. COOK (65TH): Thank you. Thank you very much.

REP. STEINBERG (136TH): Representative Betts.

REP. BETTS (78TH): Thank you, Mr. Chairman, and thank you both for your testimony. When I first heard about this proposal, I mean, we’re well aware of the problem with falls for patients whether in hospitals or in nursing homes. But for the life of me, I cannot understand how a state law is going to actually improve or motivate you anymore to eliminate your focus on reducing falls; I would think you’d be self-motivated to do this just in terms of limiting your liability much less the bad
press you get from marketing and you have people who are having falls. I know in the hospital that I represent, it’s probably the number one priority and they really preach it to everybody, including the janitors to make sure that nobody’s in the position to fall.

So, I can’t help but scratch my head in saying, how is a state law going to get you to either implement a better program or what is the role of state government in terms of doing something that you clearly have to do from a medical point of view if you want to stay in business?

MAG MORELLI: I would, I would tend to agree in that fact from the perspective of the nursing homes right otherwise are currently trying their best to put together the best falls prevention program. Investing in training of the staff. I think that one of our big issues probably coming up is the workforce issue and being able to recruit the number of staff and being able to retrain staff, not for just this year, but in future years, to be able to work in aging services, not just in the nursing home. And so, I think from that perspective, any kind of assistance we can get in workforce recruitment, enhancing the employment opportunities within aging services would be extremely welcomed by the nursing home field.

MATT BARRETT: And I’d just say, Representative Betts that your point is very well taken. And I would point to Representative Cook, staffing bill as an important first step in a direction of, you know, this bill really gets to the issue of what are the underlying reasons for falls; well, one underlying reason for a fall is a very difficult issue of
staffing in nursing facilities and environment, as of right now, an economic environment where our employment hovers around 4 percent, the recruitment and the retention of nursing home workers is a very significant issue. And I think that’s something that the Connecticut General Assembly and the industry really should be working on together how to address that under a broad-based underlying issue.

REP. BETTS (78TH): You know, I would agree with that being a better approach overall. I know we do workforce training in other areas as well. So, I think that a pretty good suggestion and one that maybe the committee can take a look at. But I’m not aware of any state law that can be passed that’s going to prevent falls or going to motivate anybody more because frankly, falls is not only bad for business, it’s bad for the patients, it’s bad for the families. So, I’m not sure what our role is in participating other than that looks punitive as opposed to trying to develop a better workforce, getting better training, educate people better including the families.

So, I thank you very much, Mr. Chairman.

REP. STEINBERG (136TH): Thank you, Representative. Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chair. And just very quickly. You mentioned the person-centered plan that you put into effect. And could you just comment so if you had, for instance, a resident who had multiple falls or were falling more frequently than others, do you go in and then go back to the plan with the professionals to see what
action can be taken to try to prevent those falls from continuing?

MAG MORELLI: Yes, you would do a reassessment. Sometimes you do, as was discussed earlier this morning, if it’s a new condition that’s come up, you might do an analysis over two or three days, the daily routine of the resident, what might be, you know, be the cause of these falls, is there something that’s causing the resident to try to get up or try to get out of the wheelchair or whatever and then address that, try to, and the care, you know, a multi-team approach, multidisciplinary team approach, try to work out a fall prevention program, a way to prevent this person from, from those, from, the patients that happened that would cause them to fall.

REP. MCCARTY (38TH): Thank you.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for taking the time to share with us. Again, this is at best, a work in process that may or may not be addressed by this particular bill, but we appreciate your input.

MAG MORELLI: Thank you very much.

REP. STEINBERG (136TH): Sure. I should have studied this last time, Mairead Painter, is she here as well? She was here earlier, but a different bill. Okay. So, it just seems like different days at this point. We are now, I think everybody will be pleased to hear down to our second to last bill. As I said, no applause, no applause. All right. First up on House Bill 5442, is Nathan Tinker. Then we will go with Norman Plude, is that correct?
NORMAN PLUDE: Good evening everybody on the Public Health Committee and thank you for having us here today. I’ve been here a number of times to testify and this is the first time I’m testifying as a patient on a medical marijuana program.

To start off, my name is Norman Plude, and I’m from Seymour, Connecticut. I want to tell you, I’m in favor of House Bill 5442. A little bit of history on myself. Back in 1993, I broke my back. I came into the program after many years of opiates, muscle relaxers. About 10 years after I broke my back, I decided to get away from the prescription medications and deal with my pain the best that I could.

Up until 2012, once the program, the medical marijuana program started, I had joined, I was one of the first patients on the program. At that time there was no way for people in the program to have, to get in there for pain. I was, if you want to call it lucky enough, I had spasms in my back, which got me into the program. I also had secondary conditions, which were intense pain. But it wasn’t in my back, it was all over my body.

And up until actually last year, when I went for a second opinion, I finally out what my problem was. I have a second called CPRS, Constant Regional Pain Syndrome, and that’s where pain originates anywhere in the body, it can be from an injury in an elbow, but it shows up in a leg. Nobody knows why it happens. Without the medical marijuana program, CPRS is also known as a suicide disease. Most people, I won’t say all, but a good majority of the people that do have it without having a way to eliminate the pain, commit suicide.
I, I heard a lot of talk here today where we have, how do we classify pain? Well, pain is pain. I don’t care where it comes from. Mine is constant. So, I don’t know if we can define constant and chronic, but to me they’re the same thing. And it’s about time that this state lets chronic pain in.

There’s a lot of people that are misdiagnosed or not even diagnosed, but they have an issue. And this is one way that they can get the relief that they need, it does work.

I myself, I use a form of cannabis, it’s rock cannabis, so it’s eaten live off of the plant. I had to travel to Colorado and Oregon to get my medication. It’s not even available in this state. I know we have a number of bills this year coming up for grow rates for patients. And again, it’s another form of medication. I know rock cannabis works best for me, it’s non-psychoactive. So, along with this bill here for the pain management, I’d like everybody to understand that there’s other issues along with the program and one would be types of medication, which I know this year we’re starting to address.

In closing, I just, I feel that it’s been since 2012 and we’ve had this discussion a number of times with the physician’s board, and we’re going nowhere. We have, it is time, it’s time. There’s a lot of people in this state that are suffering that they can’t get the medication. We’re trying to get them off of opiates and this is just one of those, it’s an alternative medication for them that does work.

So, I’d like this board to seriously consider allowing medical cannabis for the pain management of
patients who don’t have that opportunity at this time.

REP. STEINBERG (136TH): Thank you for your testimony.

NORMAN PLUDE: Thank you.

REP. STEINBERG (136TH): You know, we are obviously considering this bill because we are concerned about those who suffer from chronic pain and it’s actually good to hear that you’ve chosen to wean yourself off of opiates. We wish there was more credible research that made that connection that marijuana is an effective alternative to opiates. Maybe someday we can get the federal government to do the research they should have done all along. So, that’s a reason we also discuss that as a potential condition to add.

As I’ve mentioned earlier in other hearings, we’re also extremely wary of overruling the Board of Physicians from the Department of Consumer Protection because we’re very proud and competent in the program we have currently and loathed to overrule them concerning also that they’re the medical professionals in the mix here. But I think we take your points very clearly. If you have no other options, certainly suicide would be a horrible outcome.

NORMAN PLUDE: It’s not an option.

REP. STEINBERG (136TH): So, I can’t tell you how it’s gonna turn out other than to say, for the reason we’re talking today, is to address problems such as the ones that you experienced, and we’d love to be able to help with. Representative Michel.
REP. MICHEL (146TH): Thank you, Chairman. Thank you for, just a comment, thank you for holding on all day and coming and speaking for these bills, before the last bill. And it’s just a thank you and also the fact that I think we spoke earlier about pain and chronic pain. There are pain conditions and so, I tend to think that chronic pain is more debilitating than just pain. So, I appreciate your comments and thank you again.

NORMAN PLUDE: You’re welcome.

REP. STEINBERG (136TH): Other comments or questions? You know, I’ll just say that if chronic pain didn’t seem so broad a term, if it was more easily defined, I don’t think we’d be having this much weariness about the entire thing. But on the other hand, as you say, if you’ve got pain, the specific diagnosis doesn’t really matter, you’re dealing with the reality. So, it makes it more challenging for us. But thank you for your testimony.

NORMAN PLUDE: You’re welcome. Thank you for having me.

REP. STEINBERG (136TH): Next up is Nancy, is it Nurge, I’m not really sure. Is Nancy here? Okay. We’ll move along. Ann Marie Rosado.

ANN MARIE ROSADO: Good evening, I’m here in support of Bill H.B. 5442, this is my time, so everyone bear with me. My name is Anne Marie Luis Rosado. I suffer from chronic pain. I have two herniated disks. I’m a hair stylist and I’m on my feet all day long. I was continuously prescribed narcotics by my orthopedic surgeon. They did more harm than good, upset my stomach, made me tired and lazy, was
very unhealthy. I weighed 242 pounds. And I also live with someone addicted to opioids. He would steal them on me, along with all of my other valuables. I finally had enough. My twin is also an addict. I was so fearful of going down that road that I refused to take them. Muscle relaxers were not helping me. 1600 mg of Motrin was eating at my stomach. I grew up around a functioning addict. I consumed cannabis before, and it was really the only thing that helped.

Due to some of the horrendous events that the addicts in my life put me through, along with other trauma, I was able to get my medical marijuana card. I was qualified for it with PTSD, not for chronic pain. I finally didn’t need to suffer anymore. I lost weight, dealt with anxiety and finally slept through the night. During this time I was given custody of my 17-year-old niece. Her mother had Lupus. She could no longer care for her daughter. She chose to move to Florida, having heard of these pain management clinics. Her mother became addicted to opioids and she always wanted to use cannabis, but it was frowned upon by her medical providers, the same professionals that were not being properly educated on cannabis. The same providers that over-prescribed opioids to her. The same ones that are now being fined for over-prescribing.

She was found dead in her bed at the age of 39. This is my second family member that I have lost to an overdose that was prescribed drugs by physicians. I am now trying to get the potential third overdose off of suboxone because he was over-prescribed by a work injury and is in chronic pain. He is an addict.
Please listen to my story. Don’t make my family any smaller. I am living proof that chronic pain can be managed safely with cannabis. Writing this testimony has put me in an emotional hole for days, but I am able to pull myself out of it with the help of cannabis, not pharmaceuticals.

I thank you all for your time.

REP. STEINBERG (136TH): Thank you for your testimony, particularly he challenge that you’ve gone through even to be here today and certainly for the story of your family, which really, I think, puts it in perspective. I think what you described is a perfect example of the opiate crisis that we have in our country and our desire to turn the corner and find alternatives for those in pain. And that for many people, marijuana does seem to be the answer. And that’s why we are taking this very seriously. I think we’re also looking perhaps at the example of what’s transpired in other states, which has made us a bit more wary of how we want to go about it and for us the process is going to matter a lot. And that’s why we have tended to defer to the existing medical marijuana program, which we happen to believe is a model that other states should be emulating to control the product, the packaging and the marketing of it, so people know what they’re dealing with here.

It’s made us perhaps extra deliberate and maybe slow for those who are seeking remedies, but it is a process that we think is in the best interest of the people of Connecticut. But today we’re talking about chronic pain because we think it is a serious problem. Are there questions or comments? Representative Michel.
REP. MICHEL (146TH): Thank you, Chairman. Thank you for sharing with us this heartfelt testimony, very touching. And that’s it, I just wanted to thank you for sharing this. I protested in front of, I’m the Representative for Stamford and we have Purdue Pharma headquarters in our city, and I was there always ready to protest in front of their building. So, thank you.

REP. STEINBERG (136TH): And to be clear, Representative Michel was the one who brought this bill forward and you have him to thank for that. Next up is Christina Diaz.

CHRISTINA DIAZ: Hi. I was gonna say good morning, but I think it’s almost midnight, so. I’ll tell you, good morning tomorrow. Hi, my name is Christina Diaz, I’m a little shaky and honestly I suffer from a nerve, like a degenerative nerve issue. So, I’ve been here without my medication and cannabis, you can’t smoke, you can’t do it in the public, so, I’ve been very spastic with my muscles, so please forgive me.

First of all, thank you so very much for staying this late to listen to all of us. We really appreciate it. This is a subject really near and dear to most of our hearts. I just wanted to say that I come from a really unique perspective because I actually used to work in the medical field for, since 2001 until May of this year, excuse me, that just passed, when I, my illness took me out completely.

I originally got my, I’ve been a cannabis patient for three years. And originally it was very frowned upon in my household because I am married to law
enforcement, but I did it the right way and it was really something that was, I’ll just show you. So, I feel like visuals are easier. Before cannabis, I was prescribed, and this is just a visual, 20 different medications, like this is representing 20 different individual bottles. And now, working with co-treatments and my doctors because I have a team, like an actual team and I’m very, very open and we work very well together, and now, thankfully, although my symptoms have progressed, it is the disease’s fault, not, you know, the medications. And now I’m only like taking five or six medications a day with cannabis.

And I just get nervous because nobody likes to talk about something that is very controversial, especially when you are the wife of somebody in law enforcement and you are also a mother. But I feel that my voice needs to be heard because if I don’t speak, nobody else will. And I know because I worked in an emergency department for over 10 years. And I was the person who interpreted all the procedures, all the times that they got over-prescribed or I had to deal with the people who would come in because I was also a liaison, so I would deal with a lot of people who were addicted from previous visits. And then they’d say, you prescribed it to us, like what do you want us to do? And I know chronic pain is subjective, but it’s very difficult to deny that a lot of people are in pain and cannabis is just another treatment, an alternative treatment. It is not a magic pill and it is not a cure-all, just like the medications that I take in addition to cannabis, aren’t a magic pill either.
So, I just simply state that I think chronic pain should just be added because doctors should also have another form of treating somebody and not being worried that they’re gonna overdose in front of their children or that their children are going to get into that medication. I am not, I am not a doctor. I am nothing other than observer. And what I have observed for the past 20 years of interpreting in the medical field, I haven’t seen anybody die of an overdose of cannabis. And that is the only thing that I’m saying, that if we’re dealing with chronic pain, we should try and give medications that aren’t gonna take some, you know, kill somebody. That’s all, sorry.

REP. STEINBERG (136TH): Thank you for your testimony. And again, thank you for, for having the courage to deal with your health issues and still be here today to testify, it’s very compelling. And I really appreciated your visual demonstration, which I think encapsulates, use the phrase, the problems that we’re facing today.

CHRISTINA DIAZ: I just wanted to say one more thing, and I apologize. I just really wanted to say that I was fighting for quality of life because before cannabis was in my life, I was bedridden and I was a zombie and I was not a very good mother for, you know, for a little bit, period of time and not a very good wife. But after my husband and my children have said they have their mom and their wife back and I have, kind of like I’m here fighting for something that I believe in. Before I’d be in bed. So, I just thought, if I can get up today when normally I can’t and tomorrow I’ll probably be in the bed because I’ll have a rebound, but I just want
you to know, I made it from 10 o’clock to now. And I need to go take my medication, but I would just like to say that sometimes you have to fight for what you believe in, no matter what. And I was part of the medical force for a really long time and I respected every doctor I worked with, but I also saw the pitfalls of narcotics and opioids and when it was my turn to be prescribed opioids and narcotics, I said, no, but I’ve had to deal with all this pain.

So, please don’t make me feel ashamed or judge me for an alternative treatment. Thank you for your time.

REP. STEINBERG (136TH): Well, it was not our intention to test you quite as much today.

CHRISTINA DIAZ: You can ask me questions, if you like.

REP. STEINBERG (136TH): I just want to add that you make a very good point, it’s rarely about the individual, the impact on families and friends is extremely significant.

CHRISTINA DIAZ: Yeah.

REP. STEINBERG (136TH): So, a lot of people get affected --

CHRISTINA DIAZ: Yeah. I wasn’t very fun to be around, but much better now.


CHRISTINA DIAZ: Thank you.

REP. MICHEL (146TH): I just wanted to thank you for coming to testify.
REP. STEINBERG (136TH): Thank you for your testimony.

CHRISTINA DIAZ: Thank you. Have a lovely evening.

REP. STEINBERG (136TH): We’ll be here. Next up is Lisa Jensen.

LISA JENSEN: Good evening and thank you for the opportunity to speak. I’m a drug and alcohol recovery coach. I am in favor of this bill. My point of view might seem very different from those of other people who are speaking today. I have clients who are opioid naïve until they were prescribed for chronic pain that was associated with cancer care. They then became addicted and had some really horrible situations. Now, two of those clients, who are both men who are in their 70s, they are not children who decided to party. One of them didn’t even drink socially. They are now using cannabis through because they were allowed to be prescribed through cancer.

And I don’t want you to take my, you know, my point of view. Somebody was speaking about research and that it needs to be done. We have research that has been done. I’m gonna share one little part of that. And the other thing I wanted to speak to as far as research is that we need to make sure that any research that you are using isn’t research that’s been backed by big pharma, because they are opposed to this because it is going to tuck into their profit. And I’m sorry, but I have no concern for big pharma.

The research that I have is the, the lead study author is Dr. Marcus Bachhuber. And it was done as far back as 2010. They took the states that did
have medical cannabis laws and they studied them for six years afterwards. And they discovered quickly that the rates of fatal opioid overdoses were significantly lower in states that had legalized medicinal cannabis. In the year 2010 alone, they saw 1700 fewer opiate-related overdose deaths. We’re talking about deaths, not just overdoses, we’re talking about overdose deaths.

And the lead study author, Dr. Bachhuber, I’m sorry, he said, we found there was about a 25 percent lower rate of prescription pain killer overdose deaths on average after implementation of a medical marijuana law. It goes on to explain that 75 percent of the overdose deaths that involved opioid pain killers were prescription. And these, these have decreased 33 percent in 13 states in the following six years after the use of medical cannabis. They were people who had prescription, legitimate prescriptions, we need to make that clear. And if we are talking about chronic pain, and you used the term that it was rather broad, but we’ve been using opioid pain relief for chronic pain for years. And where has everybody been? Why haven’t we been, you know, addressing that? Why was that allowed? And now we’re scrutinizing this.

And most of these conditions that they do allow it for, including cancer, HIV, MS, glaucoma, those, the main use that they use is for pain. It is used for pain. And I understand that there is a separate bill that has, addressing opioid use disorder, I’ll be back to talk about that. You know, this is just, Connecticut, I’m sorry, we’re slacking. Our neighbor states are doing much better than we are with this opioid epidemic. New York State has lower
than the national average overdose deaths because they’ve been aggressive.

Connecticut, we are significantly higher. We’re number 11 out of 50 states in overdose deaths. And the overdose deaths are primarily opioids. We have, we have parents who are losing children. I’m tired of facing these parents when I go to events. Tired of hearing about how a child was given opioid pain medication for an athletic injury in high school. And parents are crying because they feel they’re part of their child’s death because they encouraged them to take their meds. You know, this is not okay. I’m sorry, we need to be better than we are.

REP. STEINBERG (136TH): Thank you for your testimony.

LISA JENSEN: Thank you.

REP. STEINBERG (136TH): I think you raise a very valid point, which is, would we be as concerned about the term chronic pain, if we had not been going through the opioid epidemic, where people at all levels abused the prescription of opiates for chronic pain and now suddenly, we’re trying to be discerning about it in the context of something that’s somewhat more moderate in marijuana.

LISA JENSEN: Well, I don’t know of any cannabis overdose deaths. I don’t know of any overdose cannabis at this point.

REP. STEINBERG (136TH): Well, there have been some bad outcomes for those who ingested edibles.

LISA JENSEN: Bad outcomes as opposed to opioids --
REP. STEINBERG (136TH): I understand there have been some who have had very negative medical reactions, not death, per se, but certainly we have reason to be concerned, not so much about the product but about its labeling and marketing so people know what they’re dealing with to a large degree. So, that’s another reason why we’ve been perhaps deliberate in the State of Connecticut. I think when we want to get out of the gate, we want to do it correctly and I think you raised some very good points, particularly the statistics that you described.

LISA JENSEN: And I understand being deliberate, but in the meantime, we are at almost 200 deaths a day in this country. The year 2017 alone, we had more deaths from overdose than we did in the whole Vietnam war. That’s a big number.

REP. STEINBERG (136TH): You’re absolutely right.

LISA JENSEN: We need to be, and I’m sorry, I don’t mean to, you know, suggest that you are dawdling, but we do need to, we do need to speak to this, and we need to address it. And we need no more, I’m tired. I’m tired of death. I don’t, I don’t understand why nobody else is. I’m tired of it. I don’t want to see children crying at the loss of their sibling or their parent or a parent losing another child. You know, it’s too much. We need to act.

REP. STEINBERG (136TH): Thank you very much. That’s why we are here today talking about it.

LISA JENSEN: Thank you.
REP. STEINBERG (136TH): Are there other comments or questions? Representative Michel.

REP. MICHEL (146TH): Thank you, Lisa for coming to testify.

LISA JENSEN: Thank you.

REP. STEINBERG (136TH): Representative Petit, please.

REP. PETIT (22ND): Just to comment and maybe you think this, I think we need to do what we can in the state. But I’ve always felt the biggest issue is the lack of research on a national level. So, I think we need to move it from a Schedule I so that we can continue forward with research to find out what’s the best way? What’s the best cannabinoid? Does certain cannabinoid work for a certain conditions --

LISA JENSEN: Right.

REP. BETTS (78TH): -- and a certain one doesn’t work and get that data. And I think a lot of that has to do with the federal prohibition --

LISA JENSEN: I don’t disagree with you that the federal, the federal position is a problem. But other states have been doing this and I think that, you know, we are supposed to be a more progressive state than we are proving to be. As far as the components that offer pain-relieving properties, there’s Delta 9 THC’s, CBD’S, CBN and THCV, all found in cannabis that are pain relief, that have pain relief properties. And as far as research, there is research that has been done. That research that I cited was, that was not brand new. You know, this is 2019, that was from 2010, 2011. I mean,
there has been research done. We need to, you know, seek the research that’s there. And I’m disappointed that, you know, this body here is being told by the medical board, you know, they are the ones who are directing this and they’re not being, I don’t think they’re being responsible in this case. They know that there’s research there. They can find that research better than I can. I’m not a medical professional.

REP. STEINBERG (136TH): Thank you, Doctor. I think his point is, we’re all frustrated there isn’t more research on a lot of the specific benefits of different aspects of the marijuana plant that would allow us really to focus on a lot of conditions. But I take your point that there is enough out there for us to be making some informed decisions and hopefully the Physician Board from the Department of Consumer Protection is listening to this testimony today and we’ll think very seriously about their previous decision.

LISA JENSEN: Thank you.

REP. STEINBERG (136TH): Other comments? Thank you, thank you, thank you for your passion --

LISA JENSEN: Thank you.

REP. STEINBERG (136TH): -- on this subject. Next up is, I think it’s Taylor Nicholas.

TAYLOR NICHOLAS: Good evening, ladies and gentlemen, members of the board. Thank you very much for having us here today. My name is Taylor Nicholas, I’m a Vernon resident. I’ve been a Connecticut resident for the majority, pretty much all of my life. The only time I moved out of the
State of Connecticut was for the military and for cannabis itself. I served in the Marine Corps for four years, one of which was served overseas in Afghanistan. During my time in the Marine Corps, well, as most people would think, it’s a lot of physical labor, running, jumping, hikes and generally you put yourself in situations where most people don’t want to go.

During that time, well, needless to say, I’m a very small individual and I stayed a small individual throughout my time during the Marine Corps. So, for me, my normal kit was my body weight, if not more. And I would go on humps from anywhere up to three miles, anywhere to seven or eight. So, needless to say, my back and my knees, they get a little creaky every once in a while from time to time. And that is very difficult for someone to say, being that I am only 28 years old. But being here today, I will say that I need to heavily medicate when I get home because my back and my knees are so tight, it’s a little difficult to stand here and, well, sit here, excuse me, and speak to you fine people today.

On top of that, not just for my own personal use, I try and help advocate for the other Veterans in this state as well. Not only this state, but throughout the New England area. I help a, pardon me, I help with a, well, somewhat local non-profit organization to help Veterans and things of that nature as well. And during that time, I have come into contact with multiple stories and many Veterans that not only myself, we utilize cannabis for chronic pain. And as you’ve heard other testimonies, the amount of pills prescribed currently, whether it be first
responder, EMT, military or just regular civilian, it is, it’s ridiculous in my personal opinion.

And unfortunately, I’ve had to witness and see my brothers and sisters in arms take their own lives as well as hear horrible stories of them taking their own lives in front of children. In fact, it was one of my first meetings with MEVA, where an individual, he had come down, he had just come from a funeral from one of his friends. Unfortunately, both parents were serving and unfortunately, the, the amount of medication that, that the woman was taking, one of which, one of the medications was for chronic pain. She ended up taking her own life, but in so doing, and I, I, I’m sorry for being graphic, but I do need to drive the point home. She took a butcher knife from the block and continued to stab herself in the neck until she bled out. And her children were present in the same room with her.

So, if something that grows in the ground naturally can help reduce the amount of opiates and medications they are given, you know, to, again, to civilian, private sector, military, first responders, this plant actually can help people and can reduce the traumatic events, why, I mean why is it taking so long? There are 21 states with a medicinal program out of 45 whole states that have a medical program that recognize chronic pain, 21. That’s almost half of the United States. And they recognize chronic pain before Connecticut, and we claim to be one of the shining example.

I will say that, yes, we do have the largest amount of debilitating conditions that qualify, and that is a positive step, I will agree with that. And there have been --
REP. STEINBERG (136TH):  I’ll ask you to summarize because you’re well over --

TAYLOR NICHOLAS: To summarize my point being that we need to allow chronic pain and we need to view other methods being; i.e., cannabis for pain and a bunch of other reasons where opiates are heavily over-prescribed.

REP. STEINBERG (136TH):  Thank you for your testimony.

TAYLOR NICHOLAS: Thank you.

REP. STEINBERG (136TH): And evenly importantly, thank you for your service and for the aid you provided to others. I have to think that we as a nation are somewhat responsible for the high incidents of drug issues with out Veterans, we really do need to address. I think you make a compelling case. Yes, Connecticut has not been a leader on this. I would say our medical program overall, to your point, has many fine features that make it a model for others. And we’re talking today is that we are looking at what other states have done, and we want to make sure that we’re doing all that we can. And again, I don’t know if I necessarily feel we need to apologize, but we have taken a slow, but steady approach to making sure we do right by people when we protect people as much as we help them with their chronic pain issues. Are others with comments or questions? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chairman. So, I just want to thank you for coming here and testifying and thank you for your service. I’ve been Chair of the Veteran’s committee for a number
of years, and I’m a Veteran myself. I was a radio operator in a ranger battalion, so I know what it’s like.

TAYLOR NICHOLAS: Thank you for your service, sir. And to go off topic of your point, I used to fix your equipment, so. Thank you.

REP. HENNESSY (127TH): Just a comment. Big pharma kind of controls a lot of the debate that goes around here and, you know, it’s too bad that we can’t be serving the people instead of serving big corporations.

TAYLOR NICHOLAS: Yes, sir. And thank you very much Representative, that is one of my biggest, well, just for me personally, why is it that Veterans who have signed their rights away and I’ll make it a fact that Veterans do sign their rights away --

REP. HENNESSY (127TH): That’s right.

TAYLOR NICHOLAS: -- when we join the service. So, for us then to be told, well, no, you have to listen to us, we’re telling you that this is right, okay, well explain to me why, well, the story that I just presented to you, ladies and gentlemen this evening, as well as many other cases. And I’m pretty sure you are well, well aware of the statistic that loves to be thrown around when it talks to Vets and suicides, about 22 a day.

REP. HENNESSY (127TH): Okay.

TAYLOR NICHOLAS: That does, it rings true. And I would truly like for us to be able to reduce that. I would love to be, put it down to zero. As you said, Representative Steinberg, we do need to take the methods that are very safe and that will help
everyone and not just group, you know, small groups of people. It needs to be everyone that has helped. And if it, well, coming from a Veteran’s standpoint, if someone has to take, keep on taking, I mean, I’ll keep going. I’m still standing. I’m still breathing, so I’ll keep fighting if I have to.

REP. HENNESSY (127TH): Thank you for your testimony. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): And thank you for testifying on behalf of not only yourself but so many others. Any other comments or questions? Thank you very much.

TAYLOR NICHOLAS: Thank you very much ladies and gentlemen.

REP. STEINBERG (136TH): We are now down to the last person testifying on this bill. Christina Capitan.

CHRISTINA CAPITAN: Good evening friends, I know you all very well by now. I appreciate you all waiting so long to hear our bill. So, scratch the afternoon, good evening members of the Public Health Committee. Thank you for taking the time to hear all of our testimonies today. I am here in support of H.B. 5442, AN ACT ADDING CHRONIC PAIN TO THE QUALIFYING CONDITIONS FOR THE MEDICAL MARIJUANA Program. I am honestly also in support of adding any condition that someone’s qualified, that someone’s provider or specialist sees fit for them to be qualified for the program.

I do believe that, you know, putting so many barriers in place for people to gain access, only forces them to gain access elsewhere and that can be extremely dangerous. I see many elderly individuals
who come forward, who wait for their card, wait for their condition to be approved, who have no other access, seeking access in unsafe ways, and that really bothers me, so, I encourage you to definitely think this over and to understand why we are all here today.

I would also like to voice my dearest gratitude to Representative Michel as well as Representative Elliott for bringing this forward, as we have voiced so many concerns as patient advocates and as patients about the processes in place in this program. And while this program is exemplary, it’s a wonderful program, it’s our opportunity to really trace what is going to happen with these conditions and how they work and to really document these things wonderfully as much as it’s much needed. I do believe that there is some degree of over-regulation that has become a hindrance, which I discussed last week with you guys.

