CHAIRPERSONS: Representative Sean Scanlon, Senator Matt Lesser

SENATORS: Hartley, Kelly, Anwar, Bizzaro, Cassano

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

REP. SCANLON (98TH): Good morning everyone who is here today. For those of you who don't know, my name is Sean Scanlon, I am the House chair of the Insurance and Real Estate Committee. I want to thank you for joining us all this morning.

As the designated Committee Chair but also kind of as a flight attendant, I should remind you that the exits are over here. If for some reason there is some sort of emergency, please just proceed calmly to the exit. There is a couple other things that they ask you to say but I entrust all of you will -- will be respectful of one another in case we do have an actual emergency.

If not, we will proceed directly to the beginning of the meeting. And the way that this does work here for folks to know is that the first hour is always reserved for commissioners and elected officials. And then, in the second hour, we move onto the public. Obviously if we can get through the elected officials quick enough, we will start the public testimony earlier. But politicians are usually very

long winded so sometimes that does last for a full hour. We'll -- we'll see if we can move them along for you because we certainly to respect everybody's time today and want to hear from you for sure.

So, with that, I have Senator Fasano on the list, number one, but I do not see him here. So, we will move onto Representative Exum. Representative, please feel free to take some of the chairs for your constituents.

REP. EXUM (19TH): Good morning. The Chairs, Senator Lesser and Representative Scanlon, to the Ranking and Committee members of the Insurance and Real Estate Committee, thank you for the opportunity to testify before you today in support of H.B. 5255 AN ACT CONCERNING LIVING DONOR ORGAN DONOR INSURANCE DISCRIMINATION.

I will yield momentarily to Robin Gilmartin and Diane Mack so that they can share their stories or experiences with you. Robin and Diane made me aware of this issue as these caring, empathetic women have each donated a kidney so that others might live and have a higher quality of life.

It never occurred to me that such an act of kindness could result in denied coverage or higher premiums after donating. This is also a personal issue for me. My mother died from renal failure and acquiring a kidney could literally have saved her life. Let's put an end to any punitive insurance measures against donors. And at this time, it is my pleasure to introduce to you Robin and Diane.

REP. SCANLON (98TH): If you could just please state your name for the record and where you're from that'd be great. Thank you.

MS. GILMARTIN: My name is Robin Gilmartin and I'm from West Hartford. I want to thank Representative Exum for her heart -- heartfelt support on this. And thank you to the Committee members for allowing me to testify today.

I support H.B. 5255. In 2017, I donated a kidney at Yale New Haven Hospital to someone I didn't know. I know her now, she's my kidney sister. My donation started an 18 person kidney chain. That is 9 organ donors donated to strangers, thereby guaranteeing loved ones with advanced kidney disease a lifesaving organ.

Since donating, I've become an advocate for the National Kidney Foundation. Living organ donors are desperately needed because cadaver organs are difficult to procure. And because there are 112,000 Americans, 1250 in Connecticut currently on the National Organ Transplant List. 83 percent are waiting for a kidney.

Most of those waiting will either be removed from the list because they've become too sick or will be among the 22 Americans who die each day while waiting for an organ. Meanwhile, every 10 minutes another American is added to the list.

There are barriers to increasing living organ donation. One is the misconception that donating a kidney is risky and will impact the donor's health or life expectancy. Another barrier is that the donor will suffer negative consequences such as loss of wages or denial of insurance.

There is no evidence that donating a kidney adversely affects health or life expectancy. There is actually some evidence that organ donors are

healthier than non-donors. Donor candidates are carefully evaluated by lab tests and physical and psychological examinations to ensure that the candidate is healthy enough to donate and that he or she is making an informed decision.

There has been on national systematic long term data collection on the risks associated with living organ donation but there are studies in process which indicate that overall risks are broadly considered to be low.

While every surgery has some potential risks, donation neither reduces life expectancy nor prevents donors from living a normal life. Increased insurance premiums or denial of coverage are based on misconception, not evidence.

We don't know how many individuals have experienced insurance discrimination as a result of donating an organ or how many chose not to donate because of such barriers. There is no hard data but there are personal accounts, some of which have been shared with the National Kidney Foundation.

Here are two representative examples. A fellow in Ellisville, Missouri. He donated a kidney to his wife and then after the donation, applied for $250,000 of life insurance. He was initially denied coverage. He threatened to sue and subsequently the insurance company agreed to issue a policy with a $25,000 annual premium.

I'll read the next one, she named names. Suzi Lockard from Thornton, Colorado. I worked for HealthOne and the life Insurance I got was through my employment. On the yearly questionnaire, they ask if I donated an organ and I answered honestly.