So, as a medical cannabis patient’s advocate in our state, I’d like to clarify the reasons why we have come to you today, the Connecticut legislature, for your help with adding these serious conditions to the program as well as why we need your help in making many other changes within this program.

This program, as stated in the title of the regulation itself as written, is a palliative use program; meaning, that it is for severe, chronic and end-of-life care conditions. This means that time is not only of the essence, but that days can make the difference between life or death.

In the past seven years, since the inception of the Connecticut Medical Marijuana Program, we have seen
a lack of urgency on behalf of the Department of Consumer Protection as well as the part of the Board of Physicians in pushing these things forward and coming forward and getting the regulations rewritten so people can gain access. And somebody who’s being on the frontline, I’ve seen people’s mothers, fathers, sisters, brothers pass away while waiting and that’s unfortunate and it hurts.

The patients and advocates have been coming forward for many years about the medical marijuana program. We’ve seen, I’m sorry, about the lack of state level compassion, which is also a public health issue. I would also like to mention that, you know, the lack of transparency of agency actions may directly impact the patient’s health is also a public health issue. And the obvious absence of cannabis and the needs of the Connecticut patients by the Department of Consumer Protection is disheartening.

Therefore, we really appreciate you listening to us and coming, coming, you know, coming to us, Representative Michel and Elliott have been really responsive to the Connecticut patients and the advocates, but we do need you guys to stand behind us because we haven’t gotten anywhere with the DCP, when we feel like we’ve been unheard and unfortunately life or death is a real concern here.

We desperately need this program. We do not want to lose this program. We just want to make sure that it is available for all to access Veterans, children, and those who are financially desperate.

Thank you very much for hearing me again.

REP. STEINBERG (136TH): Thank you again. I will disagree with you on one point. I do not believe
that the actions of DCP reflect any lack of compassion for the people. I think they feel their responsibility very seriously to do the right thing in the right way. It may appear as such. I will tell you that virtually all of those who are involved with our medical marijuana program want it to be the best program that it can be and to help as many people as possible. So, I can assure there’s lots of compassion in this room and that’s why we’re having this conversation. I want to thank you for pointing out all of the health issues we have in the state. We try hard to be a healthy state. We actually rank pretty well in that regard. But we have a lot of work to do and often times with diminished resources to provide the kind of care and opportunity that we want to. I can give you any number of other instances where, we may seem less than compassionate because we’re cutting programs to provide care for people that really don’t have alternatives. And it is not a lack of compassion, it is a reflection of the desperation we feel as a state because of the financial circumstances we find ourselves in. So, again, I’ll differ with you only on the point that people do care, and we want to do the right thing.

CHRISTINA CAPITAN: Thank you, Representative Steinberg. Can I just clarify, so what I truly meant was that on the state level there are no compassionate need programs for people who are financially desperate. And, therefore, that leaves many people without access, those who don’t have the funds, are on a fixed income, to provide the yearly fees to a provider as well as the state. And there are no state-level programs for that, like we see within the dispensaries, unfortunately.
REP. STEINBERG (136TH): Thank you for that distinction, and again, it does come back to the fact that we’re short on resources and that has a lot of bad implications. Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman. Thank you for testifying again tonight. This reminds me when I was at the protest in front of Purdue Pharma, I remember meeting, it was warm outside and he was not wearing a T-shirt, he has a long tattoo on his back which was a poem, written by his daughter, who promised that she’ll take care of her dad, then she passed away. So, nothing less, nothing short of compassion on my side and engaged and I’m sure Josh is also engaged as well. And we’ll do our best also with the committee, the committee is definitely compassionate, it’s the Public Health Committee. And so, we’ll do our best to work together and move things forward.

CHRISTINA CAPITAN: Thank you.

REP. MICHEL (146TH): Thank you.

REP. STEINBERG (136TH): Thank you for your testimony.

CHRISTINA CAPITAN: Thank you very much.

REP. STEINBERG (136TH): Well, we’re almost ready to move on to the last bill, but there’s one more person who’s asked to testify on this bill, Brian Essenter. Everybody in the room, thank you for your continued patience for another three to four minutes.

BRIAN ESSENTER: Yes, thank you for your patience. I appreciate you guys all waiting for me to get this in very quickly. I’d like to thank Representative
Steinberg and Senator Abrams for having this hearing with us today. I’d also like to thank Representative Michel and Representative Elliott for bringing this bill as I think it’s an extremely important one.

My name is Brian Essenter, I was here a week ago to talk about the opiate use disorder with you guys. I’m a little bit better prepared today. But I am a pharmacist. I was a dispensary manager in Connecticut, here for about three years. I will be a dispensary manager again in Connecticut again in a couple of months when we are able to open. Just, I did submit my testimony online, so I’m gonna make a few other points right here.

I did send an email at the request of Representative Steinberg to every one of the members of this committee last week with all kinds of information regarding chronic pain, opiate use disorder, and tons of research that has been done regarding chronic pain, opiate use disorder and how cannabis can be used to help with both of them. I do hope you guys had a few minutes to be able to look that over.

Obviously, much of the information we’re talking about today is going to cross over with the conversation we had last week. But just a few different points, coming right from the DCP website, and how to submit a procedure or add a debilitating condition. It says, “If a medical condition, medical treatment or disease in a petition has been previously considered and rejected or is determined to be subsequently similar to previously rejected condition, treatment, or disease, the commissioner may deny the petition without first submitting it to
the Board of Physicians, unless new scientific research that supports the request is offered in the petition.” Therefore, we were under the impression that once a condition is denied, we are not allowed to bring it back again. That was something that was brought to our attention after the opiate abuse disorder was denied.

Secondly, on the, the petition itself, the submitted new condition, if you look to the second page to Section E of the petition that reads, negative affects of condition treatment. Provide information regarding the extent to which the condition or the treatment thereof caused severe or chronic pain, severe nausea, spasticity or otherwise subsequently limits one’s major life experiences. So, I ask, why would we ask this question as part of this document, yet deny the condition itself? Just by having this question on the form, speaks to the fact that marijuana does help with pain, specifically chronic pain.

So, recently both chronic pain and opiate use disorder were denied by the Board of Physicians. The last time they had a meeting regarding any of this was on June 25th, and that was simply a vote to decline the opiate use disorder. It was four months after the first meeting as well.

I’ll sum up pretty quickly. So, oh, in that four-month period between the original public hearing, they, they tabled it because they wanted to receive testimony from public health people, you know, doctors, pharmacists, anybody that had information and wanted to testify. I submitted my, my testimony. About two weeks later I attended a conference that was run, and the entire conference
was with some of the biggest scientists in the cannabis industry regarding cannabis and opiates.
It was all the information that I presented to you guys in that email.

I presented to one of the doctors on the board before that June 25th hearing, over a month before that hearing, and asked that he share that information with the rest of the board members, at which time, I was told that information would be shared with them.

So, fast forward, we get to the meeting. And we were going through the meeting and throughout the meeting, we hear a couple of the board members saying that they would be comfortable adding chronic pain, but I’m not sure about opiate use disorder because of the criteria for diagnosis. Many of the statements that were made earlier today went to, well, chronic pain is too long of a, too broad of a scope.

Well, chronic pain actually has criteria to determine chronic pain, that’s what all doctors want is something to CYA, something that they can refer back to, well, this is the determination that I use, this is the criteria I used for that diagnosis. Really quickly, too, the Board of Physicians at that time did approve chronic neuropathic pain associated with degenerative spinal disorders. The original condition that was a petition to the board that was on the table for discussion that day, was progressive degenerative disk disease of the spine. The Board of Physicians changed the name and the language in order to allow for a “more general condition to make it easier to certify more patients
as they thought the specific, the first one was too specific.”

And then my last point, by not allowing our medical program to grow and adding conditions that are in the best interests of the state, the healthcare system and our patients, we are allowing our Connecticut medical marijuana program to go from what was once touted as one of the best in the country to now being one that is just okay.

REP. STEINBERG (136TH): Thanks for your testimony. I want to particularly thank you for all the information you provided this committee. I’ll disagree with you on the point that our program has grown, we’ve added conditions. Perhaps chronic pain suffers because it is used sometimes as a symptom rather than a root cause. And as I said before, it was part of the opiate abuse crisis we had that has made us a little, lack of a better phrase, gun shy to extend it. But I think you raise a very good point, which is so much of the conversation about the conditions that have been added, specifically mentioned, chronic pain, that’s related to it, I think it’s a really interesting and valid point that you make.

BRIAN ESSENTER: Thank you.

REP. STEINBERG (136TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Chairman. Thank you, Brian, for coming to testify. Do you think we are undercutting the Board of Physicians?

BRIAN ESSENTER: I appreciate that question actually. It’s so, nothing but respect for the Board of Physicians and what they do. I completely
agree with you, Representative Steinberg, we have expanded the program and more recently they’ve done a better job at doing that quickly as well. However, in situations like this, where you’re talking about chronic conditions, we’ve talked about the time sensitive situation of many of these, as I’ve mentioned the Board of Physicians meets maybe twice a year. If they happen to table an issue until their next meeting, who knows how long that’s gonna be until those conditions get added. Not to mention the fact, if I go to a doctor and they diagnose me with cancer, I’m gonna be like, okay, thank you very much, but I’m gonna go get a second opinion. Well, we as patients or anybody else looking to add a debilitating condition, you guys are our second opinion. We don’t have that opportunity to go back to that Board of Physicians again. So, it’s only fair that we have that opportunity here with our elected officials.

REP. MICHEL (146TH): Thank you for that and just one last question. We’ve got 21 states that must have done some research. Are you at all familiar with that kind of research or can you confirm --

BRIAN ESSENTER: There is a lot of research that is, is going into this. Actually, there are groups up in Massachusetts, C3RN is doing a ton of research around this. A lot of the research on it is coming from out of the country. There’s a company called Tikun Olam out of Israel that has some unbelievable research, double blind, randomized, placebo controlled studies, that’s what we want, right? So, just because we’re not doing it nationally, here in the United States, does not invalidate that research that is out there as well.
REP. MICHEL (146TH): Thank you very much. And thanks for waiting this long and coming to testify.

BRIAN ESSENER: Thank you everybody for waiting and being patient with me as well, I appreciate it.

REP. STEINBERG (136TH): Thank you. And it sounds like we have a lot of homework to do yet before we’re done.

BRIAN ESSENER: Thank you very much.

REP. STEINBERG (136TH): Testimony? Well, ladies and gentlemen, we’ve arrived at the final bill. To my mind, I must be hallucinating, there seems to be more people in the room now than when we started. And I, I want to congratulate you all for staying the course, which is not an easy thing, but I also think we should, without applauding, congratulate our legislators who are still here. And I will tell you that there are legislators who are here who are not physically here, who are seeking nutrition because we’re not ironmen and ironwomen as you might expect. And since we’re blessed to being on TV today, we’re actually watching it from where people are grabbing a bite. So, if you see people peel away for a while and then come back, sort of like the von Trapp family singers, we are just grabbing a bite and coming back again. Your testimony is being heard.

So, without further ado, we will move to House Bill 7070. And first up is Lisa Maloney.

LISA MALONEY: Good evening committee members and thank you so much. I know that you have already heard quite a bit about Bill H.B. 7070. I am Lisa Maloney. I am a licensed Marriage and Family
Therapist, the Executive Director of Care Net Pregnancy Resource Center, in New London, and the president of the Connecticut Pregnancy Care Coalition. And I am speaking out in opposition to Bill, H.B. 7070.

For the last 18 years the State of Connecticut, Department of Public Health has recognized my center, Care Net Pregnancy Resource Center, as a family planning clinic, yes. We are recognized by the State of Connecticut as a family planning clinic. We undergo an inspection every two years. But we do provide limited services. We see about 500 women a year and have a 99 percent approval rating in our exit surveys. And we have been open for 25 years. And to date, not a single complaint has been filed against our center for deceptive advertising.

Our centers are very clear about what we provide and what we don’t provide, which is very interesting, considering most businesses do not put on their websites the services they don’t provide. They only put on what they do provide. But we feel that we’re better than that and we want to make sure that a girl knows what she’s getting when she comes into our office.

If a girl is looking for information about an abortion, then we can give her that. If she is looking for information about adoption, we can give her that. But we don’t provide either one of those services. Just like if someone were to go into a Planned Parenthood looking for prenatal care, they would get information, but not prenatal care.
I don’t see what the difference is. If you call yourself Planned Parenthood, but you don’t provide prenatal care and you give information, I don’t, where’s the deception? Where’s the deception on our website when we put information about abortion? We don’t provide abortions and it’s very clear.

In the reports that have been cited by NARAL, they have screenshot only a partial shot of my website. My website has made it up in many places today and I’m actually quite thankful for all that publicity.

I would like to close stating that the Department of Public Health code, 1913-C4.F states, no person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs. We are protected in our State Department of Public Health from having to promote abortion. But yet we still put that we don’t provide abortion. We’re very clear. Section 42110, under the Fair Trade Act, does cover persons, natural or LLC. We are an LLC. And it also defines advertising of any services.

So, as far as we’re concerned, this is an unnecessary bill because it’s already covered under our own statutes. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. I just have one question for you. From everything you’ve described, you have gone out of your way to provide full disclosure about the services you provide and don’t provide. How would this piece of legislation negatively impact your enterprise?

LISA MALONEY: I believe because throughout all of the paperwork that’s been submitted, my center has
been targeted multiple times on NARAL site and testimony that you can see on the Public Health Committee as being deceptive, and so I think that it would provide an undue burden on us to fight the accusations of being deceptive.

REP. STEINBERG (136TH): Thank you. Yes, Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman. And just to ascertain that I heard you correctly, did you say that you’ve met with approximately 500 individuals this past year?

LISA MALONEY: Yes.

REP. MCCARTY (38TH): And so, and you’re in business for 18 years?

LISA MALONEY: We’ve been in business for 25 years. We’ve been a licensed clinic for 18. So, I would just venture to guess on an average that would probably be about 10,000 individuals with not one complaint.

REP. MCCARTY (38TH): Not one complaint. Thank you.

LISA MALONEY: Yes.

REP. STEINBERG (136TH): Representative, excuse me, Senator Somers.

SENATOR SOMERS (18TH): Good evening. What are we going on, hour 14 right now?

LISA MALONEY: I don’t know.

SENATOR SOMERS (18TH): I would like to have you answer the question, if someone came into your center and your center philosophically does not
agree with termination and they asked about getting a termination, that was their decision.

LISA MALONEY: Uh-huh.

SENATOR SOMERS (18TH): What would your response be?

LISA MALONEY: My response would be to encourage them, to find them the same way they found us, which is mostly on their phone searching for an abortion clinic under Google or Bing. Again, that’s not hard to do. They found us for the services that they were looking for. And the abortion clinics would come up readily. I would also let them know that regardless of what they choose, they can return to come and see us. We provide post-abortion support for anyone who needs it. And we see probably about, I would say seven or eight women a year who come back to us for support after an abortion.

SENATOR SOMERS (18TH): One of the things that you said previously was that you felt that your center was being targeted. Can you, and then you talked about like half a screenshot or something of the website. Can you expand on that? Is there anything else that you felt, just so we have an understanding of what you’re meaning when you say that?

LISA MALONEY: Yes. In 2015, NARAL Pro-Choice Connecticut released their so-called study, the right to life, and in that study several times they listed our website. They took a picture of one of our brochures that was probably picked up by their secret shoppers. And in that brochure, we put out there that says, you have a choice regarding your pregnancy. You can choose to parent; you can choose adoption and you can choose abortion. And they circled the statement that says, you can choose
abortion, and claim that that was misleading because we are telling girls they could choose abortion. I’m not sure where the misleading statements are in that. And then again, in 2018, they issued another report citing my center several times, calling us a fake clinic and screenshotting only the top half of my website, not the second half, not the bottom half where it has our hours, our address, and in bold letters, this PRC does not refer or perform abortions.

And so, I feel like that is just a blatant attack on what we do as opposed to, you know, deceptive advertising.

SENATOR SOMERS (18TH): Okay. And you’re considered a clinic, is that correct?

LISA MALONEY: We are. We are a licensed outpatient clinic under family planning in the Department of Public Health, and we have been for 18 years. Inspected every two years without any violations or complaints filed against us. But we don’t advertise as a clinic. We advertise as a pregnancy resource center. We work with HUSKY. Many times girls who need insurance are sent to us by HUSKY to get a confirmation of pregnancy so they can turn around and get on the health insurance that is provided for them by the State of Connecticut. And we work with many other agencies as well.

SENATOR SOMERS (18TH): Thank you.

REP. STEINBERG (136TH): Other comments or questions? If not, thank you, oh, sorry.

SENATOR LESSER (9TH): Thank you. And thank you for your testimony tonight.
LISA MALONEY: Uh-huh.

SENATOR LESSER (9TH): You mentioned that you’re a licensed family planning clinic. I didn’t see your name on the list on the DPH website, so maybe I’m not finding it. But can you walk us through how you’re, what services that you do provide that are classified as clinic services?

LISA MALONEY: Yes. We provide pregnancy tests, limited obstetrical ultrasounds to diagnose pregnancy. We provide STD testing and treatment and we also provide HIV testing for the State of Connecticut. If you were to look under Department of Public Health under outpatient clinics, we are under Care Net Pregnancy Resource Center.

SENATOR LESSER (9TH): Okay. So, under outpatient clinic, not under, there’s a family planning license as well, but you’re not actually listed in family planning?

LISA MALONEY: The application for outpatient clinic, you have to check off different categories and the category that is checked off is family planning.

SENATOR LESSER (9TH): So, essentially the two services are pregnancy tests and STD tests, those are the services that you provide?

LISA MALONEY: Yes.

SENATOR LESSER (9TH): And are you clear to your, to the people who come into the clinic, the women who come in, as to which services are clinical services and which ones are not clinical services?
LISA MALONEY: Absolutely. They would be assigned a day. So, on Tuesdays and Thursdays, we do our medical appointments. On Mondays, Wednesdays and Fridays, we do our support appointments, which could be anywhere from classes, diapers, and different types of support, ongoing peer counseling. But when a girl fills out the initial paperwork with our request for services, it is very clearly stated on the paperwork that we do not provide or refer for abortions.

SENATOR LESSER (9TH): I understand that. But I guess, you’re saying, so if a girl or a woman walks into the, to provide, into the center, on a day in which you are providing either an STD test or a pregnancy check, those are the only things that happen that day, there is no other, there’s no other services, there’s no other, nothing else happens in the clinic that day?

LISA MALONEY: Right. If she were to come in looking for medical services that day, we would be very clear that it would be the pregnancy test and pregnancy diagnosis and STD testing or treatment.

SENATOR LESSER (9TH): Are you able to provide any services in the, in association with that pregnancy test in order to determine whether or not, for example, there’s a, a problem with the pregnancy, is that something that you’re able to diagnosis or do you simply, you’re just ascertaining whether or not the girl is, in fact, pregnant?

LISA MALONEY: No. With the ultrasound, if there is a problem, we have a protocol with our medical director that we would either be calling a local Ob-Gyn right then and there, get her into an emergency
room, which is right up the street from us, if there was a problem seen on the ultrasound. Our medical professionals are trained to spot that type of problem and refer immediately.

SENATOR LESSER (9TH): So, you do diagnose ectopic pregnancies, that’s something that you, that’s a service that you perform?

LISA MALONEY: If we saw an ectopic pregnancy, absolutely.

SENATOR LESSER (9TH): Thank you very much.

LISA MALONEY: Yeah.

REP. STEINBERG (136TH): Other comments or questions? If not, thank you for your testimony here today.

LISA MALONEY: Thank you.

REP. STEINBERG (136TH): Next up we have Christina Bennett.

CHRISTINA BENNETT: My name is Christina Bennett and I’m the Communications Director for the Family Institute of Connecticut. You have my written testimony. I’m here to offer opposition to H.B. 7070. I believe it’s part of a coordinated attempt and a national campaign by abortion rights groups, specifically NARAL Pro-Choice Connecticut to discredit the work of pregnancy centers. One campaign has even entitled, expose fake clinics. While examining pregnancy center websites, would you please NARAL’s website, accusing centers, it’s www.exposurecpcct.org. If they only want to regulate centers with deceptive advertising, then why does their website have a map of all Connecticut
pregnancy centers, along with the description of them being fake women’s health centers. They base their information on all Connecticut centers, including their website and the hours they are open.

In the last two weeks, a pregnancy center in Virginia was vandalized with the words, fake clinic, spray painted over their signs. The accusations that centers exist to deceive women are serious, which can put pregnancy centers staff in potential danger. In the past, I served as a staff member at a pregnancy center and I witnessed attacks from NARAL. They protested outside of our center in Middletown, causing the center to have to close for the day and cancel appointments of clients. They sent volunteers or spies into centers to create their biased report and we’ve received fake Google reviews on social media.

NARAL submitted testimonies and research must be examined in light of the fact that they are not a neutral, unbiased organization. They are an abortion rights group opposed to the core beliefs of pregnancy centers and those with pro-life views.

This is evidenced in their statements when they claim pregnancy centers exist to deceive women. Would the committee take seriously anonymous testimony accusing abortion clinics of false advertising that were collected by a pro-life organization and their team of volunteers? I would imagine you would take their opposing views into consideration.

Last year during a similar hearing for H.B. 5416, NARAL staff said the words, pregnant need help were deceptive. They believe any reproductive health
organizations that don’t offer abortion or refer are deceptive. Disbelief does a disservice to women by not acknowledging the multiple ways in which pregnant and parenting women need help. My own mother was pressured into scheduling an abortion here in Hartford at Mount Sinai Hospital in 1981. She received no information or other options, though she was visibly upset. Thankfully a hospital janitor saw her crying and asked her if she wanted to keep her baby. She left the hospital after being forcibly told to stay by a doctor. She would have loved to have gone to a pregnancy center if she knew about one. That’s why their advertisements are so important. There are no clients who testified against the centers, no complaints to the Better Business Bureau, Department of Consumer Affairs, social service organizations, though many clients, though many clients who go to pregnancy centers also visit social service organizations.

Because NARAL Pro-Choice Connecticut is championing this bill, attacking centers and has submitted research for this testimony, I want to respectively, respectfully voice my concern about the fact that Senator Lesser’s wife is listed on NARAL’s website as a board member.

I hope pregnancy centers will have an impartial investigation in light of any elected officials connections to this organization, who’s championing this bill. Connecticut is one of the most accessible states for abortion in the entire country. We don’t even require parental notification for minors seeking abortions, although parental notification is required for minors seeking tattoos, piercings and to go tanning. Women in
Connecticut have more accessibility to abortion than most of the entire country. What they need is options and support, that’s what pregnancy centers offer to them.

Please oppose this legislation, unfairly discriminates and targets pregnancy centers.

REP. STEINBERG (136TH): Wow, you covered a lot of ground in three minutes. It was more, but still really close. Thank you for your testimony. I will assure you that this committee is taking into account all points of view. And that we haven’t made up our minds on anything yet, that’s the whole purpose of the public hearing process. Senator Lesser.

SENATOR LESSER (9TH): Ms. Bennett, I thank you, thank you, Mr. Chairman. Ms. Bennett, I have to take issue with what I guess I interpreted as your comments a minute ago. I think all of us are serving on this committee because we believe in the mission of the Connecticut General Assembly and our roles as legislators to advance, protect public health in the State of Connecticut. We’re here, this is what the, we’ve been here for over 10 hours in this committee room serving because we believe in the mission of the State of Connecticut. And you can agree with us or disagree with us, you can attack us and whatnot, but I thought your comments with regard to my wife and her service as a volunteer member of a board is unrelated to my service here in this General Assembly I thought were out of line. And we can talk about this bill, and I’m happy to have a discussion with you about the bill. I’m not sure I understand why you brought up my wife in this hearing tonight.
CHRISTINA BENNETT: NARAL Pro-Choice Connecticut is championing this bill. You’re endorsed by them. In 2015, you won their highest award. I came to your office and talked to you about that when I was working at a pregnancy center and you said in quote, I don’t even know why they gave me this award. I work with many organizations. I never knew that your wife was a board member. So, I think that it’s relevant, it’s on NARAL’s website and they’re talking about pregnancy centers websites, they’re examining pregnancy centers websites. I think that’s important. I never said that you will rule in a certain way based on that. I’m just bringing up that information in case anyone wants to know that I think it’s relevant. They’re championing this bill. There about to give a bunch of testimony on behalf of it. And there is a very personal connection personal connection you have with the organization as well as being a recipient of one of their highest awards.

And so I want to make sure that pregnancy centers are getting a fair hearing because I care about people and I know that you care about people. And I want to make sure there’s no political preferences in regards to this bill.

REP. STEINBERG (136TH): Ms. Bennett, I think you’re --

CHRISTINA BENNETT: We’re not allowed to clap.

REP. STEINBERG (136TH): There may be some new people here who weren’t here earlier. We’re very careful in this committee not to indicate favor or disfavor of anybody testifying. At the very least, I’m sure everybody here understands that, so as not
to intimidate anyone. So, I want to ask that no matter how passionate you are about the issue, that you refrain from expressing it publicly for the benefit of all those here. Thank you.

Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman. I had absolutely no intention on making a comment on this. I’ve had meetings in my office regarding this conversation. I do though take issue with anybody that comes in front of our committee and testify and brings our family into it.

CHRISTINA BENNETT: Even if they’re a board member on the group that’s --

REP. COOK (65TH): You know what that’s --

CHRISTINA BENNETT: -- bringing up this bill?

REP. COOK (65TH): No, no. Hold on. Hold on. I’m not trying to be rude, disrespectful or inappropriate, but I am trying to say one thing. It is not our families, whether they be spouses, significant or otherwise that are sitting in this chair making decisions. It is us. It is us that are elected. And it is us that take the heat for everything that we do, not our families. And I’m a firm believer, first and foremost, that our families must come first, whether it be our spouse, our children, our parents, it doesn’t matter. There’s a time and a place for that conversation, but to bring someone’s family member into a conversation regarding of the topic, is totally inappropriate in my world. And I would ask that it not happen again.

CHRISTINA BENNETT: I can respect that. I mean, I disagree, and I think if not now, then when would I
ever be able to bring that up. And I think it’s important for people to know that. But I respect your opinion.

REP. STEINBERG (136TH): I’ll just add before I hand it off, that I have to concur with my colleagues on this. One would argue that politics has infected every aspect of our life and it’s almost impossible for us to dismiss it. But in my experience, even in the context of politics, you cross the line when you start talking about family members. I think the points that are made is, we stand by our records. We stand by our words, but we do not involve family members in this. And I would hope that in this committee room, as we try to practice, even in the context of campaigns, we keep families out of it. And whereas, you may feel it’s relevant, it is definitely, in my mind, crossing a line. Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you for your testimony. I just wanted to assure you that many times legislators, if they feel personally a conflict, they have an ability to recuse themselves from a vote. We have that in my Senate, where people are voting on energy bills and some of them work or are affiliated with Eversource. So, I am confident that my fellow Senator would, if he felt there was a conflict, would make that decision. And that’s his decision. And again, I just wanted to reiterate just because a family member, my husband’s a physician, that doesn’t mean that I’m going to be voting for everything that physicians want. And I would not want anyone not infer that I would, as I am sure Senator Lesser feels the same way. I don’t want to speak for him. But I just wanted to let you
know that we do have that ability as legislators, if we feel that we are conflicted. And I just wanted to make sure everybody knew that. And I do think, although for you it was important for you to point out the relationship, it is very difficult as a legislator to have people assume that just because your child or your spouse is involved in something that that reflects on you. So, I just wanted to let everyone know that there is an ability for legislators to, if they feel conflicted, to not vote on something.

CHRISTINA BENNETT: And I understand that. And I apologize if I offended. I mean, I brought it up in light of the fact that when I met with Senator Lesser, he said, I don’t know why you think I’m associated with this organization. And then to find that out, felt very confusing in light of what he had said, and so, but again, any other questions?

REP. STEINBERG (136TH): Are there any other comments or questions? Comment, Senator Abrams.

SENATOR ABRAMS (13TH): I just want to make a comment about the fact that I think there’s going to be very emotional testimony going on here for the next few hours and that many of us have been in this room for a very long time, some since the very start of this. And so, I want to make it very clear that it is important that we have some boundaries about what is said here in this room and the way it is said. And I agree with my colleagues in terms of what some of those boundaries need to be.

So, I hope that as we move forward we remember that, and we are respectful of one another and the opinions that we share here. thank you.
REP. STEINBERG (136TH): Thank you, Senator. Any other comments or questions? I want to say that since you were the first to speak to this point, perhaps you didn’t understand. I hope it is clear as we go forward. I think the old maxim is, treat others as you’d like to be treated yourself. So, hopefully that will be something that everybody thinks about when they come to testify. Many people have waited long hours to testify. And let us move on. Representative McCarty.

REP. MCCARTY (38TH): Thank you, Mr. Chairman. Yes, I just wanted to thank you for the other parts of your testimony and for coming up and speaking to what really you are passionate about. Thank you.

CHRISTINA BENNETT: Oh, you’re welcome, and do agree. I hope that you guys will treat pregnancy centers as you want to be treated because that is very important, that’s why we’re here. Thank you.

REP. STEINBERG (136TH): Totally agree. Thank you. next up is Sarah Croucher.

SARAH CROUCHER: Good, Senator Abrams, Representative Steinberg, members of the Public Health Committee. My name is Sarah Croucher, I’m the Executive Director of NARAL Pro-Choice Connecticut, and I’m here to testify in strong support of H.B. 7070. And I really want to bring us back to the narrow nature of this bill to focus again on some of the legal discussion that we have this morning about how limited in scope this bill is, and to focus on some issues are 1., there are some centers in Connecticut that we believe are presenting themselves through affirmative statements suggesting to people that they offer time-sensitive
medical services on abortion and emergency contraception; when, in fact, they are opposed to those services. They are problematic and could be perceived in legal terms as deceptive.

Also, that these organizations are very clearly affiliated with national organizations proven very clear in their mission that they want to stop people who are looking for abortion from accessing those services. And thirdly, the argument that we should base whether or not this bill is passed on whether consumer protection complaints have been brought forward is a problematic notion in light of the kind of things that are going on.

I also want to reiterate, you know, as a pro-choice organization, it’s really important that when an individual is faced with an unplanned pregnancy, they are able to offer, to access whatever services they want. And that should include, if they are seeking a religiously-based counseling. What we are concerned about are the people who know that they want to go to a medical provider and that they want to go and have an unbiased discussion with someone who they think is not for or against any medical service and find out factual information as is met and supported by major medical organizations in making that decision.

And we want to make sure that those people, when they are seeking those services, are able to immediately find them and are not faced with time blocks when those services are time sensitive. And so, that’s what we think that this bill supports.

So, the first point that I want to make is when Googling in Connecticut and Google is the most
common search engine that I think people would use, terms such as abortion, how Connecticut and pregnancy help Connecticut bring up links to these centers.

The second point that I’d like to make very briefly is that several of these centers make affirmative statements on their website that say things that suggest that if you are looking for an abortion, they are the first step, which is problematic given the fact that these centers will not refer someone forward for abortion services. And so to say to someone, come to us if you are looking for information about an abortion is deceptive when you, in fact, are gonna be a hard stop on that person looking for an abortion.

These centers are affiliated with national networks, who as I’ve outlined in my full testimony, make very clear in their materials that their aim is to get in the way of people who are looking for an abortion and to slow down their path of that treatment and to try and block them from reaching that.

And then the third point is, you’re gonna hear some testimony here about patient stories that were reflected in Hartford about stories from medical providers and from a couple of people who have been to these centers and been deceived. And more I hope that you’ll understand that abortion remains, despite the fact that there is a legal right to people in our state, highly stigmatized medical treatment to go and seek.

And most of the people that are targeted by these centers tend to be medically underserved young people, people who might not want to tell their
families about the fact that they are seeking an abortion. And mostly, although we certainly know from testimony in Hartford, when we were working on the ordinance here, that at least one person in Hartford were seeking an abortion and ended up in a medical room with, in an emergency room with a resident at Hartford Hospital, who testified on the Hartford ordinance that the resident has since moved out of the state, so she can’t be here to testify today. That the patient that she was treating had had the clock run out on her on one of these centers and could no longer actually receive the abortion care that she was seeking for. These patients then just want to go and get their abortion and get on with their lives. It doesn’t occur to them to call the Department of Consumer Protection.

And so all that we want to do with this legislation is to make sure that when people are seeking unbiased medical care about these very particular time-sensitive services and which, half-way to their care is disrupted. It is clear to them about where they can go to actually find information about abortion from a provider who is going to give them the information that is recognized by all of our major medical societies such as ACOG versus a center that is offering religiously-based counseling but is not going to help them find a route to that care that they’re looking for.

So, that summarizes very briefly, I hope, my testimony. And I hope that you will very seriously consider passing what we think is a very limited and very tightly --

REP. STEINBERG (136TH): I’m gonna ask you to summarize your --
SARAH CROUCHER: Yeah, I’m done.

REP. STEINBERG (136TH): Okay. Thank you. Let me make sure I understand you correctly. In your support of this bill, it is not your intent to abolish the care centers that testified that you’re --

SARAH CROUCHER: There is, yeah, there is nothing in the language of this bill that would stop these centers from operating. And as you heard earlier form the Attorney General, and from Jordan Goldberg from the National Institute of Reproductive Health, from their Luke Bronan and the passage of this ordinance in San Francisco, the passage of this ordinance in Hartford. And based on the same deceptive advertising framework has nothing in it that would stop one of these centers from operating, from doing all the many services, obviously good things that they offer, like parenting support for people, like religiously-based counseling.

The thing that this bill does literally in very limited scope is to say, if you should not be making statements to people that affirmatively suggest that you offer abortion or emergency contraceptive services when you do not actually offer those services.

REP. STEINBERG (136TH): Obviously, the, the central aspect of this entire conversation is with regard to deceptive advertising. And you have made statements that you have evidence that indicates this affirmative, misleading claims or promises. You’ve heard other say, and I think they will continue to say that some of the evidence you supplied has been edited in some fashion?
SARAH CROUCHER: So, I think that as far as we understand it in terms of legal terms of what could be construed as deceptive, statements that affirmatively state to people, thinking about abortion, we’re your first stop. But say those statements very clearly as the first thing. And then in a footnote, say, we do not perform or refer for abortion, could be legally construed as deceptive. And the thing is, it’s not gonna be my job to have a legal case on who is or isn’t being deceptive.

The other thing that I can say is, over the last couple of years as we’ve really pursued this passage of legislation, it’s clear that some of these websites have changed and that clearer disclaimers have been posted. And I would say that a really wonderful outcome to passing this legislation would be if all of these websites clean themselves up, so it was very clear to people that there was no pathway to abortion care at centers that are opposed to abortion.

That’s all we want to make clear. And so, it’s not, I don’t mean it’s in anyone’s interest to have a court case for the sake of it. What is in our interest is to make sure that people, when they are searching for a specific kind of time-sensitive medical care are not misled into going somewhere that isn’t where they want to be.


SENATOR SOMERS (18TH): Good and thank you for waiting so long to testify. I know that we’ve talked in my office and I still am struggling with
the deceptive portion of it. So, I wanted to ask you, I’m looking at exposetcpc@CT.org --

SARAH CROUCHER: Yeah.

SENATOR SOMERS (18TH): -- so I just want to read something off of the website. What are fake women’s health centers? Fake women’s health centers are also known as crisis pregnancy centers or CPCs. There are anti-abortion counseling centers that often use this advertising to lure in people facing unplanned pregnancies. These fake clinics are unlicensed and unregulated by state and often give out false medical information and biased counseling. Residents now, Connecticut residents are being lied to, deceived and shamed by fake women’s health centers when they’re seeking legitimate medical care.

Now, I have to say, with what we’ve heard today about NARAL accusing pregnancy centers being fake and misleading, I find that statement misleading personally. Because what we heard is there’s licensed clinics providing information that’s, you know, requested from the potential patient directly. So, it’s hard for me to have it both ways. I realize that you’re both on opposite ends of the spectrum. I want to make sure that we have legislation so any woman that is seeking care or trying to help make a choice of what she wants to do with an unplanned pregnancy gets the correct medical information, but this or what I see on there and this right here talking about fake mobile clinics, that’s deceptive in its own way. So, for me anyway. So, I want to make sure that when we leave this today, that we can have a clear understanding as far as both sides what’s deceptive, what’s not, you both
have agendas that are different, and we can come to some understanding to move this forward. Because, quite frankly, I don’t want to, I don’t want to have another hearing like this for another year. And we might be here another year. But it’s hard for me to say one’s doing something when I see, you know, the other side doing something that seems just as deceptive because clearly they’re not all fake, they’re not all out to deceive women. So, that’s, that’s an issue that I have. And I wanted to bring that to your attention. And I want to come out with a best result because I think every woman in Connecticut, actually across the country, deserves to make their choice and be informed on what the choice is. And I don’t want anyone to be deceived on either side of the issue.

So, I just want to make sure that I state that.

SARAH CROUCHER: Yeah, and I would just say that there are 17 licensed abortion clinics in our state. And the question here is specifically about advertising for abortion and emergency contraception. And so, being a clinic licensed to do pregnancy tests and licensed to do STI testing and then saying to someone, if you are looking for an abortion, we are your first step. When you are not going to give that person any help to actually go and find help with an abortion, with seeking an abortion. I think that that is deceptive and disingenuous. I think that’s very different from someone who is seeking information about an abortion from a licensed abortion provider, going to one of those licensed abortion clinics.

SENATOR SOMERS (18TH): But if I may, you just heard testimony today in front of the legislator, that is
somebody went to a pregnancy crisis center and they were asked about abortion or they would give them the information, they also said that they would tell them where to go. So, that’s different from what you’re saying.

SARAH CROUCHER: No. We opened up to the number of undercover visits at these centers over the years and in none of those visits has anyone ever been told information on where they can actually go to find an abortion. And so this becomes a he said, she said, but that’s actually also not about the content of this bill. This bill is about the advertising and is about saying, if you do not offer abortion, you should not be putting yourself out in the realm of commercial speech, which we have heard very clearly defined in legal terms this morning, as suggesting to people that you do offer abortion. And maybe one of these centers does actually honestly say to someone, hey, there’s a Planned Parenthood a few blocks away that you can go, if you’re seeking an abortion. But that’s certainly not the information that we have found.

But also I have to say that again, that outside of the scope of this bill, because the scope of this bill is about, are you advertising to people in a way that suggests that you offer services that you do not. And that in terms of the legal language of this bill, that we have heard discussed in very clear terms, is all that this bill does.


SENATOR ABRAMS (13TH): I have to say that I don’t see this as being like two sides of a coin and that
you’re coming at if from different places. I think that actually it’s simple to me to say, these are the services we do provide, and these are the services that we do not provide very clearly to people is all that’s being asked. Similarly, if, so, to me, the opposite of it would be if Planned Parenthood said, we’re going to provide religious counseling and things that they do not provide, then they would be doing a similar thing.

So, I hear you saying, and what I heard the last testimony, the first testimony saying was that they do not do referrals. They have that on their website actually, I was looking at it and it says, we do not perform or refer for abortion. And they would tell somebody to go Google it or look it up on their phone, but would not tell them, here, this is where you can go.

So, I don’t, I see this as you’re saying more narrowly, I guess, that it’s simply about just say exactly what you provide. And I’ve heard people testify today that that’s exactly the services they were looking for. And I think there’s nothing wrong with that, that if those are the services they’re looking for, then I think that some of these centers are doing some really excellent work in supporting women in the choice that they want to make, just so long as they’re clear about that.

SARAH CROUCHER: Yeah, I want to make clear that there is nothing in this bill that requires people to affirmatively tell people about services that they do not offer. It simply states that you should not be advertising as though you are for services that you do not, in fact, offer. You do not have to provide any kind of disclaimer that you don’t offer
those services, or you should do, if not disingenuously suggest to people, if you are looking for an abortion or emergency contraception, come to us when you do not offer those services.

REP. STEINBERG (136TH): Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman. Thank you for your testimony. As I did, while you were talking, I did a little Google search. And I came to a pregnancy care center website. And the first three sentences down it says, we would like to suggest that the very best unbiased trend at this time is an advisor from our pregnancy center. So, at the top of that it says that they are unbiased.

Then if you scroll down just a tad, it says, it starts talking about, we repeatedly hear pregnancy center advisors share how they have seen girls personally blossom in a situation, by keeping their children, as they maturely explored alternatives, creative plans for themselves and dealt with outside influences and deterrent. It is about a young girl from Harlem, New York, who was violently raped. She tells how giving birth to her daughter and watching her daughter be nurtured and loved by the adoptive family, actually healed her of the rage of violence and rape.

Now, personally, I have a huge problem with that. But and the rest is this, adversely having an abortion is an opinion that pregnancy centers do not discuss. But you’re supposed to be unbiased. Though they may review the dangers of abortion because it’s legal, that does not mean it’s safe. In fact, abortion is now less safe for the reasons discussed in the abortion section.
It is because they know, through their experience, that this decision is not the decision of a powerful woman. It is the decision of a weak teen or woman, who has been pushed around by life or abuse, and is trying to stay afloat. It is the decision of despair, which involves achieving success through a life submission. This is not the type of track record you want to carve out for yourself. A pattern of dealing through submission, imagine, spending your whole life being blindly submissive, no, not good.

For the record, the pregnancy care center website, ctforwomen.com. So, in my world, that is completely biased, and it is horrible. And if anybody knows anybody who has ever been sexually assaulted, raped or otherwise becomes pregnant, that’s a huge problem for me and that is about false advertisement.

Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Other comments, questions? If not, thank you. Next up is Wildaliz Bermudez.

WILDALIZ BERMUDEZ: Good evening, Senator Abrams, Representative Steinberg and the distinguished members of this Public Health Committee. My name is Wildaliz Bermudez, I’m the Minority Leader in the Hartford Court of Common Council. And thank you so much, everyone, for being here tonight and for hearing all this testimony that’s so important. I’m here in support of H.B. 7070. And I’m here to tell you what happened in Hartford’s case.

So, Hartford, as you all know, you’re aware, we passed an ordinance. We passed an ordinance so that there can be more transparency and so that these crisis pregnancy centers could be better regulated.
so that there are no false advertisements that are happening.

When we were in the process of passing the ordinance and before we passed the ordinance, we received dozens of complaints. We heard directly from medical providers in Hartford, particularly those working in the Hartford GYN Center. And at that time, I’m not sure how many of you are aware, but at that time, St. Gerard’s Center for Life, doing business as Hartford Women’s Center, set up shop right, very close in proximity to the Hartford GYN Center.

When you Google the Hartford GYN Center that’s been there for a very long time, the website is thewomenscenters.com. Now, the womens center and then all of a sudden you have a new center, Hartford, doing business as Hartford Women’s Center, very similar in how, you know, you’re going into one center and thinking that you’re gonna go to the Hartford GYN Center, but you actually end up in the Hartford Women’s Center, so a very similar name.

But beyond that, we at the Hartford Court of Common Council, heard from medical service providers. We also heard from patients who at the time when they were setting up St. Gerard’s Center for Life, doing business as the Hartford Women’s Center, as soon as they set up shop, women were being swayed from going to the Hartford GYN Center and instead going into the Hartford Women’s Center. So, there was certainly deceptive practices that were happening. And furthermore, women, we heard from dozens of women who had been harassed after, while they were trying to get into the Hartford GYN Center, but being swayed to go into the Hartford Women’s Center.
And one particular story really stands out for me, and it’s the one where the woman was trying to receive an abortion and by the time, and she ended up in the Hartford Women’s Center, but by the time that she actually made it to an actual medical service provider, it was too late.

So, it’s really important for women to be able to find the clinics that they want and like anything else, it’s important as a consumer to know what it is that you’re getting.

Of course, any organization can provide services, but we have to be very clear and precise what kinds of services are being provided. And regardless of what your personal opinions are in terms of abortion, there should be no misleading medical care, and that’s really what the bottom line is here. Reproductive health decisions are time sensitive and beyond that, medical care should not be delayed because it can have very serious impacts and very serious harm on a woman’s life.

If you go and look at Hartford’s story, it’s a clear indication of why we discussed to pass this ordinance to make sure that misleading practices did not happen. And that’s something that we all decided was very important for our residents in Hartford.

There are two types of service centers. There are those who are, that are regulated by the state and then there are those, like the crisis pregnancy service centers, prime example was the Hartford Women’s Center, that are not regulated by the state.

And so, we have to also take all of that into account. Thank you.
REP. STEINBERG (136TH): Thank you for your testimony. How long has the Hartford ordinance been in effect?

WILDALIZ BERMUDEZ: Now, over a year.

REP. STEINBERG (136TH): Can you describe your experience; has there been any change in the marketing activities of the centers you referred to?

WILDALIZ BERMUDEZ: So, in terms of the post and now the current doing business as, I can make sure that our corporation counsel’s office answers that specific question in terms of the language. But if you Google, at this particular moment, Hartford Women’s Center, it does say it’s a religious, I’ll do that right now. If you Google Hartford Women’s Center, it does say that it’s a religious organization. So, it says it right there. And if you try to go into their website, you can’t. So, you’d have to go there in person at this particular moment.

If you Google the Hartford GYN Center, which website is thewomenscenter.com, you have the full list of the services that are provided.

REP. STEINBERG (136TH): So, would you characterize the experience thus far with the Hartford ordinance as successful in addressing the issues that you sought?

WILDALIZ BERMUDEZ: The Hartford ordinance is crucial because it provides a clear structure in terms of saying, what we will be allowing, what is allowed. Because without the ordinance, there’s, because there’s no type of regulation, if there was misleading, which there was misleading practices
that were happening, there was no way to do anything about it. And so, through the ordinance, we could incur penalties, for example.

REP. STEINBERG (136TH): Perhaps you can answer this and perhaps this is a better question, counsel, have there been any legal actions filed against the City of Hartford for taking this action, claiming some sort of disadvantage?

WILDALIZ BERMUDEZ: There certainly have been folks who have been very opposed to the ordinance. But again, in terms of the exact legal standing, I will certainly get back to this committee so that you can have a direct answer from our corporation counsel’s office.

REP. STEINBERG (136TH): Thank you for that. Are there comments? Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. I’d just like to make a comment because I’ve heard it not just with you, I’ve heard it quite a few times tonight about names being so close. Another hat that I wear is with the nonprofit. And there are plenty of times, I work with the Fairfield Community Foundation and I work with the Fairfield Foundation. I work with the Greater New Hartford Foundation, I mean, New Haven Foundation and I work with the New Haven Foundation. So, to me, you know, there’s in every type of industry, business, whatever, there’s names that are close.

So, I’ve heard that a lot tonight, again, not just from you, but I just wanted to make that point. That’s just not in this arena, that’s everywhere.

WILDALIZ BERMUDEZ: Thank you.
REP. STEINBERG (136TH): Any comments or questions? If not, thank you for your testimony here today.

WILDALIZ BERMUDEZ: Thank you.

REP. STEINBERG (136TH): Next up is Susan Okamoto, I believe.

SUSAN OKAMOTO: What struck me most about this bill when I read it was the narrow focus, which I guess people are saying that’s a good thing, but it’s, there must be an awful lot of bills out there, a lot of pieces of legislation that are really maybe unnecessary if bills focus this narrowly. By the definition giving, and it seemed to me to be biased, toward limited service pregnancy centers; by the definition given in the bill, the two missing services that render a pregnancy services center limited are abortion and contraception.

The fact that well organized and well-funded pro-abortion organizations, such as NARAL and Planned Parenthood are systematically trying to harass these limited services pregnancy centers through legislation and the courts across the nation and are behind this particular bill in Connecticut, makes one wonder how interested they are in the good of women or in safeguarding the abortion industry from those who would reduce the number of abortions by focusing on real care of women during pregnancy and after birth.

Pregnancy is the success outcome biologically speaking of sexual intercourse. And I object to definitions that consider contraception and abortion as somehow part of giving care related to pregnancy.
Also, false advertising, as it’s been pointed out, is already prohibited by laws in Connecticut. And there aren’t complaints under these laws about pregnancy centers. So, I don’t see why you need this law.

Third, because please consider that these limited services pregnancy centers operate without any state or federal money, they are funded solely by donations, when there are so many pressing problems in Connecticut, particularly when it comes to money matters, the budget, why would Connecticut legislators make it difficult for these limited services pregnancy centers that really help women?

Fourth, I’ve heard many women say that had an abortion because they felt they had no choice. Limited services pregnancy centers not only offer choices other than abortion; they help the women throughout the process and afterwards. I’ve never heard a woman who chose to bear her child after an unplanned pregnancy say that she regretted this choice, including when the child is disabled.

I’ve heard the testimony of plenty of women who do regret having an abortion. In some cases, unconsciously suppressing the regret for years.

So, why make it difficult for these pregnancy care centers? I’ll end on that. I’m confident you will do the right thing in letting this bill die in Connecticut. Thank you.

SENATOR LESSER (9TH): Thank you for your testimony. Other questions from members of the committee? If not, thank you. Next up we have Lorri Valle, followed by Peter Schwartz. Good evening, Lorri.
LORRI VALLE: My name is Lorri Valle, and I’m an RN BSN, I’ve been a nurse for over 20 years. I’m trained in Ob-Gyn for 20 years. I’ve worked in the NICU, I’ve worked in organizations both in the hospital and outside of the hospital. And at this present time, I am employed by a pregnancy, crisis pregnancy center. I drive a mobile van, which is 9 feet by 25 feet and it clearly says on the side of it, free pregnancy tests and on-site ultrasounds. I am cross-trained as a nurse, who does limited obstetric ultrasounds. And in all of those, not one time have I deceived by language or by documents that our patient’s sign, other than that we do not refer for nor do we perform abortions.

Every one of our documents that we ask our clients to either fill out or sign, clearly states each one of those points. When the young ladies come on into our center or in our van, they are given all of their options. And as a clinical nurse manager, I can tell you that the training of my advocates is most important annually that they understand that all of that information is to be given by the medical director, myself, because we have the education to give them that information.

Our advocates do not give them the information that is medical. They give them information which has to do with post-abortive recovery or that they have for, for adoptions or that they have for any other part that they ask for. And on our website, it clearly states what we do and do not do as a limited scope.

SENATOR LESSER (9TH): Thank you for your testimony. Are there questions from members of the committee? Yes, Representative Michel.
REP. MICHEL (146TH): Thank you, Senator Lesser. Thank you for your testifying. Thank you for not being deceptive in your advertising. But just to remind the members of the public, the bill is about and is pointing towards or really purposely directed at those that are being deceptive. Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? If not, thank you for your testimony. Next up we have Peter Schwartz, followed by David Reynolds.

PETER SCHWARTZ: Good evening, committee members.

SENATOR LESSER (9TH): Good evening.

PETER SCHWARTZ: Thank you for your courtesy and your endurance today. My name is Peter Schwartz, I’m a resident of West Hartford and I’ve also been a practicing attorney for almost 35 years. First, my opposition to this bill is not grounded in my views on the rightness or wrongness of abortion. I acknowledge, we live in a pluralistic society and there are many views on this. But those views really should not overtake a discussion of the reasons why this bill is a very bad idea.

Unlike many who advocate for this bill, I have had first-hand experience as a volunteer at a pregnancy care center. Not once in all of my time at this center have I seen anything remotely resembling a deceptive practice. The women and men who visit the center are treated respectfully and compassionately and most importantly, for this bill, honestly, and seem to deeply appreciate the care and support they receive.
For as long as I can remember, a consistent criticism of so-called pro-life advocates, is that they strongly oppose abortion but then don’t have any concern and offer no support for women once they have their children.

Pregnancy care centers are a beautiful and effective response to that concern and should be supported and applauded rather than face legislation unfairly aimed at them. The women, many of them quite poor, who I’ve seen at the center, are provided emotional material and if they want it, spiritual support. And I personally handed out diapers, infant clothing and formula to these families and there has been nothing deceptive about it.

Speaking now just as a lawyer, I recall the basic legislative principle that a law should never be passed that is just not necessary and this is that case. This bill is a solution in search of a problem.

At minimum, I urge the committee members to responsibly investigate the claims that have inspired this bill. And if you do so, you will find no basis for it. On this score, I do note the title of the bill, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS. The goal by its very title has skipped past an appropriate due diligence, and based on nothing more than anecdotes, caricatures and what maybe unconscious or maybe even conscious bias, states the conclusion that is false and unfair.

The proposed legislation also appears to me to be very much at odds with the June Supreme Court holding in Becerra, which struck down a California
law, which was similarly aimed at pregnancy care centers. Here, as in Becerra, the proposed legislation singles out pregnancy care centers on the flimsiest of grounds and has the affect of discriminating against the centers based on their constitutionally protected views.

And if I could just say one more thing. I read this case yesterday, and I noted with interest, Justice Kennedy’s separate concurring opinion very short. And he points out, this separate writing seeks to underscore that the apparent viewpoint discrimination here is a matter of serious constitutional concern. And he goes on to say that the history of the act’s passage and its underinclusive applications suggests a real possibility that these individuals were targeted because of their beliefs. And I think that is a real cautionary note for this panel.

Thank you for your attention.

SENATOR LESSER (9TH): Thank you, Mr. Schwartz. And Mr. Schwartz, the, the case, and I asked the same question of Attorney General Tong, many, many hours ago, when he was before the committee. But I think he sort of pointed to a major difference I that that case involved the issue of compelled speech and that does not seem to be an issue in this case, unless I’m missing something. Is there any --

PETER SCHWARTZ: No, I think that’s --

SENATOR LESSER (9TH): -- in this case?

PETER SCHWARTZ: -- that’s fair. And the basis of the Becerra case, they really were working on First Amendment grounds, in that case, based on forced
speech, which is why I pointed to Justice Kennedy’s concern, which was a different one. And he made the point that he didn’t really need to reach this point because the case had been decided on First Amendment grounds but was very concerned about the other aspect of it, which seemed to be viewpoint discrimination, which I would suggest this is as well.

SENATOR LESSER (9TH): So, thank you for that. And, and so you wouldn’t dispute the Attorney General’s characterization that this proposal before us, whether you agree with it or you disagree with it, doesn’t seem to conflict with a central holding of the Nifla case with regard to compelled speech?

PETER SCHWARTZ: I don’t know that I would agree with that. I would agree that it’s different. But I, I think that at the end of the day, the Supreme Court’s primary concern was that the pregnancy care centers in that case were being singled out for treatment that didn’t apply to any other businesses that were very similarly situated. And I think that’s the case here.

SENATOR LESSER (9TH): And as a practicing attorney in Connecticut, I’m also, I’m sure you’re also familiar with the Connecticut Unfair Trade Practices Act?

PETER SCHWARTZ: I am.

SENATOR LESSER (9TH): Please speak broadly to what that act does and what similar legislation with regard to trade practices does?
PETER SCHWARTZ: I’m certainly not an expert on that act or CUTPA as it’s sometimes referred to, and so I would, I would punt on that one.

SENATOR LESSER (9TH): Do you know whether or not that act limits unfair deceptive trade practices in general, whether you think about a hotdog stand or any other business operating as well?

PETER SCHWARTZ: I know that it is designed to do that and that being the case, maybe that’s enough.

SENATOR LESSER (9TH): Thank you very much. Are there questions from members of the committee? If not, thank you very much. Next up we have David Reynolds, followed by Susan Baker. Good evening, Mr. Reynolds.

DAVID REYNOLDS: Members of the committee, thank you for having me here tonight after long hours. My name’s David Reynolds. I’m Chairman of the Two Hearts Pregnancy Care Center in Torrington, Connecticut. We opened our doors in 2012 and we’ve been helping woman within the Torrington area for those many years. In fact, I’m deviating from my prepared testimony, but I did attach some informational sheets to my testimony that was submitted. One is our 2018 statistics and how many women served, 209, and the supplies that was given out to those women, not listed on that sheet is, of course, the emotional support and other types of support we give. Also attached is our brochure. And our brochure reflects our advertising and there’s a clear disclaimer in that brochure that says we do not provide any abortion services or birth control services.
There’s a couple of things as I deviate from my written testimony that I’d like to address. One, the comments that I’ve heard this evening and this morning is that as Chairman of the Board of the center, we have never met with other pregnancy care centers to plan out how to deny women access to abortion services. Those conversations just do not take place. That’s another deceptive comment that is made by the advocates of this. I’ve been in this for many years and I’ve never once had a meeting between myself and any other members of the clinics, pregnancy care clinics in the State of Connecticut for that. Also, there’s this new term that’s starting to come up, primarily from NARAL, talking about religiously-based counseling. Our centers don’t give religiously-based counseling.

If a girl or a woman comes in and starts talking about she’s having a conflict of faith or something like that, we talk to her about it. Our center’s focus, and I talk about Two Hearts and all the other centers I am very familiar with, focus on servicing the women. Meeting here where she is at when she comes through that door.

So, we don’t have any service called religiously-based counseling, and I’m not, and as far as I’m aware, no other centers do. Also, in terms of this bill targeting particular centers, we are targeted by NARAL as a fake clinic, as were all other pregnancy care centers, even though we do not provide any medical services at all. It was a shot-gun approach. Every real clinic provides abortion services. Every fake clinic doesn’t provide abortion services. Abortion is the hin-ping of the, a lynchpin of this, this bill, and I believe what
the previous lawyer talked about, I had that mentioned in here, that this bill is viewpoint discrimination aimed just at one thing. And one more thing, Senator, I’ll wrap it up. Also, please, we talk a lot about he said, she said claims or evidence. I would like to point this committee to three legal cases, one Nifla case, where in that they ruled that California didn’t demonstrate any justification because most of the complaints were purely hypothetical. That statement was released, repeated again in a 2016 Baltimore, Maryland US District Court case. They said also that there is insufficient evidence to demonstrate deception takes place. Baltimore had to pay $1.1-million dollars back to the pregnancy care centers for legal fees. And I’ll wrap up with more court case. Again, Montgomery County, Maryland, the record produced by defenders is simply insufficient to sustain a regulation and it goes on to talk about absolutely no evidence of any type of comments or things happening that were being stated by their proponents. In those cases, NARAL was involved in all those four cases.

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

SUSAN BAKER: Good evening, thank you for your perseverance in this. I’m Susan Baker. I am a resident of Mystic and I am the nurse manager at Care Net Pregnancy Resource Center, in New London. I’ve been there for over six years. I have been working with pregnant woman all of this time, of course, there. And they have told me some awful
stories of lies and deception, but none of those involved a pregnancy center. I’d like to tell you two of the most recent stories.

If you go to plannedparenthood.org, there’s a list of pregnancy services they provide, including prenatal care. But a client who came to us found out they don’t. She called her local Planned Parenthood and told them she wanted to schedule an appointment for prenatal care. They scheduled her an appointment without telling her they did not provide prenatal care. Thus, delaying her getting the care she needed. When she arrived, she told them she was there for her prenatal appointment. And they took her insurance information, but still didn’t tell her they don’t provide prenatal care.

It wasn’t until they put her in an exam room that someone finally told her they don’t provide that and proceeded to shame and humiliate her by telling her, she couldn’t possibly raise a child and pressured her by insisting that her only option was abortion. And they refused to acknowledge the validity of the option she said she wanted to choose. If anyone calls our center to schedule an appointment for a service we don’t provide, we tell them immediately that we don’t provide that. And we let them know what services we have to offer.