I then a got a letter from Prudential cancelling my life insurance.

We should reduce barriers to living donation, including any form of insurance discrimination to increase donation. It saves lives. Public policy should reflect the need and have the backs of every living -- living organ donor by ensuring they are not penalized by any form of insurance discrimination. I want to thank the Committee for hearing my testimony.

MS. MACK: Good morning, Committee members and friends here today. My name is Diane Mack, I live in West Hartford. I donated a kidney in 2015. I'm taking the opportunity this morning to read a testimony submitted by April Capone who lives in North Haven, Connecticut.

She is the manager of Yale New Haven's living organ donor -- Center for Living Organ Donors. Thank you. In 2009, I was sitting at my desk at the East Haven Mayor's office where I was serving as the town's chief elected and executive official. When a message posted on the Facebook account of one of the nearly 30,000 constituents in my town came through.

This man that I had met, maybe two or three times prior, was at that moment, in the clinic of Yale New Haven transplant. He was learning that his kidneys were failing him and that finding a living donor was his best chance of survival.

With that sobering news he posted on Facebook, I am in need of a living kidney donor. All of my friends and family have been tested and there is none available. If you are interested, please contact, and he gave the contact information.

In that moment, I knew like I knew my own name that I was meant to be his donor. So, on April 8, 2010, I was wheeled into the OR in Yale New Haven where my left kidney was removed and transplanted into my recipient.

We are currently preparing to celebrate our 10 year transplant adversary and I feel so humbled and grateful to have shared the gift of good health with another person.

The testing and evaluation to become a living donor is extensive and exhaustive. Donors must be physically, emotionally and socially healthy. Many of us find that as we go through this process, if we are given negative feedback it's from our close family and friends who are often scared and misinformed.

One very concerning piece of feedback that I received was a long time close friend who, as a registered nurse, had also worked in the insurance industry. While she was afraid for my safety, she was speaking with knowledge and experience. She called me to say, honey, do not do this. You can be denied insurance coverage for the rest of your life, I've seen it happen.

I took her words seriously but the Affordable Care Act passed around the same time. I felt protected knowing that Obama Care was the law of the land and would never be overturned. As the political climate and landscape has changed over the last 10 years, I no longer feel that sense of safety.

I would not change my decision to donate my kidney to someone in need but I would also like to be protected going forward. In my role as manager of

the Yale New Haven Transplant Center for living organ donors, I am repeatedly asked the question about insurance coverage and the possibility of living organ donation being viewed as a pre-existing condition.

I talk about how we as donors are protected by the ACA right now. It would be a great comfort to me and all living donors to advise them that the State of Connecticut takes their gift seriously and has taken additional steps to protect us as well.

To that end, I urge you to vote yes on H.B. 5255 AN ACT CONCERNING LIVING ORGAN DONOR INSURANCE DISCRIMINATION. Not everyone can be a living organ donor but everyone can help in some way. You have a tremendous power in front of you right now to help those in need of a living donor kidney or a liver by protecting us and future living donors against discrimination. Thank you for your time, attention and support. Sincerely, April Capone.

REP. SCANLON (98TH): Thank you both and thank you, Representative Exum. I think that I speak for everybody here when I say that we appreciate you coming and sharing those very powerful stories. Obviously, donating life is one of the greatest gifts that any of us can give to anybody and nobody should bear the consequences of doing that from an insurance perspective, as far as I'm concerned. So, we're looking forward to a hearing today on this. I want to open it up to questions from the Committee. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you both for your testimony. I -- I know you're with Representative Exum who has just been a -- a real stalwart advocate on this issue and I know

we'll do the work that's necessary to -- to fight for living donors in this state.

I've also heard as well from Senator Slap who, I believe, represents you in West Hartford and has been a real advocate on this as well. It was important to hear that letter that you read from April Capone. A dear friend who has just an incredibly compelling story.

And for all of us in elective office, I think she's a model for how you can serve your constituents by giving, you know, the constituent service of which, of course, is the gift of life. And so, she puts us all, I think, a little bit to -- to shame.

You know, this is really important issue. I was looking up, we were trying to figure out exactly how many people in Connecticut are awaiting organs right now and it looks like it's about 1214 are -- are waiting for a transplant. So, anything that could stand in the way of -- of a donation is a problem. It's a policy problem for those of us in this building.

I just had sort of a question. This is not -- I don't think we're the first state to consider legislation along these lines, to prohibit discrimination against living donors. And I just wanted to know if you were aware of any other states that had done this?