While we were here, since we were talking about Google searches, I did a Google search for prenatal care, and Planned Parenthood is on the first page there. But there isn’t any Planned Parenthood in Connecticut that provides prenatal care. How is that not deceptive?
And if you click on the site, it goes to a lot of information about prenatal care and it doesn’t say anything about them not providing it. Another client who came to us said she’d made an appointment with Planned Parenthood because she needed a written verification of her pregnancy from a medical professional so she could get insurance for prenatal care. They made the appointment, but when she was put in the exam room, the person who came in, again, tried to shame and humiliate her and pressure her by telling her she was in no, no way could she raise a child. And the only option she should be considering is abortion. Then they told her they would only help her get insurance so they could perform an abortion, that’s when she came to us. We gave her a verification of pregnancy without regard to what services she intended to use it for.

We treat all our clients with compassion, respect and professionalism. We’re supportive of whatever choice they make. The bill says that the definition of a limited services pregnancy center is they do not provide referrals for abortions or emergency contraceptives, that’s the only definition.

If they’re talking about wanting to help women, then they need to look at all aspects of this care. It is targeting just pregnancy centers.

SENIOR LESSER (9TH): Thank you for your testimony. Other questions from members of this committee?

Yes, Representative.

REP. ZUPKUS (89TH): Thank you. I just have a question. This is about the third time I’ve heard about prenatal care --

SUSAN BAKER: Uh-huh.-
REP. ZUPKUS (89TH): -- and Planned Parenthood. I’m curious as if you think we should expand it to cover that? Do you think that --

SUSAN BAKER: I don’t know, do you think that? It’s targeting pregnancy centers because they don’t provide abortions. They’re saying that our services are limited, their services are too limited.

REP. ZUPKUS (89TH): And if we’re talking about deceptive advertising --

SUSAN BAKER: Is that not deceptive?

REP. ZUPKUS (89TH): -- we have to look at the whole picture.

SUSAN BAKER: Weren’t those deceptive practices when they told, made an appointment for prenatal care that they don’t provide?

REP. ZUPKUS (89TH): Thank you. Okay.

SENATOR LESSER (9TH): Thank you. Are there other questions?

SUSAN BAKER: Can answer a question? There was a question earlier about doing ultrasounds and ectopics, looking for ectopics; did you want me to clarify that because that’s what I do.

SENATOR LESSER (9TH): There’s a question from a member of the committee.

SUSAN BAKER: Earlier --

SENATOR LESSER (9TH): That, no, thank you very much and appreciate your testimony here today.

SUSAN BAKER: Yep.

JEREMY BRADLEY: Good evening, my name is Jeremy Bradley. I am the Executive Director of Caring Families Pregnancy Services, and we’re stationed in Willimantic, Connecticut. We have been serving women and their families since 1986.

Caring Families operates the women’s center of Eastern Connecticut in Willimantic, as well as the mobile care van that travels around the state.

My testimony, I pointed out a few things, and you have that to look at. You can see some of the great and amazing things that we’ve been able to do since 1986. But I think as I oppose this bill, it’s important to point out a couple reasons why I so strongly oppose this bill.

The first reason is probably the most obvious that we talked about this bill last year. And since that time, there’s really, nothing has happened. I invited everyone here at that committee to take a chance to visit these pregnancy centers, engage the pregnancy centers and that didn’t happen. We’re working on creating a bill about deceptive advertising pregnancy centers for having conversations about deceptive practices. We’re admitting that there’s good actors and bad actors. But none of those good actors have ever been contacted. We’ve never been consulted as this bills been putting forward and that’s really disheartening because we’re saying we’re putting this nonbiased thing together and it doesn’t seem to be the case.

The bill clearly targets pregnancy centers and the definitions in that bill do make it very clear that
abortion is definitely the issue in which deceptive advertising would be regulated.

I think we also have come to understand that the problem of trying to define what deceptive advertising is kind of vague. We’ve heard this idea of what is pornography, well, I don’t know if I see it, you know, then we’ll know. And it’s kind of like the same thing that we’re seeing here with deceptive advertising, nobody really knows what it is. When asked, can you give me an example of a specific center here in Connecticut that’s done something specifically deceptive, I’ll get back to you. I’ll get back to you. I’ll get back to you.

The same question was raised last year and there were promises of getting back to the mayor and we’re still waiting. And maybe 2020, not to be kind of, you know, crass, but maybe we’ll be waiting there for more answers. The reality is that there hasn’t been any cases of deceptive advertising come before the pregnancy centers here in the State of Connecticut.

We’ve also noticed though, however, some of the Google searches. A lot of conversations about Google that’s been going on. I don’t think there’s a real understanding of what Google does and how Google works. One of the things I would love to be talk about, if you give me another 30 seconds, is the last problem of this bill is, has to do what I believe is going to be continued harassment and attacks. You can see in my testimony; I submitted a tweet from the NARAL feed. And you can all see some of the things that they’ve said about my organization. And all those things can be reputed.
You can ask me a question and I’ll tell you exactly why everything in there is false.

But this is disparaging to our organization, it’s making claims that our, that we’re molesting women because, because we operate a van. I mean, this is really a terrible thing, and I’m a little worked up about it because it hasn’t been addressed her by the committee.

SENATOR LESSER (9TH): Thank you for your testimony. You said, I think at the beginning of your testimony, that you thought that there were good actors and bad actors in the field. Do I understand you correctly or --

JEREMY BRADLEY: Those are your words.

SENATOR LESSER (9TH): Oh --

JEREMY BRADLEY: I’m saying if you believe there are good actors, none of those good actors have ever been approached to be a part of this conversation as we’re forming bills about advertising in regards to pregnancy centers.

SENATOR LESSER (9TH): Thank you. Are there questions from members of the committee?

REP. STEINBERG (136TH): Yes.

SENATOR LESSER (9TH): Mr. Chair.

REP. STEINBERG (136TH): I would, I just want to clarify the last point you made. The entire purpose of a public hearing is to bring all the interested parties and stakeholders together to have this conversation. So, we appreciate everybody who is here, who represents, as we’ve said, the good actors. And that is exactly the process that we
choose to follow. So, I would rather have you focus on the fact that this is an opportunity today and there are future opportunities to have an impact on any final legislation we may go forward with. And it was not intended to represent only one point of view.

JEREMY BRADLEY: Well, that, that’s great, I’m glad to hear that. However, this bill came up last year and not a lot’s changed over the years, over the past year. So, there have been a lot of conversations that have happened about this bill that have not been in this room today. And that’s the point I’m making, is all those conversations that have been had about this bill over the last however months, these pregnancy care centers have not been included or been part of that conversation, where it’s obvious they ought to be.

SENATOR LESSER (9TH): Thank you. Representative Michel.

REP. MICHEL (146TH): Thank you, Senator Lesser. Thank you for your testimony. I just wanted to bring up a point that I don’t think anybody in this committee, and I’ve talked to many members of the committee, is like really going after the issue of anti-abortion, pro-abortion, really, really honestly. And I think that if there are bad players out there, they wouldn’t make the good players look bad. I think they would, they could, you know, potentially do bad publicity. And we’re only, once again, going or looking to protect women who are facing difficult decisions. And we’re making sure that the language or the publicity used by potential bad players was not, not deceptive.
So, we’re just trying to make sure that, I just want to say, we’re not going after the abortion issue.

JEREMY BRADLEY: Well, you bring up a great point as to what you were saying. You actually, my, my registered nurse who operates our mobile care van was up here and you congratulated her that we are upstanding and that we, we’re doing everything. However, if you take a look at the testimony that I shared, these tweets are saying a completely different story. And so if you take a look at it, we’re being told that we’re lying. We’re told that we have a sketchy van. We’re told that the stranger danger involved in these vans. We’re told that fake women’s health centers are, are hindering access to medical care. We’re also told that because of the locations and the partnerships we formed in the community with like Access Agency and WIC offices, that somehow those partnerships are deceptive. And this is important because part of this conversation, NARAL has really appointed themselves to be the pregnancy regulators and their the ones that are bringing all these accusations. So, when we hear this bill with, with said to have good intentions, but this is the same bill that’s been presented with NARAL’s involvement through different parts of the country and here in the state, it’s, it makes complete sense for us to take a look and see what NARAL really thinks they think is deceptive for us to kind of understand where this conversation’s gonna be going in the next weeks and months ahead.

REP. MICHEL (146TH): Sure. But NARAL is not who’s, who’s working on the bill. And nobody is talking such ways here. And this is why there’s a public
hearing so everybody can voice their opinions. I, I, you know --

JEREMY BRADLEY: I would, I would just suggest that if you were able to take a look at those who are submitting testimony here today, that aren’t with NARAL or have been organized in some way to be here by NARAL, that would definitely cut the numbers back. And I’m not being critical of that, that’s just the reality that there is political involvement on this part of the bill, so we can’t ignore that.

REP. MICHEL (146TH): It seems that both sides are working on it. Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? Oh, yes.

REP. MCCARTY (38TH): Sorry, thank you, Mr. Chair. Could you just reiterate for my self-edification, the name of your center and who was making those attacks on your center?

JEREMY BRADLEY: Okay. So, the name of my organization, that’s our LLC, if you will, is Caring Families Pregnancy Services. We operate the mobile care van that travels throughout the State of Connecticut. And what we do with a mobile care van is we provide ultrasounds, pregnancy tests and community referrals. This is what’s on our website. This is what we do on the van. Our website states, again, not because we’re compelled to by the state, but just out of, just courtesy and a realism that we do not provide or refer for abortions.

So, the services that we provide are the services that we provide. NARAL Pro-Choice Connecticut in a
tweet, in a feed last week, took some pictures of the van asking people to grain the van, which means they want to take pictures of this van, put it all over Instagram and honestly, I’m a little cautious because of seeing what happened in Virginia, where the van, where pregnancy centers were vandalized with fake clinics. They’re using that same language here, when they’re critiquing my van. And I’m not saying that NARAL would do that, but it’s a concern because this is what I’m seeing happening and it’s, it's not true.

So, again NARAL’s never contacted me to see what kinds of services we’re providing on our van. They’ve never asked us. So, that’s kind of an issue too that there’s all these assumptions that these things are happening, but there’s never been a conversation and never been a discussion about what’s happening and we’re just playing sides.

At this point though, as you can see in that feed, that’s, that’s over the line. And I will be looking at some, somethings that we can take a look at here to the state and other legal actions on that because we can’t have organizations who are non-profits, who raise all their funds by private donors be treated like that.

REP. MCCARTY (38TH): Thank you.

SENATOR LESSER (9TH): Thank you, Representative McCarty. Are there other questions from members of the committee? If not, thank you for your testimony, Mr. Bradley. Following, we have Trudy Higgins and after her, Paul Knag.

TRUDY HIGGINS: Good evening, honorable and esteemed members of the Public Health Committee. Thank you
for the opportunity to speak with you this evening. My name is Trudy Higgins, and I am testifying in opposition to H.B. 7070. I’m vehemently opposed to this bill because it falsely describes a pregnancy services center. I currently serve as a volunteer at Carolyn’s Place in Waterbury. This bill suggests that our center has the appearance of a medical facility and that staff or volunteers wear medical attire and uniforms. That is absolutely not the case at all.

The bill also states that a pregnancy services center has a private or semi-private room containing medical supplies or medical instruments. I can assure you that no such room exists at Carolyn’s Place. And we are certainly not located on the same premises as a licensed healthcare facility. We have never engaged in any false, misleading or deceptive advertising. We are very clear in our publications that we exist to empower individuals through education and support and thereby, helping women decide what is best for them and their babies.

We provide free, confidential pregnancy testing, a 24-hour phoneline, childbirth preparation classes, parenting classes and emotional support. And our support is not time limited. It’s rather offered for as long as needed. All of our services are free and strictly confidential.

Therefore, I urge you to oppose H.B. 7070, and vote no on this bill. And I appreciate your consideration.

Thank you.
SENATOR LESSER (9TH): Thank you, Ms. Higgins. Are there questions from members of the committee? Yes, Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Thank you for coming up today. I was, as these conversations have been taking place, I was thinking of Carolyn’s Place because it’s close to where I represent, close to my district and actually there, and I do know the great work that they do. And as you stated, I don’t see them as medical clinic, what, in no stretch of the imagination.

TRUDY HIGGINS: You are 100 percent correct there.

REP. ZUPKUS (89TH): I also know that Carolyn’s Place does do, just a minute, I’ll wrap up. Carolyn’s Place does do, I’ve lost my wording, help with women that have abortions after they have an abortion, they can come back and get help from Carolyn’s Place.

TRUDY HIGGINS: Absolutely. We are all about the women and what’s best for them. So, if someone has had an abortion, and they’re feeling the need to speak with someone afterwards for whatever reason, we provide that for them, absolutely.

REP. ZUPKUS (89TH): Thank you. Thank you very much.

SENATOR LESSER (9TH): Thank you. Other questions from members of the committee? If not, you’re done, thank you.

TRUDY HIGGINS: Thank you.

SENATOR LESSER (9TH): Mr. Knag, followed by Liz Gustafson.
PAUL KNAG: Thank you. My name is Paul Knag, and I’m an attorney and I am here to oppose the bill which would single out crisis pregnancy centers for treatment under unfair trade practices. I have frequently litigated cases involving claims by me on behalf of clients that there have been deceptive practices, that there have been unfair trade practices. That’s CUTPA. CUTPA applies to any unfair trade practices that might be committed by pregnancy centers, it might be committed by abortion clinics or it might be committed by others involving trade or commerce.

So, it’s not necessary to have a bill that singles out one particular type of service for special treatment. The CUTPA law is, is broad and should be the vehicle that’s utilized. But what bothers me here is that a number of years ago my wife was the President of Stamford Birth Right. And at that time, Stamford Birth Right would provide various services. It would, we took a lady into our house because she had been kicked out of her house and she had no place to live. And we housed that person, we provided clothing, we provided other need, for other needs of these ladies. We provided counseling. We provided referrals to community resources. Everybody understood that Birth Right was not a place where you went to get an abortion.

And at that time it was replacing what had been there, which before abortion, there were major services that provided help for women that were pregnant and provided for their needs to have the baby. Now, those services have dissipated and these volunteer agencies with limited resources are left to try to fill the gap. And I don’t understand why
suddenly they’ve become a target of NARAL and the other pro-choice advocates because if you’re in favor of choice, that should mean that you are not opposed to having a lady have the opportunity to find out what her options are, if she doesn’t want an abortion as well as her option if she does want an abortion.

So, I say, don’t single out these wonderful caring volunteers, who don’t have money to be fighting with the Attorney General in court. Instead, if there are unfair trade practices, rely on the law of general applicability that we have had in effect for many years.

SENATOR LESSER (9TH): Thank you, Mr. Knag for your testimony. Just one quick legal question and you are a lawyer and I’m not, but you mentioned CUTPA as I asked a similar question of Attorney Schwartz a few minutes ago. My understanding is the reason, one of the things that came up, I think, in last year’s hearing, member of the committee at the time, was that CUTPA relies on a commercial relationship. Is that something that you think exists in this case?

PAUL KNAG: Yes. The question is, is it trade or commerce, as defined in, as defined in CUTPA. And Mr. Langer, Bob Langer, my friend, wrote a treatise on what CUTPA means and recites the definition. It just means that you’re putting goods or services into distribution. It doesn’t have to be for pay. It can be provided for free. These circumstances are, the reach of CUTPA is very broad and clearly applies in this case. And also would apply to the abortion clinics or anybody, any other entities that
we’re trying to provide goods or services in this segment.

SENATOR LESSER (9TH): Thank you. And I think Mr. Langer should be in a position to know, since he helped write the laws, my understanding. So, it’s your understanding, just be very clear, you think that if a, if a limited services pregnancy center or any other entity engage in false or deceptive marketing today, they could be subject to litigation or prosecution under CUTPA?

PAUL KNAG: Right. Without any, without any new laws that single them out for special condemnation.

SENATOR LESSER (9TH): Thank you very much for your testimony. Other questions of members of the committee? Thank you very much. Liz Gustafson, followed by Dr. Daniel O’Neil.

LIZ GUSTAFSON: Hello. Senator Abrams, Representative Steinberg and distinguished members of the Public Health Committee, my name is Liz Gustafson, and I’m the organizer and volunteer coordinator, which I do want to add, includes overseeing the clinic escort program to protect the safety of patients and providers because their lives have also been threatened. And I’m here because I testify in strong support of H.B. 7070.

My predecessor oversaw a volunteer program to study the practices of fake women’s health centers and documented specific cases of deception with medical providers and their patients who had been deceived, misled and delayed by the practices of fake women’s health centers in the state. Building on a series of a 22 in-person investigation from 2015, and completing an additional five visits in 2017,
NARAL’s staff and volunteer team studied the practices of these pregnancy centers through website analysis, phone surveys and in-person visits.

From the research conducted, it is clear that there is a wide range of practices by pregnancy centers in our state. Since the release of this original report on crisis pregnancy centers in 2015, it is clear that some pregnancy centers are now forthright about their anti-abortion stance and the services truly available at their centers. Clearly, public pressure has had an influence on some of these centers to be truthful in their advertising.

Unfortunately, however, it is documented that other fake women’s health centers are intentionally confusing and deceptive about what they offer. And there’s extensive documentation with patients and doctors on the harm that has resulted from this deception. From some of the patients and the volunteer visits conducted, it was not made clear to them through the advertisement, signage, phone calls or even in-person visits, what services were available. Advertisements say, pregnant, you have choices, we can help. Thinking about abortion, CareNet is your first step. Your option, adopting, parenting, abortion. Thinking about abortion, first things first. When, in reality, none of these centers actually offer abortion.

Delaying access to a full range of reproductive healthcare services is a threat to an individual’s health and a threat to public health. As someone who has had an abortion and who made a decision to choose a medication abortion, which is only offered up to 10 weeks, the time-sensitive nature of receiving this procedure, I wanted and needed and do
not regret, highlights the importance of knowing where one could go to receive this care.

My experience is not one that everyone has. And my privilege of knowing what some centers offer and what others do not, provides an important reminder of why this bill needs to be passed.

There are clear cases of deception that are happening in this state, such as the one that Sarah Croucher touched on earlier about the emergency room in Hartford and so a full report on fake women’s health centers is available on NARAL Pro-Choice Connecticut’s website.

SENATOR LESSER (9TH): Thank you, Ms. Gustafson for your testimony. Are there questions from members of the committee? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chair. I’m just curious, what’s your motivation for, for testifying and doing this? I believe it takes a lot of courage and I’d just be interested in why you are doing this?

LIZ GUSTAFSON: Well, it is my constitutional right to have an abortion. And I’m also very privileged in being educated on, you know, where I could go to receive this care and know that I will be given all my options. And so, I am very passionate about this because it’s the right of every person who wants to seek the same care to be able to do so.

REP. HENNESSY (127TH): Okay. Thank you for your testimony.

LIZ GUSTAFSON: Thank you.

REP. HENNESSY (127TH): Thank you, Mr. Chair.
SENATOR LESSER (9TH): Thank you, Representative Michel.

REP. MICHEL (146TH): I’m sorry, I was trying to take notes. But thank you for testifying and thank you, Senator Lesser. Do you have, did you mention a couple of examples and I was trying to take notes, of deceptive --

LIZ GUSTAFSON: Yes. So, for example, I mentioned, I do oversee the volunteer clinic escort program, which are clinic escorts that come and, you know, help out at the Hartford GYN Center and up to last week, they’re still given, pregnant, need help, you know, little handouts, still on Saturdays when they have anti-choice protesters outside of the clinic.

REP. MICHEL (146TH): Okay. Thank you.

LIZ GUSTAFSON: And there’s also a lot more of those on our full report online.

REP. MICHEL (146TH): And that’s on NARAL Pro-Choice, go ahead, I’m sorry.

LIZ GUSTAFSON: prochoicect.org, and my full testimony I submitted there are excerpts from the research conducted.

REP. MICHEL (146TH): Thank you very much.

LIZ GUSTAFSON: Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? If not, thank you, Ms. Gustafson for your testimony.

LIZ GUSTAFSON: Thank you.

DANIEL O’NEILL: Thank you, Senators and Representatives. I appreciate your tenacity. I’m a Medical Director at ABC Women’s Center in Middletown and also Caring Families in Willimantic. And I’m writing in opposition to H.B. 7070, because it’s severely prejudiced and it’s a deliberate effort to suppress freedom of speech. The two centers, which I’m Medical Director, work under my license in the State of Connecticut. And it’s an extension of my practice. We provide pregnancy testing and neonatal ultrasound, which the State of Connecticut has given us permission to do.

We staff licensed medical professionals who are certified and trained in the services that they provide. According to the American College of Ob-Gyn Association of Women’s Health, Obstetric and Neonatal Nursing Association Guidelines, each of these, in each case that we provide ultrasound services in a legitimate medical indication to perform the ultrasound. Our policies and procedures reflect the highest medical, legal and ethical standards and conform to the laws of the State of Connecticut.

The information we provide is evidence-based and I ensure that it includes all options, including abortion. And we support women, regardless of the decision about the pregnancy. Our centers do not advertise any services other than the ones we provide.
So, H.B. 7070, 7070 contains false presuppositions starting with the title of the bill, that has already been mentioned, which categorically assumes that limited services pregnancy centers practice deceptive advertising. It also unfairly seeks to set a definition of limited services, as only those who do not provide service or refer. So, the bill should be rejected because of its prejudiced and discriminatory content. We already heard about testimony from Attorney Knag about CUTPA. CUTPA clearly is a violation that can be prosecuted in the State of Connecticut and for these centers as well. H.B. 7070, by the way, has the recent NARAL defamatory campaigns, that included recent targeted twitter feeds that Jeremy had mentioned, accusing our centers of deceptive practices in order for them to deceive and manipulate public opinion.

This itself is a violation of CUTPA, § 42-110b-18 (g), which basically states that it is an unfair or deceptive act or practice to “Disparage another's merchandise, services, or business by false or misleading representation of facts.”

There is no reason to pass H.B 7070, other than to succumb to the intimidating manipulations of pro-abortion advocates who want to limit free speech of citizens and licensed professionals who wish to speak a different narrative than the abortion solution for women and men faced with pregnancy-related issues.

So, I urge the committee, and one other thing to mention is that the definition put forth in Section 1 of H.B. 7070, 17, does not even use the core content of the proposed bill. So, there’s a lot of definitions put out, but it doesn’t actually enter
into Section 2, which is the core content of the bill. So, what’s the point of creating these definitions through legislation when, in fact, it has nothing to do with the proposed bill.

SENATOR LESSER (9TH): Thank you for your testimony.

DANIEL O’NEILL: Thank you.

SENATOR LESSER (9TH): Doctor, thank you. You mentioned, you mentioned that the medical professionals under your supervision perform ultrasound for the purpose of pregnancy verification. Is that the standard way of, in medical context? I assume you’re a medical doctor. Is that the standard way of determining if a person is pregnant?

DANIEL O’NEILL: Well, the standard way is a urine pregnancy test, followed by a limited first trimester, but it could be other trimester’s ultrasound to determine fetal viability and intrauterine of pregnancy in dating.

SENATOR LESSER (9TH): So, the medical professionals under your supervision, what kinds of services do they determine, do they perform while observing the ultrasound? Are they able to, for example, detect an ectopic pregnancy or other pregnancy --

DANIEL O’NEILL: If there’s a positive pregnancy test and there’s no intrauterine pregnancy detected, there’s a concern about ectopic pregnancy and that’s brought up and there’s a policy and procedure that then refers the client for care and services, if we cannot verify an intrauterine pregnancy.
SENATOR LESSER (9TH): And it’s within their scope to be able to determine whether or not a pregnancy is ectopic?

DANIEL O’NEILL: It’s within their scope to determine if there’s a viable intrauterine pregnancy, yes.

SENATOR LESSER (9TH): Thank you. Other questions from members of the committee? If not --

DANIEL O’NEILL: By the way, the ultrasonographer’s are DMS certified ultrasonographer’s and nurses that were trained to those standards of practice.

SENATOR LESSER (9TH): Thank you. Thank you, Doctor for your testimony. And up next we have Sally Grossman, after Sally, we have Deidra Hall.

SALLY GROSSMAN: Hi. My name is Sally Grossman, I’m from Windsor. I’m here to testify in favor of H.B. 7070. I’m currently a volunteer clinic escort at the Hartford GYN Center, which is women’s health clinic that also offers abortion services. Ten feet away from its entrance is a CPC called Hartford Women’s Center that was opened with the hopes of intercepting women on the way to their appointment at Hartford GYN Center and preventing them from terminating a pregnancy.

Many of the protesters outside the clinic are associated with the CPC. When patient’s approach me, asking me where the entrance to Hartford GYN Center is, protesters tell them not to listen to me and to go to the door on the left, meaning the entrance to the CPC.

When I inform patients that these people are protesters and that they don’t have to talk to them
if they don’t want to, the protesters tell patients that they aren’t protesters and that they, in fact, work at Hartford Women’s Center. Patients are often confused and scared and don’t know where to go to get to their actual appointment.

After the birth of my first child, I had an IUD implanted as my form of birth control. Nine months later I became pregnant. There is an increased risk of miscarriage and complications when you become pregnant with an IUD in place. Over the course of the next six weeks, I was in and out of my OB/GYN’s office were multiple ultrasounds were performed, as well as two failed attempts at removing the IUD. I was informed, due to information obtained through the multiple ultrasounds, that the fetus may not be viable. At twelve weeks, I went into the hospital to have the IUD removed while under sedation and I told the doctors that if the fetus wasn’t viable, I wanted the pregnancy terminated.

When I woke up from the procedure, I learned that the fetus had grown around the IUD and had no chance of life outside the womb, and that an abortion was performed. This was the day before my son’s first birthday. It was a pretty emotional and sad time in my life, but what made it bearable was the compassionate and timely care I received from medical professionals.

I was given medically sound advice from the beginning and I was able to make decisions, with the help of my doctors, that were in the best interest of me and my family.

The care I received should not be different than another woman in my position simply because my
OB/GYN’s office is not situated next door to a CPC. Each time I went to see my doctor, I was able to easily find the facility without being lured into a CPC under false pretenses.

I had multiple office visits where I spoke to my OB/GYN each and every time, had multiple ultrasounds that were performed by my doctor and I had a hospital procedure. None of the care would have been possible at a CPC.

I was able to make a decision based off medically sound information from actual doctors. I shouldn’t be special. Many of the women who go to Hartford GYN Center have never been there before and aren’t aware that a CPC is next door. No woman should be tricked into entering a facility, thinking it is a medical clinic, when it is not. And no woman should be lied to suit someone else’s religious agenda.

So, I urge you to vote in favor of H.B. 7070 to make sure the women of Connecticut are easily able to differentiate between a medical facility and a faith-based center.

Thank you.

SENATOR LESSER (9TH): Thank you for your testimony. Questions from members of the committee, Representative Michel.

REP. MICHEL (146TH): Thank you, Senator Lesser. Thank you for your testimony. I’m just gonna read something that was being given in the tunnel between the LOB, the legislators of this building and the capitol. And maybe you can let me know what you think, if you think this is deceptive. It was distributed by Care Net. So, I’m gonna read the
excerpt. We also offer information about abortion service and abortion alternatives, including adoption. If you are considering the possibility of an abortion and live in the New London town area or any of the surrounding communities, then please contact us first. We can provide you with a free pregnancy test to confirm your pregnancy and work with you as you navigate your options.

SALLY GROSSMAN: In my opinion, that would be deceptive.

REP. MICHEL (146TH): Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Any other questions from members of the committee? If not, thank you for your testimony. Up next is Deidra Hall, followed by Brian Hall.

DEIDRA HALL: Hello, distinguished members of the Public Health Committee. In 1865, slavery was outlawed. In 1870, African-Americans were given the right to vote. In 1920, women received the right to vote. America has always been the land of the free. But while we have not been the perfect nation, we have always taken steps in the right direction.

However, today we are being asked to take a step backwards, to become more discriminatory, not less. Bill 7070 has three important flaws. First, let’s look at the definition of limited services pregnancy center. This is defined as a pregnancy services center that does not provide referrals to clients for abortions or emergency contraception. This definition is saying that these centers and services are limited, unless they provide referrals to abortion facilities.
As I’ve stated before this hearing, it’s like telling Hillary Clinton that her services are limited without a referral to Donald Trump’s webpage, since she doesn’t provide a wall. Just because, just because some candidates or organizations don’t provide certain things, doesn’t mean that they must give their client’s referrals to organizations they don’t believe in.

The next problem we see is in Section 2 that says, limited services pregnancy centers cannot use false or misleading advertising. I agree that no one should use false and deceptive advertising, and since at least someone agrees with me, we have regulations in place that deal with this issue.

Connecticut Regulation 42-110b-18 already addresses this problem.

The final problem with this bill and arguably the most egregious is that the proposed bill is not content neutral, which is required by Supreme Court precedence. This bill applies to only one select group of organizations. For centuries, women were marginalized, looked down upon, and not allowed to have a say in the process of government.

Now, that we have a voice, instead of using it for the common good, we instead decide to use it to marginalize others. This bill is discriminating against these pregnancy resource centers simply because they have different beliefs.

In earlier testimony today, it was specifically stated that abortion providers were exempt, simply because they were not faith based. So, this bill has the purpose of specifically targeting faith-based organizations.
Getting back to my example earlier, if Hillary Clinton believes that a wall is unnecessary, she has the right to believe that. Even if I might not agree with her, she still has the right to believe what she wants. These centers are attempting to help women. And if we implement this bill, we are becoming what we hate. We are becoming the ones with discriminatory practices.

Since we already have a bill in place to deal with all organizations that may use discriminatory deceptive practices, why do we feel like we need this bill? The only reason is because there are those that don’t agree with these centers. They don’t want them to succeed. But committee members, we cannot discriminate against these pregnancy resource centers. We cannot become what we hate.

If we allow this bill to pass, we will become the people we are inevitably trying to stop, the people who feel like they have to manipulate others just to get their own way.

Committee members, let us use our laws that are already in place to keep women and men from being manipulated. Let us say no to this bill. We may never allow ourselves to believe it is all right to manipulate and stifle other’s freedoms with our law.

SENATOR LESSER (9TH): Thank you, Deidra. Other questions from members of this committee? Thank you very much. Have a good evening.

DEIDRA HALL: Thank you for your time.

SENATOR LESSER (9TH): Next up we’ll have Brian Hall, followed by Connor Hall.
BRIAN HALL: I’d like to thank you for your patience and endurance tonight. My name is Brian Hall, and Bill 7070 is about deception and that is what it is, very deceptive. It is deceptive because it infringes on the First Amendment right of Freedom of Speech. It is an attempt to compel speech and it is liable.

This proposed bill only, is only applicable to groups that do not provide referrals for abortions and; therefore, is intended to hamper a particular viewpoint, which does not meet the requirement of being content neutral, as established by Supreme Court in 1989 in the case Ward v. Rock against Racism.

Since this bill would not apply to pregnancy resource centers, PRCs, if they refer for abortions, this is exactly, this is actually a deceptive attempt to compel PRCs to refer clients for abortions. Compelled speech is unconstitutional, as established by the Supreme Court in 2018 in the case of NIFLA v. Xavier Becerra. This really affirms that government cannot force or intimidate anyone to express a message that violates their convictions.

This bill’s title is, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS. And the intent is to damage the reputation of PRCs. Libel is defined by Oxford Dictionary as, the action of damaging the good reputation of someone. Libel is illegal in Connecticut because it’s covered by Connecticut Code, Section 52-237.

NARAL made the following statement on their website, another important update from this week is that the proposed bill to limit the deceptive practices of
crisis pregnancy centers officially has a bill number, referring to a similar bill introduced last year.

NARAL is using bills like this one to claim that PRCs are deceptive. This is false and intended to damage the good reputation of PRCs.

I urge you to vote against this bill because it infringes on the First Amendment right of Freedom of Speech, is an attempt to compel speech and it is liable.

SENATOR LESSER (9TH): Thank you, Mr. Hall. Other questions from members of this committee? If not, thank you very much. Thank you for your testimony. Next up we have Connor Hall, followed by Marla Darius.

CONNOR HALL: I’d like to thank all of the members of the committee for staying up this late with us. We really do appreciate you wanting to hear both sides of the argument. I’d just like to thank you for that.

So, without further ado, I think that if there’s one thing that every single one of us can agree on today, it’s that the women of Connecticut deserve better.

According to Guttmacher Research Organization founded by Planned Parenthood, the top reasons for abortion is lack of money, interference with education, interference with their job or relationship problems. Now, women don’t deserve this. Women deserve financial peace. A good education, a well-paying job and people to love them.
Often society tells women in crisis pregnancy that they have a choice. Why must women choose between sacrificing their child and sacrificing the things that they value in life? Why can women not have both?

Pregnancy resource centers in the State of Connecticut are dedicated to giving women both. They do not falsely advertise as many claim. But even if they did, the regulation that’s already been discussed, CUTPA 42-110(b)18, already addresses misleading and false advertisements. In essence, there is no reason for this bill to exist because it’s stated purpose to limit deceptive advertising is already fulfilled.

Not only is the purpose of this bill already fulfilled by a prior law, the way which this bill attempts to enforce its purpose has two major problems. The first problem is targeting. This bill only regulates facilities that do not provide referrals for abortion. Because pregnancy centers believe that they should not provide referrals to abortion. By definition, this bill is targeting a specific group of people, based not on the fact that they falsely advertise, but based on what they believe.

This violates the First Amendment of our Constitution and fails the Supreme Court precedent as stated earlier of Ward v. Rock against Racism.

The second problem, which has also been discussed today is that this bill is vague. Among the many definitions, included in this bill, nowhere is deceptive advertising defined. The very thing, which this bill aims to regulate.
Now, you’ve heard some arguments explaining how, specifically from the Attorney General, explaining how we would define supreme, how we would define deceptive advertising using certain core precedents or explaining the simplicity or obviousness of what deceptive advertising is. But I would argue two things.

Firstly, the law, which we already have, CUTPA, found the need to define deceptive advertising. They have an extensive list defining what deceptive advertising means, what constitutes it.

Secondly, leaving the key term of this bill undefined, is itself deceptive. If the other side truly cares about being clear and truthful, why would they leave the most important term of the bill unclear.

I’d just like to sum up by saying that these pregnancy resource centers, they address the problems that women have by providing material support, emotional support, counseling, all free of charge.

We believe that women shouldn’t have to choose between sacrificing their child or sacrificing the things that they value in life. Don’t be deceived, please. Vote against this bill.

SENATOR LESSER (9TH): Thank you, Connor, for your testimony. I think everybody can see that this is an issue that you’re passionate about. Are there questions from members of the committee? If not, thank you very much, Connor, and have a good evening.

CONNOR HALL: Thank you.
SENATOR LESSER (9TH): Next up we have Marla Darius, followed by Mandy Dejalais.

MARLA DARIUS: Good evening, thanks for being here on such a late evening. My name is Marla Darius, and I am a Registered Nurse with 30 years’ experience. And I’ve been volunteering at ABC Women’s Center for about a year. I would like you to vote no on H.B. 7070, for many of the reasons that you’ve heard over and over again this evening, and a few of them I’d like to highlight again.

There’s nothing to hide. Pregnancy resource centers aren’t hiding anything from medical staff at ABCs, they’re approved medically-sound information with all of our clients. There is no substantial evidence that clients seeking services at pregnancy resource centers has been or currently are being deceived by any advertising.

What’s deceptive in the bill? My second question. The bill offers no specifics on what language is considered deceptive, yet it forces pregnancy centers to pay for corrective advertising if the ads are deemed deceptive.

Number three, they say, no referral or performing of abortions. And the bill states that we should not do that, and it denies the fact that all the members of the Pregnancy Coalition, of which ABC is a part of, have websites that make it clear that we don’t perform abortions or refer for abortions. There have been zero claims from any of the pregnancy centers or clients claiming that they’ve been misled by our advertising.
The state hasn’t been able to identify one legitimate person who suffered any harm from this statement that this bill would protect.

Number four, precare pregnancy centers provide competent, compassionate care to all of our clients for free. Women making a pregnancy decision should have a safe place to go that does not profit from any medical procedures resulting from their decision. And pregnancy centers like the one I volunteer at; help save state taxpayers money as we serve the women.

Number five, viewpoint discrimination. There are no objective parameters for determining what must be excluded or included in a given advertisement to avoid being accused of deceptive advertising. And this is a recipe for opinion suppression, which is a direct violation of the First Amendment.

I feel this bill is part of a campaign by pro-choice organizations to discredit the work of pregnancy centers who they may view as competitors.

Number six, there is already an existing false advertising law. And I have one more point after this.

Connecticut already has false advertising laws and we heard that several times from different lawyers and some of our doctors.

Number seven, and the final point, it violates basic fairness. It invents a new category called limited services pregnancy center and defines that as a pregnancy center that doesn’t provide referrals to clients for abortions or emergency contraception. This completely and unfairly exempts centers that
provide or refer these services, targeting only those are life affirming.

SENATOR LESSER (9TH): Thank you for your testimony.

MARLA DARIUS: Thank you.

SENATOR LESSER (9TH): Thank you, Ms. Darius. Are there questions from members of this committee? If not, thank you very much for your testimony and have a good evening.

MARLA DARIUS: Thank you. Thank you for your time.

SENATOR LESSER (9TH): Next up we have Mandy Desjarlais, followed by Robin Brown. Robin Brown, are you here?

ROBIN BROWN: Yes.

SENATOR LESSER (9TH): After Robin we’ll have, I think, Mickeve Regis, apologies if I’m reading that incorrectly.

ROBIN BROWN: Good evening dear and dear Public Health Committee. Thank you very much for all your patience. My name is Robin Brown, BSN, RN. I’m the Medical Services Manager of ABC Women’s Center in Middletown, and I’m speaking in opposition to H.B. 7070.

There is no need for H.B. 7070. There have been zero claims from any pregnancy center clients claiming to have been misled by our advertising. The state has not identified even one legitimate person who suffered any of the harms that H.B. 7070 purports to protect against.

All of the members of the Pregnancy Coalition have websites that clearly state that they do not perform
or refer for abortion and explains why and how their services are beneficial to those considering abortion. Our pregnancy centers have always upheld the highest standards of integrity and truthfulness with their clients and the public.

Pregnancy Centers provide competent, compassionate care to our clients, for free. Women making a pregnancy decision should have a safe place to go that doesn’t profit from any medical procedures resulting from that decision.

Women are smart. Those that walk through our doors are happy they did because they receive love, support and services they need to make an informed decision regarding their pregnancies. Our customer satisfaction rate is 99 percent based on client exit surveys. Pregnancy centers do good and all at a savings for the state’s taxpayers. Even if a woman chooses abortion, we are still there for her and we do not make a profit off of her. All legislative members have an open invitation to visit our pregnancy centers to see all the great work they do for the citizens of Connecticut.

H.B. 7070 violates basic fairness under the law. Pregnancy centers have been maliciously targeted by this legislation for political gain. It invents a new category called, “limited services pregnancy center,” and defines that as a pregnancy service center “that does not provide referrals to clients abortions or emergency contraception.” This completely and unfairly exempts centers that provide nor refer these services targeting only those who are life-affirming.
H.B. 7070 engages in viewpoint discrimination. There are no objective parameters for determining what must be excluded or included in a given advertisement to avoid being accused of deceptive advertising. This is a recipe for opinion suppression, which is a direct violation of the First Amendment. The fines are up to $500 per violation, plus attorney’s fees and costs. This sends a chilling message to non-profit pregnancy centers.

SENATOR LESSER (9TH): Thank you.

ROBIN BROWN: In conclusion, H.B. 7070 is totally unnecessary. Connecticut already has false advertising law that could be utilized for pregnancy centers, if they, through deceptive advertising, the Connecticut Unfair Practices Act, C-U-T-P-A, which prohibits, among other things, unfair and deceptive advertising.

SENATOR LESSER (9TH): Ms. Brown, I’m sorry, your time has expired.

ROBIN BROWN: In conclusion, H.B. 7070 targets small life-affirming nonprofits and is totally unnecessary. It is just a publicity stunt for those that oppose our life-affirming values. Please vote no on H.B. 7070.

SENATOR LESSER (9TH): Thank you.

ROBIN BROWN: Thank you very much for your time.

SENATOR LESSER (9TH): Thank you. Are there questions from members of this committee? If not, thank you very much for your testimony, and have a good evening. We now next have Mickeve Regis,
followed by Molly Hurtato. I apologize if I got your name wrong.

MICKEVE REGIS: You got it. Thank you. All right. So, dear members of the Public Health Committee, again, my name is Mickeve Regis, and I am testifying in opposition to House Bill 7070.

I serve as the Client Service Manager at ABC Women’s Center in Middletown, Connecticut, overseeing the client services department. I earned a master’s degree in Interdisciplinary Studies in Human Development at the University of Pennsylvania.

In my professional opinion, I am privileged to work for an organization that stands for nothing less than hope, healing and integrity. It is with great confidence that I report how ABC has had a major impact on the community.

Within the last three years, the number of clients who visited our center grew by 17 percent. The amount of material resources received by women and men for their infants increased by 9 percent. Pregnancy and parenting education services went up by 15 percent.

If we were engaging in deceptive advertisement, how could we explain the significant growth and expansion over the past few years? I ensure the proper and effective training of our volunteer staff. In this past year alone, we have welcomed seven new client advocates and receptionists onto our team and we continuously get inquiries about volunteering with us at ABC.
With a higher number of volunteers and clientele this year, we responded by expanding our services and extending our office hours to Fridays as well.

So, let me remind the committee that ABC Women’s Center has served the greater Hartford and Middlesex community for over 29 years and is well established. We have built solid partnerships with reputable, well-known organizations and companies, such as the Department of Children and Families, Middlesex Hospital, Community Health Centers, New Horizons, I’ll conclude, Maturity Works.

So, what would motivate these community agencies to link arms with ABC to provide the best care possible for women and men and families, if we were practicing deceptive advertisement?

So, I just want to quickly share this. At no point in time have our clients reported or claimed about misleading advertising or practices. Our clients speak highly of the services we provide.

For instance, we had eight ABC clients submit testimonies and we have the permission from them to say their names; Tianna, Nicole, Anna, Ruth, Carolina, Jennifer, and Christy. Also, in our client surveys in 2018, when asked what they liked best about our services, after their parenting class, pregnancy test or ultrasound, they said verbatim, everything was very well organized. Staff are very sweet, and it was very informative. Love seeing our babies. Another, everyone was extremely --

SENATOR LESSER (9TH): Can you summarize, sorry, your time has expired, if you can please summarize, that would be great.
MICKEVE REGIS: No problem. Okay.

SENATOR LESSER (9TH): Well, thank you, Ms. Regis for your testimony. I did have a question; you did mention in your testimony that you do have a relationship with the Department of Children and Families. Do you mind saying what that relationship is?

MICKEVE REGIS: Yeah, so they’ve come to our center. They’ve done training for us at our center. We also are part of a perinatal collaborative at the Middlesex, Hospital, NBCS is also at the table with us.

SENATOR LESSER (9TH): Thank you very much. Other questions from members of the committee? If not, thank you very much for your testimony. Next up we have Molly Hurtado, followed by Judith Mascolo.

MOLLY HURTADO: Good evening.

SENATOR LESSER (9TH): Good evening.

MOLLY HURTADO: My name is Molly Hurtado, and I serve as the Executive Director of ABC Women’s Center in Middletown. I also serve as the Vice President of the Connecticut Pregnancy Care Coalition. I am speaking today in opposition of H.B. 7070. As the Executive Director, I am chiefly responsible for ensuring my center upholds the highest code of ethics and care in all of our departments, including client services, medical services, marketing and advertising.

Since 1990, ABC Women’s Center has served tens of thousands of pregnant women seeking abortion alternatives with timely quality care at no cost to them. Our clients are our top priority. Their
feedback means everything to us, which is why at our center, we encourage our clients to share their feedback at a variety of different times, including after their first pregnancy test appointment, after their ultrasounds, and after their first parenting class appointment.

We have found, sorry, annually we collect the data of these client’s surveys and over the past five years, our center has a 99.8 positive rating. In addition, we always like to know how our clients found us. 40 percent of our clients over the past five years found us by a positive referral of a from. And the other 40 percent was through a Google search engine.

Why is it that if we were practicing deceptive advertising, we would find our clients referring their friends to our services? Why would 90 percent of our clients return for a second appointment? In 30 years of service, ABC Women’s Center has not received one complaint from any previous client, claiming we have done harm or falsely advertised a service that we did not, in fact, render.

I unfortunately was not here earlier, but there were some people, some legislators that had identified parts of my website, including our abortion information page, which I would happily answer any questions about, as I was the one who designed our website and created the content for it. We do provide information on all pregnancy options, because we believe that an empowered decision is an educated decision.

Our medical staff are CT licensed medical professionals, whom you’ve heard from a few of them,
including our Medical Director, Dr. O’Neill, and they are all capable of providing such abortion information.

I’ll conclude there. If anyone has any questions, I’d be happy to answer.

SENATOR LESSER (9TH): Thank you very much for your testimony. Are there any questions from members of the committee? If not, thank you, Ms. Hurtado for your testimony. And next we’ll be hearing from Judith Mascolo, followed by Iyanna Liles, Dr. Iyanna Liles.

JUDITH MASCOLO: Good evening.

SENATOR LESSER (9TH): Good evening.

JUDITH MASCOLO: My name is Dr. Judith Mascolo, and I am the President of the Board of Directors and Medical Director of St. Gerard’s Center for Life and Hartford Women’s Center.

I strongly oppose House Bill 7070. St. Gerard’s is the only pregnancy resource center in Hartford, and it’s been operating for 15 years. 90 percent of our staff are volunteers, including myself, a licensed nurse practitioner and a licensed RN. There is nothing deceptive about what we do or say. I would not lend my name or medical license to an organization that deceives women about their health and that does not provide evidence-based medical facts.

I also fully support the right of everyone to access care. And I support allowing everyone to decide what type of care they want and need. All of our services are free, including pregnancy tests and limited obstetrical ultrasounds. We do not bill
insurance or HUSKY. We also do not accept any money from any government agencies. We are 100 percent funded through private donations across the state. Thousands, tens of thousands of Connecticut residents support the mission of the pregnancy resource centers in Connecticut.

St. Gerard’s has saved over 600 babies from abortion and has helped over 1,000 mothers and families. We help women in unplanned pregnancies choose life for their babies, no matter what it takes. Today, all pregnant woman, no matter the stage of pregnancy or her family’s situation, are abortion vulnerable. We provide materials, financial, emotional support and this continues until the child is two years old. Our goal is to save babies lives and empower women to be the best mothers they can be.

We are at ground zero at our location on Jefferson Street. We offer women their last hope before they enter the abortion clinic 20 feet away. We do not deceive women into thinking that we are an abortion facility or that we provide any medical care beyond the pregnancy test and limited obstetrical ultrasound. I’m almost done.

We also don’t advertise and do not have a website. Last year during hours of testimony over a similar bill, our opponents could not come up with any evidence that pregnancy resource centers in Connecticut deceive women nor did they present any client of a pregnancy resource center who complained that she was deceived or misled. The same is still true today.

This bill targets and harasses people who believe that life starts at conception and deserves to be
protected throughout the entire nine months of pregnancy, by not --

SENATOR LESSER (9TH): Thank you, Doctor, for your testimony.

JUDITH MASCOLO: Thank you.

SENATOR LESSER (9TH): Are there questions from members of the committee? If not, thank you very much for your testimony. Next up we have Dr. Iyanna Liles, followed by Jenny Park. Good evening, Dr. Liles.

IYANNA LILES: Thanks, good evening. Thank you guys for staying so late on this day. I really appreciate this. To the distinguished members of the Public Health Committee, my name is Dr. Iyanna Liles, and I’m a licensed obstetrician and gynecologist in the Hartford area. And I’m here representing the Connecticut Chapter of the American College of Obstetrics and Gynecology, ACOG. ACOG is our specialties premiere professional membership organization dedicated to the evidence-based practice and improvement of women’s health.

The Connecticut Chapter represents 935 Ob-Gyns in partners in women’s health here in our state. We are grateful for the opportunity to provide strong support for House Bill 7070, AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

ACOG’s position unequivocally calls for the elimination of all barriers to the provision of abortion, including those proposed by the centers. House Bill 7070, will help protect women from deceptive practices that insult their dignity and
impede their access to time-sensitive reproductive healthcare services.

As a women’s healthcare physician, ensuring my patients have access to comprehensive, accurate health, including reproductive health, is integral to my daily work. I make it a priority to provide unbiased medical advice to my patients and empower them to make informed healthcare decisions. And I have a personal experience with the negative effects of one of these centers on my patients.

A new patient, her name is Mary, recounted to me recently her harrowing experience with a limited service pregnancy center. She had become pregnant, was scared, and didn’t know her options. So she decided to seek the medical advice of a local reproductive health clinic. The clinic was in close proximity to one of these pregnancy centers.

While attempting to enter the reproductive health clinic as she intended, she was intercepted by misleading advertisements and pressure from one of these pregnancy crisis center workers; she ultimately was ushered into their building.

Once inside the facility, she was further pressured to continue her pregnancy, while no other options were discussed. She ultimately left more confused than when she arrived and ended up in my care.

Mary and I talked about all her options including termination, adoption, and parenting and she ultimately made an informed decision that she felt was in her best interest.

To me, patients deserve complete and accurate information about all of their options so they can
make informed decisions. Thus it is important that clear and honest advertising of services is the standard practice of all facilities.

This bill is about transparency and honesty in advertising and I am concerned for women and families in my community without this legislation. And it is a threat to public health when people are being deceived, delayed, or blocked in finding the medical care they deserve, including reproductive healthcare services.

So, in conclusion, I thank you for the opportunity to discuss this on behalf of ACOG, an issue that affects my patients, and support this bill to limit the deceptive practices so that we can protect individuals in our state who are seeking reproductive healthcare.

Thank you for your time.

SENATOR LESSER (9TH): Thank you, very much, Dr. Lile. Other questions from members of this committee? If not, thank you so much for your testimony.

IYANNA LILES: Thank you.

SENATOR LESSER (9TH): We now will be hearing from Jenny Park. After Jenny Park, Mattie Granato. Good evening.

JENNIFER PARK: Senator Abrams, Representative Steinberg and distinguished members of the Public Health Committee, my name is Jennifer Park. I live in Glastonbury, I’m a UConn third year medical student and future Ob-Gyn. I speak for myself and not on behalf of my institution. I testify in fervent support of H.B. 7070, AN ACT CONCERNING
DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS.

I come here to speak before you today because I’m deeply concerned about how CPCs are damaging to the community that I love and serve. This information is a threat to public health in our state. When people are being deceived, delayed or blocked in finding the reproductive health care that they are seeking.

I was raised in Connecticut and I’m proud to call it my home. It has been my privilege, as it may have been for many of you in this very room, to have access to medical care from only certified and qualified medical personnel. Through medical school and my internship with Planned Parenthood, I learned about barriers to a woman’s access to reproductive care. About one half of all pregnancies are unplanned and one quarter of all the women in this country will have an abortion within their lifetime.

And unwanted pregnancy is an incredibly stressful time for these patients to make time-sensitive decisions about their bodies and their lives. When counseled in a clinical setting, they should be fully informed about their options in regards to parenting, adoption and abortion. At Planned Parenthood I had a 16-year-old patient from a low-income household who became pregnant but was certain about getting an abortion. She had plans on choosing her dreams in college and becoming a single-teen parent was not in her vision. Her parents continuously tried to persuade her out of her decision because it was not in line with their faith. This child patient carried an enormous
amount of guilt and shame in exchange for her choice and autonomy.

After her abortion, she broke down in tears because she was so relieved that it was all over and thanked us for supporting her. The only support she had in her decision was at our clinic, as it is often times with these patients. Guilt and shame, along with misinformation are powerful tools and common tactics used by CPCs which are often fueled by religious groups. To pressure women into keeping unwanted pregnancies, women should only receive qualified medical counseling from certified providers at real women’s health centers, doctors, nurses, counselors and social workers who have accumulated decade’s long training, are highly qualified to give advice on the available choices when women are faced with the challenge of an unwanted pregnancy.

These types of providers are often not present at CPCs. Below is some information that I gathered from a CPC website, based on Connecticut, that I found very concerning. On the crisis pregnancy center, CT.org, I found information on the morning after pill. It states that you can take the pill within 72 hours after sexual intercourse. This is false. It can be taken within five days after sexual intercourse. It states that this is an early abortion. This is also false because how the pill works is that it prevents ovulation so that the sperm and egg are prevented from every meeting. As a young doctor in training, I believe that choice and opportunity empowers patients to make informed decisions. We currently live in a time where emotions, I’m almost done. We currently live in a
time where emotions and fake news often trump facts in evidence-based medicine.

It is my professional goal to combat misinformation in order to improve health outcomes in my community. No matter where you stand on the pro-choice versus pro-life debate, I hope that you can agree that passing this bill is important because healthcare should be transparent and honest.

Thank you very much for your time.

SENATOR LESSER (9TH): Thank you very much, Jenny. Are there questions from members of the committee? If not, thank you very much and good luck with your medical studies.

JENNIFER PARK: Thank you.

SENATOR LESSER (9TH): Next up we have Maddie Granato, followed by Francesca P. Maddie, are you here? Okay. Is Francesca here? Francesca is not here. Richard DeBiasi, followed by Julianna Bennett.

RICHARD DEBIASI: Good evening, distinguished members of the health board. I’m in opposition of H.B. 7070.

When I first heard about this bill, and I heard about the deception, I decided to look at it myself. I looked at the website and I am mostly familiar with the Care Net Center in New London, and I looked at every single part of the Care Net website. And I saw no deception at all. They open up a discussion about considering abortion, which is not a final decision to make or to have an abortion, it is about opening up a discussion and talking about it.
And so, that’s what most of the website focuses on is talking about the considering what to do and what the ramifications are. And so, I’ll read my testimony.

I am concerned about the falsehood and misleading of the H.B. No. 7070, that Pregnancy Resource Centers are deceptive or are deceiving in any way. In my opinion that pregnancy resource centers are needful in this day and an age when a large portion of our society thinks nothing of aborting a baby, a fetus for often no good reason other than convenience.

PRCs care about the health and support of the women, men, and the unborn babies and other family members that are impacted by an unexpected pregnancy and they give them other options than abortion. These centers also provide information such as the after effects of abortion to women, men, and families who are affected by a pregnancy situation.

It seems to me that the main goal of this bill is to attempt to shut down or control PRCs and; therefore, limit all the more of the support that women are facing unexpected pregnancy deserve and need to, and need in facing the choice of keeping their unborn babies alive.

I am opposed to this bill and its content because of its own deception, wording and untruth regarding the PRCs. I am, I read the entire content of the resource center information on the website and it is straight forward, no abortions will be performed nor are they refer to anyone to an abortion clinic.

PRCs have every right to exist under the First Amendment as an institution to help, counsel, offer resources, and free pregnancy testing --
SENATOR LESSER (9TH): Can you please summarize.

RICHARD DEBIASI: -- to any mother in need. I oppose this bill and ask you to oppose it.

Thank you very much for the opportunity to testify.

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

REP. MICHEL (146TH): Sir, just a second. Just wanting to point out, you mentioned Care Net and what their website said. Earlier I made reference to a pamphlet that they were giving in the tunnel.

RICHARD DEBIASI: I only looked at the website.

REP. MICHEL (146TH): Okay. Well, I just wanting to point out to you that my reference earlier was about the pamphlet that they gave in the tunnel between this building and the capitol.

Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions? Thank you, sir. Next up, Julianna Bennett, followed by Carolyn Bennett, followed by Lydia Bennett.

JULIANNA BENNETT: Good evening, members of the Public Health Committee. Considering it is late, I will try to brief and summarize what I submitted to you. Most of my comments have already been made by other people, as I looked at this bill that seems to me that there were already laws in place for anyone who advertises falsely and that if there were any centers that were actually doing this, we wouldn’t need a law specifically for them. It kind of, for a
hypothetical example, if the Girl Scouts were using deceptive advertising which could be anything under the vague language of this bill, would we create an act concerning the deceptive advertising practices of the Girl Scouts? Or then if the retirement home were planning to move our parents into, has deceptive advertising, we would make an act specifically for retirement facilities. It would get very nit-picky and so it seems obvious that this bill is intentionally singling out crisis pregnancy centers.

And actually as I was looking at it, I was reminded of a favorite movie of ours, It’s a Wonderful Life, and for those of you who know it, Mr. Potter is the crafty businessman who fully works his way into gaining control over the whole town, except there’s one business he can’t get his fingers on, which is George Bailey’s Building and Loan. And as George Bailey says, it gnaws at him.

And unfortunately, there are people and organizations nationwide that are attempting to discredit the work of pregnancy centers because they disagree with the core beliefs of these centers.

And like Mr. Potter, they will do anything they can to single out these centers and destroy their reputations, as well as the fine work they do. I believe this bill falls into that category, and if these efforts are successful, many women will stand to lose a vital means of support in our community.

So, once again, I urge you to reject this bill.

Thank you.
SENATOR LESSER (9TH): Thank you. Other questions from members of the committee? Yes, Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Thank you for coming up today Julianna. You mentioned about there already being a law regarding deceptive advertising and that’s where I’m really struggling with this because I know it exists. And so why are we, if it already exists, why are we doing it again? So, thank you.

JULIANNA BENNETT: Thank you very much.

SENATOR LESSER (9TH): Next up we have Carolyn Bennett, followed by Lydia Bennett.

CAROLYN BENNETT: Good evening, members of the Public Health Committee. My name is Carolyn Bennett and I ask that you oppose H.B. 7070. There are several reasons why I believe this is a bad piece of legislation.

First of all, this bill does not define what constitutes deceptive or misleading advertising. If this bill became law, it would censor the advertising of pregnancy centers by an extremely subjective standard, regardless of the intent of the pregnancy center.
Secondly, to my knowledge, there is no actual specific proof of a specific pregnancy center engaging in deceptive advertising.

The Connecticut Pregnancy Care Coalition has a 98 percent client satisfaction rate; this shows that actual clients are feeling satisfied with the services they receive. Many clients also maintain long relationship with the pregnancy center that helped them. This would not happen, if the centers were deceitful or manipulative. This bill is in essence trying to fix a problem that does not exist.

Thirdly, this bill implies that pregnancy centers are already engaging in deceptive advertising. The pregnancy centers that I know state clearly on their websites and in their brochures what services they provide and what they do not provide. They offer free and confidential services, honest information and a caring, listening ear.

The staff and volunteers truly care about their clients, and client testimony, which I have heard, confirms the fact that the women feel loved and supported through the services they receive. These centers provide exactly what they advertise.

Once again, I would ask you to oppose H.B. 7070.

Thank you.

SENATOR LESSER (9TH): Thank you. Are there questions from members of the committee? If not, thank you very much, Carolyn, for your testimony. Next up we have Lydia Bennett, followed by Rachel Moralis.

LYDIA BENNETT: Members of the Public Health Committee, my name is Lydia Bennett, and I am here
in strong opposition to H.B. 7070 AN ACT CONCERNING DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS. This bill unfairly targets crisis pregnancy centers and condemns them as guilty without evidence.

This bill is not really about deceptive advertising. It is about people and organizations who have fundamentally opposite values to crisis pregnancy centers who want to do anything they can to undermine the good work of these centers.

I read a 38 page summary on NARAL’s website of their “investigation” of crisis pregnancy centers in Connecticut. They visited only five centers, each one only once, and admitted that multiple visits to the same CPC may have yielded different results each time. They claimed that the findings do not seek to make blanket statements about all non-profit pregnancy-related centers in Connecticut, but in fact, the language of their report does exactly that.

Their example of lack of transparency in advertising, is an ad from Birthright that says, Pregnant? Need help? Birthright since 1972, free and confidential, and gives Birthright’s number. That’s their definition of deceptive.

If you go to Birthright’s website, they clearly state all the services they provide, as well as stating that they do not perform or refer for abortions.

So according to what NARAL is implying, help isn’t help, unless it means providing abortions too.
Under this bill, people and organizations who strongly oppose crisis pregnancy centers have free rein to accuse them of anything, even posting their telephone number.

Once again, I urge you to reject this bill.

SENATOR LESSER (9TH): Thank you. Thank you very much. Perfectly timed. Are there any questions from members of the committee? If not, thank you very much for your testimony. Next up we have Rachel Morales, followed by Rachel Bertels. Good evening.

RACHEL MORALES: Good evening. Thank you for letting me testify, Mr. Chairman and members of the committee. I just have a story to tell you about myself and my family. I am my parents first child. My mother became pregnant with me when she was 28 years old. The doctors told her that her high risk for carrying me and giving birth to me with a birth defect. And non-invasive testing, they said that it was very likely that I would have Downs Syndrome. They told my parents and advised abortion, terminating the pregnancy. Yes, they were given all of their options, but abortion was highly suggested.

They did decide to keep me and raise me, no matter how I came out. And as you can see, I was born without any defects and I’m very thankful that I’m able to say, I’m the second, second semester sophomore in the top 12 percent of my class at the University of Rhode Island, studying nursing.

I say all this just to ask, what information is being held from our women? I understand that there can be deception, but as we’ve seen today, there can
be deception on both sides of the spectrum in terms of providing abortion and not providing abortion.

In the cases of Planned Parenthood of Southeastern, Pennsylvania, in Casey, v. Casey and Stenberg v. Carhart, it was determined that a woman seeking abortion, give her informed consent and be provided information about the risks involved and available alternatives at least 24 hours before the procedure.

In saying this, I would like to admit that, yes, if a woman does want an abortion, it is a time-sensitive situation. But she does need to be given at least 24 hours before she makes her final decision. And if she does make her final decision sooner, the abortion cannot legally be performed before 24 hours has come up.

The research and experience with different pregnancy resource centers, I have seen that women are being provided information about all of their options concerning an unplanned pregnancy. And the examination that I have observed has been done by licensed nurses. While they do not perform abortions, comprehensive information in regard to the resource centers I have experience with, they provide information on procedures and possible side effects that are provided when it comes to abortion and I did do the research. It’s accurate information. There is no, there is nothing that says that there will be a half a baby left inside or that anyone will die.

Thank you.

SENATOR LESSER (9TH): Thank you, Rachel. Are there questions from members of the committee? Yes, Representative Comey.
REP. COMEY (102ND): Thank you. So, I might just be getting tired. Maybe a little cranky. But so your, what is your experience, what is your role here? I’m not quite sure. Do you work for a center?

RACHEL MORALES: I volunteered one summer because I wanted to go into nursing --

REP. COMEY (102ND): Okay.

RACHEL MORALES: -- and because there’s a licensed nurse there, they allowed me to observe. I had no hands-on when it came to the actual medical ultrasound. I did sign a competency to be able to do a pregnancy test. I was told it was legal, so, I’m assuming it was.

REP. COMEY (102ND): And it was here in Connecticut?

RACHEL MORALES: Yes.

REP. COMEY (102ND): And how long ago was that?

RACHEL MORALES: It was two summers ago.

REP. COMEY (102ND): Two summers ago. And you had mentioned your personal story regarding your, your mom and having, so you must be about 23, 24 years old right now.

RACHEL MORALES: 19.

REP. COMEY (102ND): You’re 18.

RACHEL MORALES: 19.

REP. COMEY (102ND): 19. So, 19 years ago, when she was pregnant, your story goes that she was told that perhaps that you were going to be Downs Syndrome baby and that she should abort. Where did, where was she getting her healthcare?
RACHEL MORALES: I assume that it was from Lawrence Memorial because that is the provider that ended up doing my birth. But I did not go that deep in asking her questions.

REP. COMEY (102ND): And does she have the same -- is she here today?

RACHEL MORALES: She’s not here today.

REP. COMEY (102ND): And does she have the same beliefs as you as far as, was she always pro, pro-life or --

RACHEL MORALES: Yes.

REP. COMEY (102ND): Okay. Thank you very much.

RACHEL MORALES: Thank you.

SENATOR LESSER (9TH): Thank you, Representative Comey. Are there other questions from members of the committee? If not, thank you very much for your testimony and best of luck with your studies in nursing.

RACHEL MORALES: Thank you.

SENATOR LESSER (9TH): Next up we have Rachel Bertels, followed by I think this says, Laura Zambrano, but apologizes if I’m misreading your handwriting.

RACHEL BERTELS: Hello, members of this committee. I thank you so very much for the privilege to be able to testify at this late hour. And, you know, I really just appreciate your patience in hearing everyone’s side of the story on this bill. So, I’m gonna start as quick as I can.
My name is Rachael Bertels. I am here to provide testimony regarding the Care Net Pregnancy Resource Center of Southeastern Connecticut. I have extensive personal first-hand experience with Care Net.

A traumatic relationship landed me pregnant twice as a teen. After the first pregnancy, I gave my beautiful daughter up for adoption. Shortly after her birth I was pregnant again. I bought the rhetoric that abortion was no big deal and no big deal after all sounded a lot easier than the difficulty adoption had just been.

My options, counseling, consisted of a gentleman agreeing with me that abortion was my best option. And he was not dressed in a white coat, by the way, just saying. I did not look for another option because I could see no other option afforded to me. After the procedure I felt emotionally numb. I tried not to think about what I had just done. It, however haunted me for years.

At 20, I encountered the gospel message, and this was my first step in healing, as I received God’s forgiveness for my choice.

I struggled again after the birth of my first son, however, seeing him made me feel the full weight of my choice, and I had nowhere to turn so I ate my pain.

Years later I encountered the pregnancy center in New London. If only there was such a place when I was so alone in my decision. Being without Care Net left me with no choice. Upon being hired, I went through the Post Abortion Bible Study program that helps women heal from the aftermath. It helped me tremendously. I found no other place to grieve my
abortion except Care Net. I then started leading the study and conducted many other free services for clients.

Clients were given an intake form with the capitalized phrase, we do not preform, I’m sorry, I keep messing these words up, they’re right next to each other, we do not preform or refer for abortions. It was no secret. And I have a side note here. Should I finish or --

SENATOR LESSER (9TH): If you can please summarize.

RACHEL BERTELS: Okay. Let me do that. Care Net, you know, has just been a wonderful place for women to go to receive many services that are needed. At my time at Care Net, if you guys don’t ask me any questions, you know, we’re very upfront and honest with people, you know. There was times where we disagreed with a woman’s choice and it broke our hearts, but we still made a commitment to the woman to love her regardless of her decision.

You know, I have testified, you know, I understand what it’s like to go through that. It’s not easy, and having that unconditional love and acceptance is, you know, just wonderful.

And I just want to add from Dr. King’s letter from the Birmingham Jail, an unjust law is a code that a majority inflicts on a minority that is not binding on itself.

So, my problem with this bill is, you know, just the, just the narrow group that it targets. You know, I ask that if there is problems with our legislation, that maybe we amend those problems with the legislation to deal with deception because that
is a problem, if there is deception. But let’s just look at our laws and maybe, you know, rewrite what we have on the books as a general covering instead of just --

SENATOR LESSER (9TH): Thank you.

RACHEL BERTELS: -- focusing on one group.

SENATOR LESSER (9TH): Thank you for your testimony.

RACHEL BERTELS: Thank you guys, appreciate it.

SENATOR LESSER (9TH): Are there questions, before you go, are there questions from members of the committee? Yes, Representative Comey.

REP. COMEY (102ND): Yes, so is Care Net a center?

RACHEL BERTELS: Is it a --

REP. COMEY (102ND): Is Care Net --

RACHEL BERTELS: -- yeah, it’s a pregnancy --

REP. COMEY (102ND): -- an organization or a pregnancy center?

RACHEL BERTELS: Yeah, it’s a pregnancy resource center.

REP. COMEY (102ND): Okay.

RACHEL BERTELS: It’s a nationwide thing. And there’s a few in New London that affiliate with, not in New London, the state, I’m sorry, that affiliate with Care Net national, so.

REP. COMEY (102ND): And do you work for them?

RACHEL BERTELS: I used to work for them. I got all frazzled in my testimony, I’m sorry. But I no longer work for them. You know, I had to quit
because I started school, you know, and I couldn’t handle everything, so. But I felt it important enough to come here today because, you know, I had firsthand experience and I saw everything that went on and there was no deception. There was no, hey, let’s put you in a headlock and make you choose what we agree with. You know, like I said, it did break our hearts when women would go, you know, the other way. But we didn’t change the information, we didn’t try to, you know, manipulate and, you know, if I may share one instance where there was a woman who, I think, I want to say she was 21 weeks pregnant. And she asked if she could have an ultrasound without seeing the baby because she had to confirm, you know, the gestation and all of that. And I just remember, you know, the difficulty of, you know, being in that place where, you know, yes, we know that she’s going to terminate this pregnancy, but we have to give her the same services, the same treatment as everybody else.

And so, you know, we did that and, you know, shortly after that, there was a request for information, and we knew that she terminated. But, you know, you know, my understanding and my experience that Care Net, you know, in New London has never tried to stop anybody from their choice. You know, we just, we shared information with people and, you know, we let them make their decision.

And I wish I had that. I so wish I had that, you know.

REP. COMEY (102ND): Thank you, your very good testimony. Thank you for sharing.

RACHEL BERTELS: When I’m shaking like this.
REP. COMEY (102ND): I’ve been on that side, too.

RACHEL BERTELS: Thank you.

REP. COMEY (102ND): And the Care Net, I think they’re very clear on what their, what their role is.

RACHEL BERTELS: Yeah, I mean, you know, it’s important, if we’re going to be honest.

REP. COMEY (102ND): So, we want to make sure that there are other, that the other centers are as clear about what they --

RACHEL BERTELS: Yeah, and, you know, I think maybe amending the --

REP. COMEY (102ND): -- that’s what we’re here talking about.

RACHEL BERTELS: -- yeah, the current legislation, amending that, that way you don’t have to get into a politically charged craziness, you know. I mean, you know, make sure that the deception doesn’t happen, but maybe not just go after one group, you know, that’s, that’s my two cents.

REP. COMEY (102ND): Thank you.

RACHEL BERTELS: Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.

RACHEL BERTELS: Thank you guys.

SENATOR ABRAMS (13TH): Therese Ritchie. Oh, I’m sorry. I skipped you.

LAURA ZAMBRANO: Good evening. I am writing to express my opposition to H.B. No. 7070. I have been
volunteering for Pregnancy Resource Centers for the last 6 years, in a variety of capacities. I am currently volunteering for HOPE Pregnancy Center, in Cheshire. I find it senseless to propose a bill about deceptive advertising at pregnancy centers, when a look at their websites, a visit, or phone conversation, will reveal just the opposite; including at Hope, and as I learned today others, the disclaimer that no abortions are done or referred.

This bill is an unsubstantiated, malicious attack on religious, 501(c)(3) pregnancy centers in Connecticut, that includes a desire to suppress free speech.

This bill does not clearly define examples of false advertising. Since there are currently laws that regulate false and deceptive advertising, why are pregnancy centers being targeted?

The truth is, I have that found HOPE provides comprehensive services and a safe, caring environment for women, before, during and after an unplanned pregnancy. As stated on their website, since 1985, they have offered these services for women and men to feel they have received help, information and hope.

The information on the website states clearly what HOPE does and does not provide. These services include, pregnancy tests, peer consultants to listen, and information on all aspects of pregnancy, STD’s and more. They also will refer for financial, legal and medical aid, as well as, to adoption facilities and maternity homes. All of this is free of charge. These vital services are offered at a
time when the need for them is greater than ever. Therefore, I urge you to vote no on H.B. No. 7070.

SENATOR ABRAMS (13TH): Thank you. Ms. Ritchie, I don’t know if you were here this morning, but Representative Linehan did testify and spoke very highly of the Hope Center in Cheshire, so. Are there any questions or comments from the committee? Thank you very much. Ms. Ritchie, Therese Ritchie.

THERESE RITCHIE: To all of you good members of this Public Health Committee, thank you for your time and your patience. My name is Therese Ritchie, and I am the Executive Director of Hope Pregnancy Center in Cheshire.

I am testifying in opposition of Bill 7070. HPC is being targeted as a part of a national campaign to discredit and eventually shutdown organizations that assist thousands of pregnant women and their children every year. They have tried to use unsubstantiated facts and hearsay to make pregnancy resource centers deceitful and manipulative.

Since 1985, HPC has offered non-judgmental, non-religious, confidential, genuine concern and material support for men and women. Every woman who calls HPC with questions receives honest answers. When a woman calls, when a woman calls with abortion-related inquiries, they are told immediately, HPC does not perform nor refer for abortions.

HPC has never shown graphic videos or pictures of abortion. HPC attempts to offer hope, compassion and support with gentleness, humility and kindness. We strive to go above and beyond serving with care and integrity to walk alongside every woman
regardless of her decision to parent, to choose adoption or abortion.

I have spoken with hundreds of women, some pregnant, some post-abortive. I have every confidence when a woman talks about her problems, she often will answer her own questions. Every woman knows her life best and HPC only acts as a listening ear.

HPC receives referrals from 211, WIC, DCF personnel, state social workers, high school counselors, teachers, probation officers and previous clients. Central Connecticut State University, social work interns have spent 70-100 hours with our staff and coaches.

Upon their internship completion in every case, HPC has received 5 stars, the highest and most difficult rating to obtain.

In 2018, HPC offered services to over 110 men and women, donated over 2,200 items and 86 babies were born to our moms.

And many thanks to Representative Liz Linehan for her support. And I would love for her to visit some of these other centers.

And in closing, I’d just like to say, HPC clients know exactly what we provide. They understand we do not provide abortions and they still come. And I’ve attached in my submitted testimony a client’s testimony.

Thank you for your time.

SENATOR ABRAMS (13TH): Thank you very much. It sounds like you’re doing a wonderful job.

THERESE RITCHIE: Thank you.
SENATOR ABRAMS (13TH): Any other questions, comments? Thank you.

THERESE RITCHIE: Thank you.

SENATOR ABRAMS (13TH): Linda Miranda.

LINDA MIRANDA: Good evening. My name is Linda Miranda. And I’m currently a volunteer at Hope Pregnancy Center. I had previously submitted a written testimony but decided based on the things that I heard today to just share some of my thoughts about the testimony that’s been shared because I just felt that had more value for you then reading what you’ve already received.

Some of the things we’ve heard today was that pregnancy centers are not being targeted, yet bill 7070, specifically calls our pregnancy centers. And testimony was provided multiple times this morning referring to pregnancy centers as faith-based and deceptive.

Although we also heard multiple times that the pregnancy centers provide very clear information in their brochures on their websites and in other materials and communications with our clients that clearly tell them what we do perform, what we don’t perform, what services are available to them.

We also heard this morning and actually Hope was used as a specific example, of a center being located near a church, which is apparently an appropriate place for us to be located as opposed to a center being located across from an abortion clinic and apparently that is defined as deceptive.
I’m not sure how a location should have any bearing on whether or not a center is being deceptive or non-deceptive.

I agree that all medical centers should, in fact, be honest, right, should not be deceiving, regardless of what side of the fence you’re sitting on, there should not be a deception coming from people who are opposed overtime abortion anymore than there should be for people who support abortion. We should be providing facts to the women who come.

I also, would like to, maybe offensively, and I apologize if it’s offensive. But a lot of the things that are being said imply that women do not have the intelligence to be able to do a Google search, to be able to find a location that they might like to go to, that might be able to read the information provided and make an informed decision for themselves where they’d like to go.

We make decisions every day about where we want to, what doctor we want to see, what services we would like to search out and we do that quite successfully. I don’t think this kind of a decision changes our ability to think things through.

SENATOR ABRAMS (13TH): I’m gonna have to ask you stop because your time’s up.

LINDA MIRANDA: Okay.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments? Thank you so much. And we do have your written testimony, so I appreciate you.

LINDA MIRANDA: Thank you. Have a good evening.
SENATOR ABRAMS (13TH): Penina Beede, and I’m sure I’m probably not saying that correctly. Oh, good. Next is Katherine Spiegel.

PENINA BEEDE: Members of the committee, thank you for hearing my testimony.

My name is Penina Beede, I’m a junior at the University of Connecticut. I live in Bloomfield, Connecticut. I’m an intern NARAL Pro-Choice Connecticut, but I’m here today to speak as a private citizen.

I can’t quote statistics or give my professional opinion because I’m not in a position to do so. I can only speak for myself. I would like to first state that attend Planned Parenthood for most of my gynecological services because I am a full-time student with two part-time jobs. I don’t really have the time to make an appointment, much less afford one with a private physician.

I hope to have a family one day. I don’t yet know what that will look like. But I do know that I want to have it on my own terms.

Today, if I were to become pregnant, I can say that I would seek advisement on abortion services as soon as possible. I do not truly know what I would do, but I do know that I would want to speak with a professional, who would not want to make, to make my decisions for me. I am responsible for my own decision and to fall prey to a misleading service, such as a fake women’s clinic would deprive me of that choice.

Centers like Hartford GYN Center and Planned Parenthood of Southern New England are invaluable
resources that allow women to make their own choices when they need it, not when they are sent to another place, further delaying this crucial decision.

This bill is about transparency and honesty and advertising. When someone is seeking a clinic, they should be able to find one without confusion or deception. The crisis pregnancy centers put women like me, women who are not ready to care for a child, who’s hopes would be interrupted by a child, who are not mature or financially stable enough to care for a child, and I’m saying that about myself, in a position that could delay my choice, to delay and delay until it is too late.

This bill will help women like me to find the services needed in a time when all we need is support and guidance. My right to choose means my right to choose my education, my career path and my family, without being manipulated by those who do not have my best interests at heart.

Crisis pregnancy centers are manipulative to women. It is a threat to public health in our state when people are being deceived, delayed or blocked in finding the reproductive healthcare they are seeking.

The false advertisement of these clinics are manipulative. Abortion is not an easy choice. But it is a choice that should be left to the mother. A choice that involves counseling chosen by the mother, and the final decision left to the mother.

Simply put, these fake clinics do nothing but trick women into losing their choice. Losing their plans and hopes.
In conclusion, I just want to summarize, a woman’s choice to have an abortion is not a sign of weakness. To refer to these young women as weak is unfair and I strongly support this bill.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Are there any questions or comments? Thank you so much for being here tonight. Katherine Spiegel.

KATHERINE SPIEGEL: All right. So, distinguished members of the Public Health Committee, my name is Katherine Spiegel and I’m a second year medical student living in Farmington, Connecticut. I am proud to have been born and raised in Connecticut and I am extremely grateful for the opportunity to provide healthcare for people of this state in the not so far-off future.

I testify in support of H.B. 7070. To give you some background in the process of becoming a licensed healthcare provider, we are trained in the nuances of informed consent. Every patient, every individual is unique. All treatment options and accurate information needs to be presented in order for an individual to come to a fully informed decision about their health.

Crisis pregnancy centers directly violate this process and threaten the health of women and their communities by securing the truth or delaying care. I want to underline the importance of delaying care. Patients are lost to follow up in much less precarious circumstances.

Abortion is an option for women seeking counsel about pregnancy. Not only is it a safe medical procedure, as addressed by my colleagues, less risky
than the pregnancy itself, but it is also well documented in the scientific literature that unintended or unwanted pregnancies are associated with negative outcomes. Studies show that these women are more likely to delay the initiation of prenatal care, receive no care, use tobacco and alcohol during pregnancy, experience post-partum depression, deliver pre-term, and even continue to smoke after giving birth.

Additionally, their children are more likely to be low birth weight and are at increased risk for a negative physical and mental health outcome.

Crisis pregnancy centers that guilt or deceive women about the fact surrounding abortion, directly violate the essence of informed consent. They put women and future generations of the community at risk.

Personally, I look forward to the counseling and education that is so fundamental to the integrity of the doctor/patient relationship. Therefore, it concerns me that these centers are not, not only mislead women about abortion, but also provide inaccurate information about contraceptives and condoms.

The majority of teenagers who visit clinics to get a free pregnancy test are not pregnant. However, some of them are engaging in high-risk sexual behavior and are at significant risk of contracting STDs and of becoming pregnant. In one study, one-third of teenagers who had a negative pregnancy test at a community clinic became pregnant within 18 months. If they visit a crisis pregnancy center, such as not teaching them about the risks they’re facing, and
work with them to take care of their entire health and wellbeing, then we are failing them as a community.

In conclusion, I strongly support H.B. 7070. I urge the committee to consider the health of their community in this decision.

Thanks.

SENATOR ABRAMS (13TH): Thank you so much for your testimony. Any questions or comments? Hang on one second. Go ahead, Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Thank you for coming. Do you work at a facility?

KATHERINE SPIEGEL: No, I’m a medical student, second year medical student.

REP. ZUPKUS (89TH): Okay. And have you ever been to either Planned Parenthood or --

KATHERINE SPIEGEL: I have used Planned Parenthood in the past for my gynecological needs, when I thought I was too scared to go to my parents and ask and them to set up an appointment. And I ended up using my insurance anyway, so like they knew about it. And they were the most supportive Ob-Gyn experience I had actually ever experienced, so.

REP. ZUPKUS (89TH): So, when you mentioned about the other facilities, being a risk for healthcare. Why do you feel that way?

KATHERINE SPIEGEL: I don’t -- what are you referring to?
REP. ZUPKUS (89TH): Well, the other pregnancy centers you’re for this bill and so you’re here testifying --

KATHERINE SPIEGEL: Delaying care.

REP. ZUPKUS (89TH): So, maybe I misunderstood you, but I thought you said that these other facilities put people’s healthcare at risk. And I was just curious why you felt that way?

KATHERINE SPIEGEL: Sure. So, any kind of delay in care or redirection of a patient is going to lead to delays in care and follow up. And it’s very easy to lose a patient to follow up in any circumstance. And when they’re led to a website that misdirects them in the first place, then this leads to delays in care and losing a patient, so.

REP. ZUPKUS (89TH): Okay. Thank you.

KATHERINE SPIEGEL: And even when they do get to the site that does the ultrasound, even if you, you can miss other medical conditions too, so they need to be with a doctor.

REP. ZUPKUS (89TH): Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Next is Laura Grabel.

LAURA GRABEL: Hi everybody, Senator Abrams, Representative Steinberg and distinguished members of the Public Health Committee. I applaud your stamina, although I see some folks may be leaving. I know it’s been a long day for you.

My name is Laura Grabel, and I live in Middletown Connecticut, and I would like to testify in strong support this bill. I have just retired from
Wesleyan University after 35 years of teaching biology, including courses on human reproduction. I’m concerned about the deceptive practices, at some crisis pregnancy centers, that they take advantage of vulnerable women at challenging times in their lives.

This bill asks for transparency and honesty in advertising. And I think that’s a difficult thing to argue against. When making a decision about reproductive health, women should have the opportunity to seek support from whomever they desire, including counseling services, whether they’re religious or otherwise, family support, and also advice from medical professionals.

When someone is seeking a medical clinic, they should be able to find one without confusion. It should be transparent what services are, or are not provided, particularly when medical expertise is called for.

As an educator in the field of reproduction, I am aware of the time-sensitive nature of decision making. Crisis pregnancy centers can confuse people, potentially limiting their options and causing them to miss an opportunity for the safest most effective treatment.

In the area of reproductive health, it’s particularly important that clear and truthful advertising of services is the standard practice, and this bill will help to see that that is the case here in Connecticut. And I’ll end there before I get dinged.
SENATOR ABRAMS (13TH): Thank you very much. Are there any comments or questions? Representative Michel.

REP. MICHEL (146TH): Thank you, Senator Abrams. Thank you for testifying tonight. I think we’ve been here 12 hours now. But I still have energy.

LAURA GRABEL: Good for you.

REP. MICHEL (146TH): You mentioned the sensitive nature of timing.

LAURA GRABEL: Yes.

REP. MICHEL (146TH): And I’m gonna quote part of the raised bill, which says, or caused to be made or disseminated in any newspaper or publications or any advertising device or in any other manner. And I think a couple of times it’s been mentioned that there were people working from the limited centers, talking to people into going into their centers.

LAURA GRABEL: But just word of mouth.

REP. MICHEL (146TH): Yes, and I would say that constitutes also some form of deception and based on the sensitive nature of the timing, I think --

LAURA GRABEL: Right, I would agree with that, but I think that’s more difficult to legislate against as opposed to advertising.

REP. MICHEL (146TH): Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any other questions or comments?

LAURA GRABEL: Thank you.
SENATOR ABRAMS (13TH): Thank you very much for your testimony. Adrienne Greto.

ADRIENNE GRETO: Hello, is it good morning yet. I feel like it’s good morning. Yeah, one hour, very soon. Well, thank you all for being here, Representative Steinberg, it’s great to see you again.

My name is Adrienne Greto and I have the privilege of serving as Executive Director at Hopeline Pregnancy Resource Centers and as the Secretary of the Connecticut Pregnancy Care Coalition. For over 32 years, Hopeline has served thousands of community members by offering life-affirming services at no cost. Our presence in Bridgeport, Danbury and Stamford have been vital for women who have sought abortion alternatives. By providing these services with no monetary incentive, we have been able to help support low income, immigrant and minority populations to name a few.

I am appalled that a second attempt to pass legislation has been brought forth, after it was rightfully dismissed last year. To my knowledge, like many of our other testimony has said, there have been no complaints from any clients. In fact, our clients are so grateful for the work that we do, they themselves have taken the time to write testimony on our behalf supporting us in our attempt to spread the truth about who we are. We in no way walk in the practice of deception or condone it.

On multiple occasions, we have extended invitations to legislators to visit our centers to see first-hand how we operate.
Unfortunately, our attempt to share truth has been met with silence, as no members of the Public Health Committee have responded with a desire to visit. So, Representative Michel, I know that you’re in our area. So, I would love for you to come visit us in Stamford.

I am deeply concerned that we have representatives in place that would write legislation without doing due diligence by visiting our centers to learn the truth.

Health Committee members, I implore you not just to listen to the words that we’re saying, but to do your own research. In testimony written by the Executive Director of NARAL, she shared a snapshot of our website, unfortunately, critical information was left out and she only included information that would support her flawed narrative and left out an entire paragraph from that exact page that, in fact, shares about how we do not refer or perform for abortions.

Please, please do us all a favor and look through our website on your own. I actually have copies of that page and I’m going to give them to the Clerk so you guys can take a look after. I also have included our limitation of services, which every woman signs before she receives our services. And I have included what’s posted in our waiting rooms that include that we do not refer, recommend or perform abortions.

The other thing I think is really important to touch on is Representative Cook, this is my last point, Representative Cook brought up a website, is ctforwomen.com, and I would like to let you know
that we have repeatedly attempted to get our information off of that website. That website is apparently hosted by the Connecticut Right to Life. We are not, they are not a pregnancy center. We have not given them the okay to put our information on that website. And I just think that it’s really important to share that information.

So, in conclusion, I invite you all to come to my center. I would love to welcome you so that you can do your research on your own and to see how we operate and the work that we do. So, please take me up on that. I would love to welcome you.

SENATOR ABRAMS (13TH): Thank you, and I love your energy at this hour.

ADRIENNE GRETO: Thank you. Thank you. Thank you so much.

SENATOR ABRAMS (13TH): Representative Steinberg.

REP. STEINBERG (136TH): I just wanted to say it’s good to see you again. I had more energy when we last spoke.

ADRIENNE GRETO: Yeah, so it was earlier in the day, I agree.

REP. STEINBERG (136TH): Let’s arrange to do that again and I would like to --

ADRIENNE GRETO: Yes, please, thank you.

SENATOR ABRAMS (13TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Senator.

ADRIENNE GRETO: Excuse me for saying your name incorrectly.
REP. MICHEL (146TH): That’s okay. It’s hard for people to understand me sometimes with my French accent.

ADRIENNE GRETO: Yeah.

REP. MICHEL (146TH): Thank you for your testimony. I’m looking forward to the --

ADRIENNE GRETO: Yes.

REP. MICHEL (146TH): -- which is Homeline, right?

ADRIENNE GRETO: Yes, Hopeline Pregnancy Center on High Ridge Road.

REP. MICHEL (146TH): Yes. I just wanted to point out, we didn’t mentioned Hopeline was being deceptive --

ADRIENNE GRETO: Sure.

REP. MICHEL (146TH): And I will do my own --

ADRIENNE GRETO: Yeah, sure.

REP. MICHEL (146TH): -- could you repeat who was hosting that site again, Connecticut Right to Life?

ADRIENNE GRETO: Yeah, it was CTforwomen.com, and it was a Connecticut Right to Life, and they are not a pregnancy center. They’re a separate organization that promote pro-life things, but they are not a pregnancy center. And again, we have attempted to get our information, multiple centers, off of that website. We have no idea who the individual is that’s running it to contact. And so, I just wanted to clarify that, yeah.

REP. MICHEL (146TH): They’re not a pregnancy center or a limited services pregnancy center?
ADRIENNE GRETO: I’m sorry?

REP. MICHEL (146TH): They’re not a limited services pregnancy center?

ADRIENNE GRETO: They are not a limited services pregnancy center, that’s correct, like we are.

REP. MICHEL (146TH): Thank you.

SENATOR ABRAMS (13TH): Representative Cook.

REP. COOK (65TH): Thank you for being here and having the amount of energy we all wish we did.

ADRIENNE GRETO: You’re very welcome.

REP. COOK (65TH): I do have a question, though.

ADRIENNE GRETO: Sure.

REP. COOK (65TH): You said that you tried numerous times to get your information off of a specific site.

ADRIENNE GRETO: Yeah, our, the members of the coalition, the Connecticut Pregnancy Care Coalition.

REP. COOK (65TH): Can you explain the process on how you’ve attempted to do that?

ADRIENNE GRETO: Yeah, so we’ve looked up ways to contact them, to get in touch with them, through the website and other things like that and correct me or add to my, you know, if there is any, the email, the email that’s there, and there has been no response.

REP. COOK (65TH): Have you ever tried filing complaints with the Better Business Bureau?

ADRIENNE GRETO: I personally have not, but that’s a great suggestion that I will absolutely look into.
REP. COOK (65TH): Just checking.

ADRIENNE GRETO: Yeah, thank you.

REP. COOK (65TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you so much for your testimony.

ADRIENNE GRETO: Thank you. Thank you so much.

SENATOR ABRAMS (13TH): Joy Adedokun, I’m not doing, I’m doing your name justice, so you’ll have to do it for me.

JOY ADEDOKUN: It’s Adedokun.

SENATOR ABRAMS (13TH): Adedokun. Thank you.

JOY ADEDOKUN: Good evening, that’s correct. I’m Joy, and I am a senior at Wesleyan University in Middletown. I had to miss work and class to be here today, but it is worth it because standing for truth is worthy, regardless of the cost. I’m in firm opposition of this bill.

As the founder and coleader of a women and children’s advocacy group on campus, I did a lot of research about the pregnancy resource centers in our state. We decided that we would volunteer at a specific center in Middletown because we value their mission and commitment to women.

The findings that I made upon browsing their website and inquiring in person, led me to learn that these centers are thoroughly transparent about the services that they do and do not offer their clients.

I want to emphasize that I was well aware that they do not perform or refer for abortions. This
information is explicitly printed in their literature, clearly stated on their website, and is always affirmed if one were to call them or do a walk-in visit, just like I did. They do not pretend to be family planning or abortion facilities. They’re not tricking women or luring them to enter their doors. They have nothing to gain or profit off of their clients because they’re served free of charge anyway.

If a woman walks into a pregnancy resource center, only looking for emergency contraception or a medical/surgical abortion procedure, she will be kindly informed that she has come to the wrong place. As a colleague student in this age of freely and readily accessible information, I testify that I would never support an organization that did not have a clear mission or was deceptive about what they do; 14 other Wesleyan students along with a few more from Yale and Yukon also oppose this bill.

Pregnancy resource centers work diligently to earn the respect of their local communities. They do not deceive women regarding their services or advertising. I mean, reputations are at stake here. Women and families willingly go to pregnancy resource centers in the same way my friends and I willingly volunteer and work with them.

I want to emphasize again, that in the last three years that I have been volunteering with my local pregnancy resource center, I have never witnessed dissemination of false information or anti-choice propaganda.

In closing, I want to echo the public and some members of this committee that this raised bill is
not a detailed piece of legislation and is vague in exactly what is and is not deceptive. This proposed bill appears to be redundant of the truth that already exists, which that these centers are already making their services clear in their advertising.

Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from the committee? Thank you very much for being here tonight.

Next we have Jo Ann Bittner.

JO ANN BITTNER: Good afternoon committee members. Actually, last time it was after midnight when I testified, so this is early for me. Okay.

My legal name is Josephine Bittner, my nickname is Jo Ann, and I forcefully and vehemently oppose HB 7070. I volunteer at a, as a client advocate, also as a front desk person at the ABC Women’s Center in Middletown, It is a faith-based 501c3 organization. I have volunteered there for over 13 years.

Now, my question to the writers and proponents of this bill is this: Where is the substantial evidence that clients seeking services at pregnancy resource centers are currently being deceived by their advertising?

On our website and in our literature it states that we do not perform abortions, nor do we refer for abortions. When someone calls in to ask about abortion, the answer is, as you’ve heard, we do not perform or refer for abortions. I ask you, how much clearer can the advertising or the answer be?
This bill seems to assume that pregnant women seeking information on making a pregnancy decision is not interested in other options and alternatives to abortion.

Many pregnant women, with unplanned pregnancies, might feel that they have to face their decision alone and that there are no options available to them.

At the ABC Women’s Center we want women to be educated on all their options so that they can make an informed decision regarding their next step. The services offered are, a free lab quality pregnancy test, a free ultrasound for the confirmation of pregnancy, done by a licensed ultrasound technician accompanied by a licensed nurse, and reviewed by a licensed physician and confidential options, counseling.

For our clients who have had their baby, there is a supply of free diapers, a supply of free wipes, free baby clothes, some free baby food, at times free formula, and individual free parenting and/or life skills classes. I hope the word registers free with you. All our services are free to our clients. And all these services cost the state or town nothing, and for me this is thrilling. There is no taxpayer money involved. As a taxpayer, I am thrilled about that.

As I close, I hope you understand that there are no deceptive advertising or practices at the pregnancy resource centers.

I ardently urge you to vote against this H.B. 7070 Bill. Thank you, from this old lady, who has lost her voice tonight.
SENATOR ABRAMS (13TH): Thank you so much. I had a question for you. You said you’re the, are you the receptionist or like the person who would be answering the phone if someone called for information?

JO ANN BITTNER: I do both. I can be at the front desk, answering the phone, greeting people that come in.

SENATOR ABRAMS (13TH): Okay.

JO ANN BITTNER: I’m also one who can meet with the client.

SENATOR ABRAMS (13TH): So, my question is, if the person doesn’t ask, are they still told that you don’t perform abortions or refer for abortions or is it only if they ask?

JO ANN BITTNER: I would say, when it comes to me, it was, it’s there I the literature, it’s there on the website, it’s there if they ask. They’re generally women --

SENATOR ABRAMS (13TH): I actually did read that. And I’m not saying on your website, I don’t remember which website it was --

JO ANN BITTNER: Right.

SENATOR ABRAMS (13TH): -- but the statement was, if asked, they would say.

JO ANN BITTNER: Correct.

SENATOR ABRAMS (13TH): But they would not say, if someone calls and just says, you know, I’m looking for services. I think I’m pregnant, they wouldn’t be forthcoming at that point and say, well, I want
you to understand that these are the services we provide, and we do not provide abortion. So, it's kind of like, in my upbringing, that would be called a sin of omission. So, you know, like you’re not telling what, what the whole story was; is that true or do you tell them when people call you?

JO ANN BITTNER: When people call and they ask what services we have, we tell them.

SENATOR ABRAMS (13TH): No, if they don’t. If they just say, you know, I think I might be pregnant, can I come in and see you? Do you explain to them at that point that these are the services you offer and that you do not offer abortions or refer for abortions?

JO ANN BITTNER: When they go to the nurse and the ultrasound technician for a pregnancy test and for an ultrasound, if they qualify for it, that’s when the nurses or would be talking to them about their options.

SENATOR ABRAMS (13TH): Okay. So, that doesn’t happen when they just call the center?

JO ANN BITTNER: Not unless they ask for it, if, we do.

SENATOR ABRAMS (13TH): Thank you. I forgot I was chairing. I was waiting for one of these guys to say something. Are there any other questions or comments? Thank you very much for your time. So, next Jane Cadett. Jane, are you here? I hope you’re home sleeping. Sophie Wheelock.

SOPHIE WHEELOCK: Good evening. Distinguished members of the Public Health Committee, my name is
Sophie Wheelock and I live in New Haven. I testify in strong support of H.B. 7070.

As a public health graduate student, at the Yale School of Public Health, I’ve studied the importance of sharing medically accurate and non-stigmatizing information with patients in all fields of medicine. This bill will benefit every patient in Connecticut, by allowing them to make independent decisions about their reproductive health, free from deception.

When a patient needs to access a medical clinic, they should be able to find one without confusion. Patients also have the right to know exactly what services a clinic provides, before they even walk through the doors.

I support women to be able to find whatever kind of support they choose for themselves, whether that’s religiously-based counseling, family support, or medical information. But it’s vital that patients know exactly what services they’re accessing without any deception.

As it’s been previously stated in other testimony, this bill only seeks to regulate centers that engage in false advertising. Let me say that again, this bill only seeks to regulate centers that engage in false advertising. It does not seek to do away with limited service pregnancy centers all together.

The problem with some of these centers is not the fact that they choose not to practice abortion, that is their right. The problem is that they mislead women in their ad.

On pages 3 to 5 of the testimony that I submitted, I’ve included images from the websites and printed
materials that I’ve collected from these health centers in Connecticut. The messaging in these materials demonstrate how these centers, none of which provide or refer for abortion, mislead women about the services they provide.

I’m going to read you just two quick examples. The Hopeline website, on page 3 of my testimony, I have a screenshot. Underneath FAQ, what are my options? It says, someone experiences, experiencing an unplanned pregnancy has multiple options, including abortion, adoption and parenting. If you are considering any of these options, please schedule an appointment today.

And I’m gonna finish just with the second, from the Care Net Community Resource packet that I collected just last week. Under who we are, it says, if you are considering the possibility of an abortion and live in the New London County area or any of the surrounding communities, then please contact us first.

SENATOR ABRAMS (13TH): Okay.

SOPHIE WHEELOCK: In summary, as a public health student and as a resident of Connecticut, I strongly support H.B. 7070, to limit the DECEPTIVE ADVERTISING PRACTICES OF LIMITED SERVICES PREGNANCY CENTERS in our state. Thank you for your time.

SENATOR ABRAMS (13TH): Thank you, Ms. Wheelock. Any questions or comments from the committee? Thank you very much for your time.

SOPHIE WHEELOCK: Thank you.

SENATOR ABRAMS (13TH): Cathy Shemeth, Shemeth.
CATHY SHEMETH: Shemeth. Dear members of the Public Health Committee, thank you so much for staying up late and hearing us. My name is Cathy, and I am a Registered Nurse Licensed in the State of Connecticut for 28 years. I also serve on the Board of the ABC Pregnancy Center in Middletown, Connecticut, where there are nine board members. And I just want to say, I don’t want to repeat all that’s been said today, there is absolutely no need for H.B. 7070.

As you’ve heard, there’s been zero claims from any Connecticut Pregnancy Center client claiming to have been misled by advertising. And as you know, if you go to their websites, they say clearly that they don’t refer or perform abortions.

Recently, a friend of mine, her daughter, was seeking out care. She had a second pregnancy. Her first pregnancy she had an abortion. And in her second pregnancy, she desired a different choice. And she sought out the ABC Pregnancy Center, knowing full well from their website and from information in calling them that they did not perform abortions. She had gone that route before, and she choose to go there and received an ultrasound and a bunch of information that helped her in her decision. She did not feel coerced. She did not feel deceived at all. And that’s a valid testimony that I’ve seen in my relationship with pregnancy centers in Connecticut for 28 years, I’ve been here, and I’ve been a part of what they do. And I believe in, in choice, choices, and opportunity for women to, to have just the choice to pursue options. And also, I respectfully remind you that the Connecticut already has legislation in place, which you already know,
the CUTPA law. My son worked, he’s a law student, he worked with Jeremy Pearlman, the Assistant Attorney General. And my son also pointed out to me because he worked in the Consumer Protection Department. And he said, there is absolutely no reason why NARAL would bypass due order of law and come to your first before they would go to Consumer Protection. There’s an agenda, underlying agenda, and that’s very evident to even a law student. And so, you’ve heard that argument time and time again. And I remember last year that was essential overtime our discussion.

And lastly, it discriminates against our Constitutional rights of free speech. It’s passing could be very costly to our state and future litigation.

And I respectfully remind you of the bill, and this is very important concerning deceptive advertising that was passed by the City of Baltimore in 2009, very similar that subsequently plunged this city into a lengthy and costly lawsuit. The Greater Baltimore Center for Pregnancy Concerns sued the city and this case wound its way through the legal system for nine years. The 4th U.S. Circuit Court of Appeal ruled in favor of the pregnancy center in January, just this last year, of 2018 and in September, just a few months ago, of 2018, Baltimore’s Spending Board voted to pay $1.1 million to cover the pregnancy center’s legal fees after a federal court ruled this city law violated the center’s First Amendment right of freedom of speech.

So, as members of our Public Health Committee, we respect you, we honor you, we value your input as a
nurse in the state, I value your input and insight and I ask you to recognize there is no absolutely no need for H.B. 7070 and to vote against it.

Thank you.

SENATOR ABRAMS (13TH): Thank you. I’m looking at your website right now. And it says, your options. The first one’s abortion. Considering abortion, ABC Women’s Center provides information on abortion procedures and risks because abortion is a medical procedure, it is important that you are educated on your options to ensure that you are making an informed decision regarding your next step. If you have questions about abortion, our staff is here to help you answer them. As a member of the board, why doesn’t it say anything in there that you neither perform them, nor refer for them?

CATHY SHEMETH: If you go down on the website --

SENATOR ABRAMS (13TH): No, I’m saying in that paragraph. The next paragraph explains adoption. And then the next paragraph explains parenting. So, I’m asking you that under the abortion paragraph, why doesn’t it say that you do not perform them or refer for them?

CATHY SHEMETH: If you look at the entire page and go --

SENATOR ABRAMS (13TH): I’m not asking about the entire page. I’m saying, in that paragraph, if you’re trying to be honest and upfront and, you know, explain exactly what you do and do not do, why would it not say in that paragraph that you neither perform nor refer for abortions? That’s my, that’s
my question. I shouldn’t have to look anywhere else to get this, is what I’m saying.

CATHY SHEMETH: And I respect what you’re saying very much. But let me also pose to you in, in, in connection to this young girl that is my friend’s daughter, she was considering an abortion, but she was also in that abortion trying to, because she had already had one, she knew she was not given the information accurately in, in going to that center of what the ramifications of that abortion were gonna have an effect. And so, when she went to the ABC Center, when it says, are you considering abortion, she didn’t immediately think that they would actually do an abortion there.

SENATOR ABRAMS (13TH): I think it would be reasonable though for someone who looked at that to want that information. And I think that’s at the crux of what we’re looking at here. That if I look at that, and I ask you this because you are a board member. So, if I’m looking at what my, it says, your options, the first one’s abortion, I would expect if you wanted me to have crystal clear understanding of what your center does and does not do that you would state very clearly in that first paragraph that you neither perform nor refer for abortions. I don’t think that that should be a problem --

CATHY SHEMETH: Well, let me --

SENATOR ABRAMS (13TH): -- because it’s just the truth of what’s there.

CATHY SHEMETH: Can I extend a question to you. So, if I was considering obtaining assisted suicide, because I had a chronic illness, and I went to a
website and that website had the question, are you considering suicide? My immediate thought would not be that site actually does or doesn’t actually promote or help me. What they’re doing is actually posing the question that I am dealing with and thinking about to actually enter into a discussion, which I think is very crucially important.

For example, I grew up in Japan. I spent 18 years there. 50 percent of the women in Japan have committed abortion, two out of three. Two to three abortions. And so, and they all would say that they, when I was there especially, that they felt coerced by the society to have the abortion, that they did have a choice.

And so, what they would have liked is the center that would have posed the question, are you considering this? Are you wanting to enter into the discussion? And to have someone there that would actually pose just an opportunity to talk about it and, and to discuss alternatives.

SENATOR ABRAMS (13TH): I’m not, maybe I’m not making myself clear. But I have no objection to the language that you have that’s there. You know, I mean, you could, because that speech to what you’re talking about that you could talk about it or whatever, I’m just asking why we got piece out, and I think that’s really at the heart of what we’re talking about with this bill. Like just say exactly what you do or do not do, that’s all.

Thank you.

CATHY SHEMETH: Yep. Could I, could I say if --

SENATOR ABRAMS (13TH): Sure.
CATHY SHEMETH: If, if someone, if I wanted to prevent someone, a young teenager, which I have assisted many a teenagers in their, I their journey to preserve life, if, if I wanted to draw them into discussion, to put on a website to draw the to that, I could say, are you considering suicide? Are you considering assisted suicide, if I was in the State of Oregon, where it’s legal, and would they immediately think, okay, I’m gonna go there and I’m gonna get help. I, I, I would be tempted to put that there if I wanted to offer help to them, to open up the discussion, to protect them. But also, not put pressure on them to make a decision. And we consider it very, very important in our center, at ABC Center to validate them in their decision and to support them in whatever decision they make. But we also want to present all the information, especially medically, not biased, but we want to present it so they can make the decision in the best way. Not coerced and, and actually forced.

SENATOR ABRAMS (13TH): I’m just questioning whether or not the first decision isn’t made, shouldn’t be made knowing exactly what I’m getting myself into. That would be my first decision. And that’s all we’re asking, just put it out there and let people make that first decision about whether you would be the agency I’d want to engage with or maybe there’s something else, that’s all. Thank you.

Senator Lesser.

SENATOR LESSER (9TH): Yes. Thank you. Sorry about that. Didn’t mean to almost let you off. You mentioned in your testimony and, and I don’t mean to peck on you, I’ve heard this from a lot of folks, this is a consistent talking point, I think,
throughout the evening, that this legislation is not necessary because of CUTPA because of the Connecticut Unfair Trade Practices Act, which governs unfair and deceptive trade practices. We don’t need to pass this because this stuff is already illegal. And I think you mentioned that your son, who is a law student spoke to and Assistant Attorney General who told him about it.

CATHY SHEMETH: He actually worked the entire summer with him and worked on many different cases on consumer protection law.

SENATOR LESSER (9TH): Understood. Thank you. We heard probably about 12 hours ago from the actual Attorney General, William Tong, who testified that that’s not the case. That the, that CUTPA does not cover the specific types of activity covered here. Because in his opinion, there wasn’t the kind of commercial relationship necessary to bring forward a claim.

You know, I guess the question for you, and I would ask the same question of other folks, are you bringing forth the same argument as, why should we discount the opinion of the Attorney General on this, with this regard?

CATHY SHEMETH: I, I have been informed otherwise. My son worked with him and from what I understand, that is, is not the due diligence of law in this particular case. And you’ve heard it reiterated here. I don’t quite understand why the Assistant Attorney General would actually say something and work with my son for an entire summer in a certain mindset. And last year, when we deliberated this actual same legislative law that was trying to be,
bill that was trying to be passed, we discussed this very same issue. And I don’t remember the Assistant Attorney General or the Attorney General saying anything about it.

And so, I find it very unusual that after a whole other year it would now just finally now be disclosed. I just think that’s a little, a little strange, especially since so many of you on the committee last year, I remember, saying so many times, you know, we’ve got this in place.

And so, I would offer possibly that there might be just a bias, I don’t know. It’s just, it’s just unusual to me. And, and so, I offered that up to you because it’s been a long period of time. And this was, you know, you all worked so hard last year. We were here to what, 1:30 in the morning.

SENATOR LESSER (9TH): Oh, I, I, I didn’t work that hard last year because I wasn’t on the committee last year. But I believe you that other folks here might have.

You know, I don’t, I don’t know but, you know, Attorney General Tong wasn’t the Attorney General last year and gave his legal opinion to this committee 12 hours ago and he said this law was necessary because or this proposal was necessary because the specific law that you mentioned does not, does not extend as you said it did. So, that’s my question, and I don’t, I’m not asking you to be a legal expert, that’s not your, that’s your background, but that is my question when I hear that talking point tonight.

Thank you.
CATHY SHEMETH: So, maybe there the, possibly the difference of opinion between the two Attorney Generals, possibly, right?

SENATOR LESSER (9TH): Thank you.

SENATOR ABRAMS (13TH): I just want you to know that I scrolled all the way down. It doesn’t say it anywhere. And I’d be more than happy to show you that.

CATHY SHEMETH: I just saw it.

SENATOR ABRAMS (13TH): Representative Cook.

CATHY SHEMETH: It’s on, it’s on the abortion page, if you take a look.

SENATOR ABRAMS (13TH): I’m just saying on the first page I got to and scrolled down, it’s not there.

CATHY SHEMETH: Did you look on the abortion page?

SENATOR ABRAMS (13TH): Dr. Petit. A comment, Madam Chair, I think the Attorney General did say, he wasn’t sure it applied. But earlier tonight the 12th person who testified, Attorney Knag, with 30 or 40 years’ experience said he thought it did. It could be applicable under CUTPA. So, we’ve heard two different opinions and I looked at the website too. When you go to the home page, if we’re on the same webpage, and you hit, your options and then abortion. And wait until that page comes up, at the bottom of that page, it says, this information is intended for educational purposes, ABC Women’s Center provides pregnancy confirmation services. It does not perform or refer for abortions.

So, you have to hit options and then abortion, and it’s at the bottom of the page.
CATHY SHEMETH: And I respectfully submit that in Baltimore, they actually passed this legislation. And it caused that city to go into a nine-year litigation battle. It was awful. And I’ve been following that. I’ve been intrigued by it. But just last year, the city ruled in favor of this pregnancy center and actually rewarded them with $1.1-million dollars in legal fees.

So, I think that’s important for you to consider in what you’re doing because it’s just an important precedent and this just happened last year.

SENATOR ABRAMS (13TH): Senator Lesser.

SENATOR LESSER (9TH): With respect, I actually differ pretty strongly on that. And this also covers ground that we covered in detail with Attorney General Tong, again, about 12 hours ago. The Baltimore ordinance, to my understanding, is like the California law that was struck down the last year by the Supreme Court in the Nifla decision, concerning the question of compelled speech or concerns about question of compelled speech, where there’s, centers are required to post notice. That is not something that’s in this legislation, as I read it, before us tonight.

And so, the issue there in Baltimore and the issue in California was whether or not a legislature or a deliberate body could compel a center to provide the notice. This is simply saying that the same kind of, as I understand this proposal, that the same kind of laws concerning deceptive marketing practices that apply to any other entity and engage in commerce would extend to, would extend to these limited services pregnancy centers.
But there’s no, I’ve asked a bunch of people on both sides of this committee the same question, and nobody has pointed to a compelled speech argument in this. So, I understand your background hasn’t been the law. Mine isn’t either, but I think that, I think it’s very important that we would be clear about what we’re talking about that we’re not conflating the two different issues that may, may both relate to this issue, the controversy of abortion, but cover very different parts of law. And thank you.

CATHY SHEMETH: If I could --

SENATOR ABRAMS (13TH): Representative Betts.

CATHY SHEMETH: Oh, I’m sorry, if I could say something. So, what NARAL uses poses in its fight because it’s been a nationwide battle against advertising deception, is usually the model that you’re creating in actually monitoring the websites and the pamphlets that then it moves to actually implementing signage in the facility that tells and communicates where the individual can go to actually get an abortion. That’s what was happening in Baltimore, but, but initially and --

SENATOR LESSER (9TH): I didn’t, I didn’t --

CATHY SHEMETH: -- in California it was the same way.

SENATOR LESSER (9TH): -- ask a question, I’m sorry. We have a lot of people waiting to testify. I, I just would point out that there’s nothing in this bill before us. All we can talk about is the bill before us. And there’s nothing in the bill before us that has anything about compelled speech that
requires any kind of notice requirements or anything of that kind. So, you know, I appreciate your concerns about future legislation. But because this is a hearing on a specific bill, all we can talk about here is really what’s in that bill. So, thank you.

CATHY SHEMETH: But --

SENATOR ABRAMS (13TH): Representative Betts.

CATHY SHEMETH: -- if you hit on freedom of speech.

SENATOR ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Yeah, thank you. Just a couple of things. I wrote down some notes this morning when Attorney Tong was speaking. And I’m just gonna add a couple of things. But I really don’t think it’s appropriate for our role to be having a debate about this. We’re here to just sort of listen to what the people are saying and have them express their opinions. We can debate the issue later. But I don’t think it’s fair or appropriate to be debating individual people. And if we do, we’re gonna be here for a much longer time than I think anybody wants to be.

But pertaining to what Attorney General Tong had said before, the three things I wrote down is he could not conclude whether CUTPA would apply. He admitted he didn’t know of any cases litigated and no one has tried to use it. And I’m just saying that not for the point of debate, but just as a matter of record because I wrote this down.

And I thank you for your testimony. And I would recommend we move on and not engage what I think is
not an appropriate way of having a public hearing. Thank you.

SENATOR ABRAMS (13TH): Okay. Are there any other questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you. So, I think it’s appropriate to point out that maybe what this bill that’s before us, it has certain language. And a lot of the testimony has nothing to do with the aspect of advertising. So, if we point that out, I don’t think that that’s out of order.

Thank you, Madam Speaker, or Chair.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much.

CATHY SHEMETH: Thank you so much.

SENATOR ABRAMS (13TH): Pamela Michaud. Pamela Michaud. Oh, I’m sorry, I didn’t see you.

PAMELA MICHAUD: Thank you so much for hearing me out. Knowledge is power. Connecticut pregnancy centers empower women by giving them the knowledge that they need to make an informed choice regarding their unplanned pregnancy. I wish that Care Net Pregnancy Resource Center had been around in 1987, when I became pregnant with an unplanned pregnancy. My boyfriend at the time gave me the cash needed to go into a Planned Parenthood to get an abortion. While I don’t remember all of the details surrounding the day of the abortion, I do remember that the staff I spoke to didn’t give me any other options. They took my money. They took my baby. And they took a part of my dignity when the doctor performing the surgery said, now, let’s make sure we
don’t see you back here again, young lady, in a very gruff voice and a very mean facial expression.

While not around when I had my abortion, Care Net Pregnancy Resource Center is a very present help in my life today. You see, I went through their course entitled, Forgive and Set Free. This course has helped me to deal with the guilt and shame I struggle with to this day as a 52-year-old woman.

Connecticut pregnancy centers are empowering women to make informed choices. And whatever that woman’s choice is, they are there for them, 25 years this Thursday, Care Net will celebrate.

My heart is for any woman who finds herself in an unplanned pregnancy, to be able to Google the word, abortion, on her phone or her computer and have a pregnancy center come up as a choice. You see, I want her to have the knowledge she needs to make an informed decision. Knowledge is power.

Please opposed H.B. 7070. Thank you.

SENATOR ABRAMS (13TH): Thank you for your testimony. Are there questions or comments from the committee?

Thank you very much.

Marla Darius. Marla Darius, no. Arena Montalvo, it’s Anna, okay. Anna. Yeah, thank you, Anna.

ANNA MONTALVO: Thank you for correcting that. Anna Montalvo. Hello. Welcome, members of the committee. So, I’m testifying in opposition to H.B. 7070. I’m a volunteer client advocate and a nurse at ABC Women’s Center in Middletown. I have a Bachelor’s in Human Services and Development. And
I’m also a Licensed Professional Nurse for over eight years.

My history includes but is not limited to, just to give you an idea of what I’ve done in my career, experience in ventilators, tracheostomy care, gastrostomy care, hospice, geriatrics, pediatrics, dialysis, wound care. I’ve been a school nurse, post-surgical nurse, diabetic care and much more.

As a nurse at ABC, I perform lab quality urine pregnancy tests, I assist the Registered Diagnostic Medical Sonographer with ultrasounds, and provide options for counseling. The pregnancy tests are performed and confirmed by a Licensed Practical Nurse and a Registered Nurse. All of our medical practices, including the ultrasounds, are overseen and confirmed by our Medical Director, Dr. Daniel W. O’Neill, who spoke here earlier.

On the ABC website and in their printed materials, ABC states that they, “provide free and confidential pregnancy resources and services to women in our community. We are here to walk with you through pregnancy and parenting decisions.”

There is no lie found in this statement. All of their services are free. We support the women from the time of conception until the child is two years old. We provide clothes, baby food, formula, diapers, wipes, new cribs, new car seats and new strollers. And we offer parenting classes and peer-counseling from trained client advocates.

We treat all of our clients and patients with the honor and respect that they request and deserve. We have never discussed or done anything without the client’s consent. I actually have, whenever I see a
client or a patient, I always tell them, you are in the driver’s seat, you are in control of today’s session. And you are allowed to say, no, at any time that you do not want to discuss or talk about anything that doesn’t make you feel, that makes you feel uncomfortable.

So, please we ask that you continue, that you help us to continue providing the quality care that we provide to our community and to the families within our communities. There are no deceptions within our organization, and we invite the entire committee for a tour of ABC Women’s Center in Middletown. And please vote no on H.B. 7070.

Thank you.

SENATOR ABRAMS (13TH): Thank you, Anna. Are there any questions or comments from the committee? Thank you very much for your testimony --

ANNA MONTALVO: Thank you.

SENATOR ABRAMS (13TH): -- and staying tonight. Callie Ginapp, and next is Laurie Schwartz.

CALLIE GINAPP: Hello. Thank you, everyone for staying out so late tonight and everyone on this committee. My name is Callie Ginapp, I live in New Haven and I’m a first year medical student at Yale. And I testify in strong support of H.B. No. 7070. When I was 18 and a few weeks into college, I was deceived by the false advertising of a crisis pregnancy center.

The advertisement for a clinic called, Informed Choices, promised free healthcare for anyone who’s pregnant or wanted STI testing and were plastered everywhere around the campus.
I was excited that there were free women’s healthcare clinics nearby and scheduled an appointment for a routine STI screening. Excited, I was taking my reproductive health into my own hands and completely unaware that crisis pregnancy centers existed.

At the center I was told by a woman, not licensed to provide healthcare that I was going to hell. That sexually transmitted infections are God’s way of preventing premarital sex and that gay people should never have sex. She showed me pictures of infants born with life-threatening herpes infections and informed me that I needed to reclaim my virginity and be preparing for motherhood. I left sobbing and in shock that centers lure women in by disguising themselves as women’s health clinics, just to force their personal ideologies on us using scare tactics.

Thankfully, I was able to seek care at student health services, but that is not always the case for many of the women these centers pray on. This incident made me acutely aware of the obstacles women face in trying to get basic healthcare. And I began volunteering at the Emma Goldman Clinic, a local, actual women’s healthcare clinic. There I cared for a woman similarly victimized by fake women’s health clinics, including several clinics endorsed by Care Net. They were ultrasounded by people with no training, lied to about how far along their pregnancy was and were similarly told they were going to hell.

This was not only traumatizing but delayed how long it took them to seek care at our clinic. I contacted my university many times about removing these advertisements, which they did for a while,
until the clinic demanded they be put back up. There were no laws prohibiting these clinics from deceiving people.

I am very thankful that I now live in a state that has among the best protections for women seeking reproductive care.

However, in Connecticut, there are more crisis pregnancy centers than family planning clinics. As a medical student at Yale, I do not want my patients to continue having the same horrifying experience that I did.

People have a right to not be lied to in trying to seek medical care. When organizations specifically prey on women, on vulnerable women and lie about medical services, women’s health suffers.

This bill will regulate deceptive advertising, helping to prevent women from unknowingly falling into the same trap that I did years ago.

I strongly support Bill No. 7070 and hope you’ll take this opportunity to protect the health of women in Connecticut.

Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments by the committee? Thank you very much for your testimony.

CALLIE GINAPP: Thank you.

SENATOR ABRAMS (13TH): Laurie Schwartz.

LAURIE SCHWARTZ: Hello to the Public Health Committee and thank you so much for being here for us tonight. In looking over my notes, many people
tonight have said more eloquently than I could say, many important points that you needed to hear. So, I’ll just scan my notes and see what I can say that might fill some of the gaps.

So, my name is Laurie Schwartz and I live in West Hartford. I spent several years working at a pregnancy care center in Hartford. And I also regularly pray in front of the abortion clinics. I pray for the mothers, I pray for the fathers, I pray for the babies and I pray for the abortion care workers.

I guess what I want to say is, starting with the names of pregnancy care centers, they pretty much speak for themselves. They are transparent. Hopeline Pregnancy Center, Saint Gianna Pregnancy Center, Two Hearts Pregnancy Center, St. Gerard’s Center for Life Pregnancy Center, Carolyn’s Place. The titles of these centers themselves speak for the mission that they provide. There’s no deception there.

When I worked at St. Gerard’s Center for life, the women who came to the center, they knew before they stepped foot into the center why they were there. They came for pregnancy care. They came to carry their babies to term. It was no confusion. They were referred by their friends. Many of them were poor. Many of them were alone. And at the center they met non-judgmental, compassionate volunteers who helped them with their emotional concerns and also provided for them material goods.

I just think that one thing we all have to know is that young girls today are educated in their schools and they all know about Planned Parenthood. When
they pick a pregnancy care center, they’re picking it because they want to have their baby, and they know about Planned Parenthood. There are no delays involved if they want an abortion, there will not be a delay.

And I also want to say one last thing, if you’ll just bear with me for one minute. I really feel that these young doctors here, when they go out to practice, look for a certain standard of honesty and of documentation if there’s anything that they do in their practice that would equate with malpractice or deception, and we expect no more. If there is an incident of deception, we all know that there are ways of properly documenting this, so it is not hearsay, it is not anecdotal information, and so that the person who makes that claim has signed their name to it.

SENATOR ABRAMS (13TH): Thank you, I’m gonna have to --

LAURIE SCHWARTZ: Please vote against H.B. 7070.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Hold on one second. Are there any comments or questions? Thank you very much. Constance DeLoreto.

CONSTANCE DELORETO: Thank you members of this committee. I’m from Glastonbury, Connecticut, Constance DeLoreto. And you’ve heard it all tonight. I’ve been at St. Gerard’s for 15 years. And Laurie stated it properly, the girls come to us who know we’re gonna help them. And it’s already their choice, most of the time. Sometimes girls come in and they have unexpected pregnancies and they’re in a dilemma. We give them their options.
We tell them what we provide. And they leave and there are several that don’t come back because they decide to have an abortion. There’s no pressure. They know where we stand. And they also know that we care for them and we don’t judge them.

And to another point, when it said that we won’t tell them where the abortion clinic is, well, I had an incidence last week where a gentleman came, a young man, very personable, big smile. He said, do you know where the abortion clinic is, I’m picking up my girlfriend. And I said, well, just follow the yellow brick road. And that’s exactly what the abortion clinic, Hartford GYN Clinic, they painted the brick walk yellow. So, girls that they direct to their building will know where they are.

So, there was no deception. I’ve never, I’ve never witnessed deception at St. Gerard’s, we’re upfront. We have to answer to a greater power.

Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Lena Sweeney.

LENA SWEENEY: Hi, my name is Lena Sweeney. I am a resident at Yale New Haven Hospital, in Ob-Gyn. But I’m here speaking today for myself and on behalf of my patients. I think the first thing to mention is that centers that practice evidence-based ethical and fair care are not at risk with this bill. It’s speaking only to present deception. And deception against some of the most vulnerable patients.

Comprehensive services for pregnancy and for abortion rely upon prompt presentation to care and difficulties with patients having access to that
care compromises their outcomes for both their pregnancies and for their abortions.

Pregnancies progress quickly and patients often have extreme barriers in their lives and their psychosocial circumstances and their economic circumstances to finding the time to present to appointment. And if they waste some of that time presenting to care that they think will lead them to services that they need, they may have compromised their ability to access the type of services that they need and that they are eligible for in this country and in the state.

I would question, based on my own experiences, patients that all women know where to find the services that they need. I think that some of the most vulnerable women are those that do not know where to find those services and who are seeking support from friends, community members and from the internet and finding confusion there.

The fact that it’s taking multiple college and graduate educated members of the committee to find the appropriate information on the websites speaks to that difficulty.

And finally, I think that something that needs to be said is that patients do not speak publicly about their inability to access abortion. It’s shameful in our society at this time and difficult in people’s family and personal circumstances to speak publicly about that. They speak about it in our exam rooms with their midwives and with their doctors and they, we are the ones who see them when they run out of time because they’ve accessed services that they thought would help them. And
they sit in our rooms and they cry, and they have no options left because their time has run out.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Thank you very much for your testimony.

LENA SWEENEY: Thank you.

SENATOR ABRAMS (13TH): Next we have Lauren Marazzi.

LAUREN MARAZZI: Hello, good evening. It’s actually Lauren Marazzi. All right. As I said, my name is Lauren Marazzi, and I’m an MD, PhD student, living in Farmington, Connecticut. I testify in support of House Bill 7070.

As both a medical student and a woman living in Connecticut for the past seven years, I am deeply concerned about the repercussions of misinformation spread in the advertising by some crisis pregnancy centers.

As stated earlier tonight and multiple times, an abortion is a safe, common, and time-sensitive medical procedure. In the United States one in four women will have an abortion in her lifetime. I also want to note that 61 percent of the women getting abortions are between the age of 20 and 29. So, when we say, girls we’re infantizing women, a large majority.

Those who provide care at real women’s health centers, doctors, nurses, licensed social workers, do so with respect and compassion for a woman’s decision. There is no guilt and there is no coercion. In medical school we are taught the importance of collaborative informed decision making with our patients.
When a woman searches for fact-based medical advice on an abortion or other reproductive health issues, physicians are taught to listen with empathy and understanding and to provide accurate compassionate counseling. The ultimate goal of counseling and education is to empower the patient to make the decision that is best for herself.

Our patients, too, are in the driver’s seat. They can say no at any time. If a patient does not want to hear anymore about abortion, other than that, it is an option they can say that with a medical doctor, with a physician.

Some crisis pregnancy centers do not provide the full options and deliberately deceive people who may attend them with misinformation. On the ABC Women’s Center website, once you find the abortion page, and if you scroll all the way down, before they say that they don’t provide the services, they have, what if I change my mind? And you mentioned, if you’ve taken the first bill, it may not be too late, it may not be too late to continue your pregnancy. And this links to a website that says that medication abortion can be reversed.

This statement is not based on controlled scientific studies. It’s been refuted by ACOG and it is not evaluated by the FDA. A woman cannot make the best decision for herself when she’s not fully or accurately informed. We owe it to the women of our community to provide accurate information when they seek reproductive health care.

SENATOR ABRAMS (13TH): I’m sorry, I’m gonna have to cut you off.
LAUREN MARAZZI: That was the end. Thank you very much.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Representative McCarty.

REP. MCCARTY (38TH): Very quickly. Thank you and thank you or your testimony. But throughout the evening we keep hearing over and over again that we’re talking about deceptive advertising and practices and we hear repeatedly that some of the pregnancy centers may be giving the false information and; therefore, it’s time sensitive to go, if you’re gonna have, decide on a different choice. And I’m just wondering, what, what is the definition of time sensitive in the dialogue that you’re leaving because I would imagine if someone came in and they decided to take a different route, that they would leave and go to the next option.

So, I’m just having difficulty, and I mean this sincerely, throughout the night it’s been said over and over again. So, is that related to the deceptive advertising piece?

LAUREN MARAZZI: Well, I think that if you, you know, not every woman knows she pregnant within, I don’t know, six weeks of a missed period or anything like that, you know, every woman has, you know, different cycles, et cetera. I believe that you can get a medication abortion up to 10 weeks and if you are going to a center that you think offers abortion and you’re in your ninth week of pregnancy and you just found out, you have one week to get that medication abortion. And then again, when you’re going on to a physical abortion as your next option,
you just found out you’re pregnant or if you are, you know, trying to make this decision and you’ve been misled to, or you think you’re going to a clinic that can provide that procedure and they cannot, you know, you’re, you’re totally up at 24 weeks before you have no more options. And you’re gonna necessarily know that you’re pregnant one week into your pregnancy.

REP. MCCARTY (38TH): I’ll just say thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. Bill Maune. Okay. This one I cannot read. What is it? Fara Tang.

FAREN TANG: Faren.

FAREN TANG: Faren.

SENATOR ABRAMS (13TH): Faren, thank you.

FAREN TANG: Good evening. My name is Faren Tang. I am a lawyer, living in New Haven, Connecticut. And I am a fellow with the program for study of Reproductive Justice at Yale Law School. Although my testimony today reflects my views and not necessarily the institutional views of Yale.

So, I just want to respond, as quickly as I can, to a number of the really spurious legal arguments that have been raised over the course of the last 13 hours. Beginning with a number of the First Amendment concerns that have been raised. People have referred to the Nifla case of last year as to a, very tangentially related case out of the City of Baltimore. Both of those laws, the only, the only resemblance they bear to the law at issue here is they happen to regulate pregnancy centers. In
substance, there’s no relation between those laws and the ones, and the law at issue here. Those laws concerned compelled speech. All this law does is ban false, deceptive and misleading advertising. False, misleading and deceptive commercial speech is an area that the Supreme Court has held through a consistent line of cases, dating back to the 1980s, which are cited, too, in my written testimony, which I believe you have, receive no First Amendment protection. There’s no First Amendment right to lie to people about commercial services.

So, all these arguments that people have raised about viewpoint discrimination, content discrimination are totally in opposite in a case that only affects misleading commercial speech. That’s the first thing.

Second thing, there have been a lot of, a lot of questions raised over the course of the last 13 hours, over what the meaning of deceptive advertising is. In fact, as Attorney General Tong pointed out this morning, it’s a very common legal term of art. Every state in the country is capable of interpreting words like deceptive in a legal context, including this one. The Supreme Court of Connecticut has had no problem interpreting the meaning of deceptive or misleading advertising in the context of CUTPA, which brings me to my third point, which is that, yes, there is an existing consumer protection law that is, that is tailored toward more commercial services and trade practices on that count. And whether this law is duplicative, I’ll defer to the Attorney General, who testified this morning.
Finally, I just want to testify as to one final point about the, about the kind of ways in which pregnancy service centers can be misleading. One way that they can be really misleading is if a woman thinks she’s receiving confidential medical services when, in fact, she’s disclosing her private health information to somebody who isn’t subject to confidentiality laws. This really struck me today. I spent a very long afternoon in the over-flow room, hearing staff members from pregnancy centers talking about the details of their client’s medical histories. At one point a staff member from a pregnancy center took out her phone with an ultrasound photo of a client’s nonviable pregnancy and passed the phone around showing that ultrasound image to a number of other people in the room. I could see it. She had no idea who I was. I was sitting across the room, pointing out the anatomical abnormalities that have made this, had made that fetus nonviable.

A woman who is experiencing a nonviable pregnancy, a woman who is experiencing any pregnancy, I assume when she goes and seeks services, is assuming that her health information is going to be treated as private and confidential and it isn’t gonna be passed around to anybody who wants to see it in a public room like that. Nobody deserves that.

Thank you.

SENATOR ABRAMS (13TH): Thank you very much. You bring up an interesting point about the confidentiality. Are there any questions or comments? Thank you very much.

FAREN TANG: Thank you.

LAUREN GRAY: Okay. Okay. Again, my name is Lauren Gray from Bridgeport, Connecticut. Thank you all for staying here. This is a really important bill. And I was personally deceived by a CPC in person and online.

When I was in college, I found out I was unexpectedly pregnant and did not know where to go to help. So, I did the Google search for pregnancy help nearby in rural North Carolina, where there was only one place to go, two miles off my college campus because Planned Parenthood, one of the only ones in the state, was an hour and a half away.

I made my appointment, walked over, and in the waiting room, there were some pretty graphic abortion videos playing, which I, you know, obviously found very intimidating. And one of the first ways they lied to me was when I had my ultrasound, they told me I was actually further along than I was, which I later found out at a Planned Parenthood I was not that far along. So, that was a delay in healthcare, they lied to me, in person. And on their website, they did not explain that they would not perform an abortion or refer me to an abortion clinic or even talk about abortion.

I asked them to explain all of the options and how abortion worked, what I would go through. And they told me, this is a pro-life facility and we will only discuss keeping the baby and adoption services
with you and we’ll help you to make one of those decisions.

I didn’t need any help making a decision. I knew what I wanted, and they refused to help. Several red flags were raised, and they were not a medical facility. I was really confused, you know, as a college student who was really seeking help. They also told me that having an abortion could lead to breast cancer and having trouble conceiving later in life and I could experience many medical problems later in life, also deceptive.

I obviously knew I needed to get the hell out there because they were refusing to help me and refusing to answer any questions that I had. I needed information and I needed help and they refused to help me.

I have no idea how many other women have gone through this deception, where they’re looking for information online or at one of these crisis pregnancy centers, but women should not be deceived like this. I was 20 years old and I needed help and, you know, these people can mutter whatever they want over there, I really don’t care because this is what happened to me.

Thankfully, I was able to get to the Planned Parenthood after a couple of weeks, because in rural North Carolina, the waiting list at a Planned Parenthood is really long and that is a delay in healthcare. And that place helped me get the accurate information I needed and obtain the abortion that I wanted.

Women deserve honest information when they are seeking help. These fake pregnancy centers are
posing as medical facilities and giving out medical advice and they should not be allowed to deceive women or mislead women or lie to women like they lied to me.

It’s hard for women to see the difference between these facilities and, in fact, when I testified in Hartford last year, one of the women over here actually said to me, didn’t you know the difference? Why should I have to know the difference, when I walk into one of these places?

SENATOR ABRAMS (13TH): I’m gonna have to cut you off.

LAUREN GRAY: That’s okay.

SENATOR ABRAMS (13TH): I’m so sorry. Are there any questions or comments? Representative Michel.

REP. MICHEL (146TH): Thank you, Senator Abrams. Thank you for your testimony. Just curious, was that in Connecticut and --

LAUREN GRAY: No, that was in North Carolina. But they’re not here tonight, but two of my friends have also received similar situations. They’ve been through similar situations here in Connecticut. They don’t feel comfortable, you know, talking about this in public because, you know, it’s hard for women to say on the record, I’ve had an abortion. And, you know, this place deceived me. So, they’re not here tonight.

REP. MICHEL (146TH): Thank you very much and sincerely appreciate your testifying again. Thank you.

LAUREN GRAY: Of course.
SENATOR ABRAMS (13TH): Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. Thank you, Lauren for staying throughout the night to testify. It takes a lot of courage to speak a very personal experience in your life. And so many times I’ve heard in other testimony that not one example of harm has occurred. Well, thank you for being here tonight to actually testify to your own experience in which harm was done upon you.

Thank you.

LAUREN GRAY: Thank you. And Representative Hennessy is my Representative from Bridgeport. So, thank you for all of your support.

SENATOR ABRAMS (13TH): Any other questions or comments? No. Thank you very much for your testimony.

LAUREN GRAY: Thank you all.

SENATOR ABRAMS (13TH): Sarah Hepburn.

SARAH HEPBURN: Right here.

SENATOR ABRAMS (13TH): Oh, thank you.

SARAH HEPBURN: Okay. Thank you very much, committee. I really appreciate. I count it an honor being here tonight. My name is Sarah Hepburn. I work for ABC Women’s Center in Middletown, Connecticut as an ultra-sonographer.

I am licensed in OB/GYN Sonography. I have been registered nationally through the ARDMS since 1998. And I would like to express my opposition to H.B. 7070.
My role at ABC is to perform limited ultrasounds for clients with a positive pregnancy test and who express a desire for my service. The imaging is done on a voluntary basis and is used to determine the viability of the pregnancy, location of the pregnancy and for dating purposes.

The equipment that we use is called a Sonoscape S9 and is perfectly suited for our service. This scan is also done under the supervision of a Registered Nurse and the scan is read by a doctor, by Dr. O’Neill.

The information that is given to the patient is valuable and allows for a more informed client when she is reviewing her options going forward. The ultrasound, like all of our services at ABC Woman’s Center, is free of charge.

The clients that come to me are educated in the role of ultrasound and the information that it will provide. The procedure is explained, and nothing is done without the written and implied consent of the client. We also educate the client of pregnancy complications such as miscarriage and the potential findings such as ectopic pregnancy. Yes, ectopic pregnancy can be discovered on one of these ultrasounds.

They are given detailed signs and symptoms, such complications and instructions if it is felt that they might be of high risk. This service is invaluable and should not come under any unnecessary scrutiny, such as H.B. 7070.

There is nothing deceptive about the choice that our facility offers. We offer the information necessary to make a well informed decision for pregnant women.
May I just conclude?

SENATOR ABRAMS (13TH): Yes, go ahead.

SARAH HEPBURN: Thank you. We know that by law every woman has three choices, those are parenting, adoption and abortion, regarding her pregnancy. What we offer is clear. We offer information needed women to make the best and most informed choice for her and her pregnancy.

There is no better service than one that can attempt to fully prepare someone to all the benefits and all the consequences of each choice and they do all have benefits and they do all each pose their own consequences and everybody should be informed of those.

Should the woman choose life, we offer the tools and services to empower that choice. This is a wonderful experience that I have working with ABC Women’s Center. I look forward to many years of offering my time and talent to the organization. Being an insider, I can assure you that we do not --

SENATOR ABRAMS (13TH): Okay. I’m gonna have to stop you.

SARAH HEPBURN: Thank you.

SENATOR ABRAMS (13TH): Thank you. Any --

REP. COOK (65TH): Thank you, Madam Chair. I just have a question. At the beginning of your testimony you said, limited ultrasound?

SARAH HEPBURN: Yes.
REP. COOK (65TH): What is the difference between a limited ultrasound and what we might know to be a traditional ultrasound?

SARAH HEPBURN: Okay. Well, for a traditional ultrasound, I would look for ovarian cysts. I would look for uterine fibroids. I could look for a whole bunch of things. There’s certain things in a limited first trimester pregnancy we look for justifiability. We look for, you know, whether or not the pregnancy is inside the uterus. And whether there’s a heartbeat. I’m missing one. Pardon me. Oh, gestational sac inside the uterus.

REP. COOK (65TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.

SARAH HEPBURN: Thank you.

SENATOR ABRAMS (13TH): Sarah Thayer.

SARAH THAYER: Good morning, thank you for staying up all night to hear my testimony today. My name is Sarah Thayer, and I am a Registered Nurse in Connecticut and Massachusetts. I am presently training as a student nurse midwife at the Baystate Midwifery Education Program in Springfield, Massachusetts.

Nurse midwives are advanced practice nurses that provide gynecologic and non-surgical obstetric care to women across the lifespan. The majority of our patients are women who are seeking care during their reproductive years.
I am here in support of House Bill 7070, and I want to just summarize some of the points from my formal testimony that I previously submitted.

I’m really glad that someone brought up the point about the unregulated crisis pregnancy centers not being obligated to follow HIPAA laws. That is very, very important. Additionally, the types of testing for a pregnancy test, sexually transmitted illness testing, and the limited ultrasounds, I think we really need to discuss a little bit that this is not provided within the scope of a full gynecological physical exam from either a physician or a nurse midwife.

So, it is concerning to me that people who are concerned about pregnancy aren’t actually looking at the overall health of pregnancy and just pregnant women in general. Because women who are looking for prenatal care and everyone who is pregnant needs prenatal care. They have to be provided with things like prenatal vitamins and other health screenings to make sure that this pregnancy is safe for this woman. And it is up to the woman at any point in time to decide if this is a pregnancy that she wishes to continue or not within the laws that we have at this time.

When women end up in a clinic setting, where they reasonably believe they are receiving full-scope medical care, it is a delay of care that can negatively impact a woman’s health and her fertility for the long-term. So, if a woman comes to their clinic and has a negative pregnancy test, if they come to see me as a student midwife under supervision, we’re gonna have a conversation about
contraception options, since they’re not planning to have a pregnancy at this time.

Also of note, patients have a 72 to 120-hour window after unprotected intercourse to access emergency contraception. On the crisis pregnancy center of Connecticut website, it lists the morning after pill, which is a type of emergency contraception as a type of abortion. That is medically inaccurate. Emergency contraception --

SENATOR ABRAMS (13TH): I’m gonna have to cut you off, I’m sorry.

SARAH THAYER: -- will not harm a pregnancy.

SENATOR ABRAMS (13TH): Thank you.

SARAH THAYER: You’re welcome.

SENATOR ABRAMS (13TH): I’m gonna have to cut you off, I’m sorry. Any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you. So, you’re a midwife?

SARAH THAYER: I am a student nurse midwife.

REP. HENNESSY (127TH): Okay. So, so, my three kids were born with lay midwives, yay, midwives, thank you.

SARAH THAYER: Thank you.

SENATOR ABRAMS (13TH): A little cheer at this time of day is never bad. Anybody else have a comment or question? No. Thank you very much for your testimony. Reverend Ernestine Holloway.
ERNESTINE HOLLOWAY: Good morning. Before I testify, I want to say something. I think it’s unfair that I’ve been here since 9:30 and half of these people that testified was not even here, but you let people, let them sign up and the people that’s been here all day and they come in half of the day and they start speaking. I think that’s wrong and unfair.

I live in Meriden and I don’t drive. So, that means I have to pay a cab to go home because I wanted to testify. It’s not fair and it’s wrong.

My name is Reverend Ernestine Holloway. I’m a community advocate. I’m a pastor. I’m a street pastor, so we’re different. I get to deal with the people actually on the street. I don’t know many people here except for Facebook. But I do not that group, NARAL, whatever they are, I’ve been invited to some of the things that they do. I don’t think they know I’m Reverend Holloway. So, I’ve been invited to some of their protests. I listen to the verbiage today and that’s what upset me. Women are not dumb. Our teenagers, our millennials and centennials are not dumb. They’re smarter than some of us. And they can work Google better than all of us.

I listen at what everybody said today, I came here with an open mind and I listened. It sounds like a tape recorder, where everybody’s repeating or they’re reading from the same script. That bothered me. I listen at the words fake centers to centers that are regulated by the state. There’s a perception and then there’s fact. I listen to the Attorney General today and I listened to him last year. I don’t know if these are two different
persons or he’s schizophrenic because I swear that’s not the testimony that I heard. And that’s just my opinion.

What bothers me is, you guys think that us women can’t read and make decisions. This is not 1960. We are 2019, women are pretty smart, even the ones that can’t read can find a center. I deal with the women on the street. And what bothers me is the verbiage and what, what you guys are talking about, the law that you’re gonna put forth. It’s biased. Now, someone say that am I pro-life, absolutely. But I also believe that God gave women the right to choose. And whatever they choose is between them and God. But you can’t grill one side because one side don’t like the other.

You know what I would do, kick them both out of Hartford. Tell them they both got to go because they’re the problem. You would have never known about a pregnancy center, we wouldn’t be sitting here today with all this, with this going on if them two clinics would not be in Hartford. So, kick them both out.

I heard one say, oh, you know what you do, include them both in the verbiage. They go for abortion centers and they go for pregnancy centers. The goose is good for the gander.

SENATOR ABRAMS (13TH): Reverend, I need you to sum up.

ERNESTINE HOLLOWAY: This is what I’m gonna say, we trust you guys and we elected you guys to do a job. I feel that some of the questions that this committee put forth today was very biased and it alarmed me. I think that everybody does have a
right to exist. They can coexist, they don’t have to agree, they can agree to disagree, but you can’t lie and be disrespectful.

I don’t know NARAL that well, if I’m saying it correctly or not because I’m sleepy, but I will tell you this, I watched them tell a lot of lies today. Because I’m their Facebook friend. And on Facebook they put a lot of stuff that they may not want you to know. So, this is my suggestion. Go to everybody’s page, investigate all of them, because guess what, you’ll find out who’s telling the truth after a while.

SENATOR ABRAMS (13TH): Reverend Holloway.

ERNESTINE HOLLOWAY: I’m almost finished. There’s your side, my side and the right side. So, you know what, if they can’t fight it out and get it right, kick them both out of Hartford.

SENATOR ABRAMS (13TH): Thank you, Reverend Holloway.

ERNESTINE HOLLOWAY: And there won’t be a problem.

SENATOR ABRAMS (13TH): Thank you very much.

ERNESTINE HOLLOWAY: You’re welcome.


MICHAEL DEREWIANKA: You know, distinguished Public Health Committee members. You do highly important work and you do it for peanuts. You know, you guys get very little compensation. Thank you very much.
My name is Mike. I’m a believer in the God of Abraham, Isaac and Jacob. I’m a follower of Jesus Christ.

When talking about false and misleading representatives and ethical behavior, Chairman Steinberg, I think he made a very salient point. He said that there is, we should treat others the way that we want to be treated. That is just a fundamental truth. You know, there’s different reasons that people get abortions. But I would submit that the great majority of abortions are because of unwanted pregnancies and because they’re inconvenient. And that’s specifically what I want to talk to.

Ask this question, how many of us here would say, I wish my mother had aborted me? There’s more than the woman at stake here. There is a, there is a person here. When we give a health service, we should administer to the whole person. There is a physical part of a person, there’s also an emotional and a spiritual part of a person. And accurate information involves all of those because those all affect the health and wellbeing of a person.

If faith-based organizations have to advertise what service they provide and be really upfront and say, hey, we don’t provide this and we do provide this, why wouldn’t we require the same of abortion providers?

You know, specifically, why wouldn’t we require them to say, we do not provide an opinion of whether an unborn child is a person. We don’t provide that. I’ve never met a mother with two heads, I’ve never met a mother with four arms. Okay.
So, in conclusion, I’d like to say that God will judge, you know, they will judge whether or not we’ve treated others the way we treat ourselves. And I think abortion providers should say, we do not provide an opinion on whether God will judge you based on how you’ve treated others. Have you loved your neighbor as yourself?

SENATOR ABRAMS (13TH): Thank you very much.

MICHAEL DEREWIANKA: Sure.

SENATOR ABRAMS (13TH): Any questions or comments? Thank you very much of your testimony.

MICHAEL DEREWIANKA: And thank you very much. You guys really work hard. And I, I, this is the first time I’ve ever done this, and I appreciate --

SENATOR ABRAMS (13TH): Oh --

MICHAEL DEREWIANKA: -- you know, the thoughtfulness that I’ve seen go on.

SENATOR ABRAMS (13TH): Thank you.

MICHAEL DEREWIANKA: Thank you very much.


NARI RATH: Okay. Thank you for letting me be here. My name is Nari Rath, I’m an intern for Hartford City Council and Wildaliz Bermudez, a student at the University of Connecticut School of Social Work and
a resident of Bristol, Connecticut. I testify in strong support of H.B. 7070, the passions of this bill is extremely important. It will benefit college students like myself greatly. These clinics have been known nationally to advertise themselves in school newspapers, even on the back of tickets for a high school graduation ceremony in Mississippi to target young people. There are several fake clinics in Connecticut that are in close proximity in college campuses. One false women’s clinic which provides misleading information to their clients include Hopeline Pregnancy Resource Center. They have three offices located in Connecticut, one less than 15 minutes away from the University of Bridgeport, another located less than 10 minutes away from UConn’s Stamford Campus and their third deliberately located less than a mile from Western Connecticut State University and Naugatuck Valley Community College’s Danbury Campus.

Unintended pregnancy rates are highest among poor and low income women, women age 18 to 24 and unplanned birth account for nearly 1 in 10 dropouts among female students at community colleges. As college students, we are struggling with many of our own challenges to attain a degree, while perhaps working to afford our education. Navigating living on our own for the first time, paying for childcare and studying, cause students to be particularly vulnerable to advertisements of these fake clinics that are strategically located near college campuses. Searching for a clinic that provides us with all our options by trained medical professionals.