MS. GILMARTIN: Yes, and I can't rattle them off off the top of my head. But I -- I think there are maybe 10 or 12.

MR. HALTER: [off mic]

MS. GILMARTIN: Can you all hear that?

REP. SCANLON (98TH): No, we can't but maybe you could.

MS. GILMARTIN: Sure. There are 11 states that currently have living donor protection acts. And then there are some additional states that have legislation in process now. And they are --

REP. SCANLON (98TH): Sir, if you could just -- we don't usually do this but since you stood up already and you're there we're going to let it go. Can you just give your name for the record?

MR. HALTER: Yes. My name is Armand Halter. I live in Ledyard, Connecticut. I'm an advocate for the National Kidney Foundation. I'm also a peer mentor. And I received my kidney 24 years ago. So, I'm doing well, thank you very much. I'm pleased to be here and have a chance.

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

REP. VAIL (52ND): Thank you, Mr. Chairman. Good morning. I'm reading through this legislation and I see a lot of references to life insurance. Is this -- is this bill -- is this encompassing health and life insurance or just life insurance because those things are two very different kinds of insurance.

MR. HALTER: The draft legislation that Matt Hallassy submitted for us did mention medical insurance. The current bill, I haven't had a chance to read through it all but I think multiple people had -- had some input into it. So yes, it would be our intent, our desire to have medical insurance included.

REP. VAIL (52ND): It wouldn’t?

MR. HALTER: It would.

REP. VAIL (52ND): It would, okay. All right, but to that -- the intent -- the intent from your perspective is to have both included.

MS. GILMARTIN: Right and disability as well.

REP. VAIL (52ND): Okay.

MS. GILMARTIN: All forms of insurance. There are different versions out there among the 11 states that currently have living donor protections acts. The broader the better in our mind.

REP. VAIL (52ND): And again, the problem is that those are very two different types of insurance with two very different types of underwriting criteria. Some base that's ongoing life insurance more based on your health at the time that you buy the insurance. So, those are two very different things. So, that's where I just want to get some clarification on that. Thank you.

MS. GILMARTIN: Sure.

REP. SCANLON (98TH): Other questions from the Committee. Senator Lesser.

SENATOR LESSER (9TH): Yes. This isn't a question but just for, I think, clarification for Representative Vail. I believe that existing law already prohibits discrimination in health insurance underwriting. Those are the pre-existing condition protections that exist in the Affordable Care Act and that have also been codified in state law.

Now obviously if there are exceptions, we can go back and clarify it. But this bill for the proposed on which before us would cover life insurance, long

term care policies and other ways that people -- other insurance that people might cover that is not covered by that pre-existing condition language that's already in existence. And obviously, we'll work with whoever to look to see if there are health insurance issues that are yet to be covered. Hope that clarifies.

REP. VAIL (52ND): It does, thank you.

SENATOR LESSER (9TH): Thank you.

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

MS. GILMARTIN: Could I just add to that?

REP. SCANLON (98TH): Just quickly, thank you.

MS. GILMARTIN: Oh sure. I think April's point, I think is that if ACA were ever rescinded or repealed or the pre-existing condition limitation was lifted, then we -- it would be a problem going forward.

REP. SCANLON (98TH): Thank you very much. And thank you all for being here this morning.

MS. GILMARTIN: Thank you.

REP. SCANLON (98TH): I don’t see Senator Fasano still so next up would be Representative Cheeseman.

REP. CHEESEMAN (37TH): Good morning.

REP. SCANLON (98TH): Good morning.

REP. CHEESEMAN (37TH): Thank you very much, Chairs Lesser and Scanlon, Ranking Members Kelly and Pavalock-D'Amato. You have my testimony in front of you and I find it very appropriate that I follow Representative Exum and her advocates for kidney donation. Because as you all know, kidney failure

is one of the major complications of uncontrolled diabetes.

My husband was diagnosed with Type I diabetes the year after we were married. He had no family history, he was a healthy individual and I remember him saying to me, I can't believe I just got diagnosed with this disease.

He had been in the service and his two greatest fears were losing a limb and going blind. And, of course, those are two of the major complications that you encounter with diabetes. Now in the 25 years that he's suffered with this disease, he did start to lose his vision. And by the time, he was virtually blind.

He had laser treatments, he had vitrectomies, he had everything. He didn't lose a limb but he was in end stage renal disease and was waiting for a kidney. He died in 2012. As you all know from my testimony, between 2012 and 2016, the cost of the insulin that kept him alive that was the only thing that could slow down and stop complications, more than doubled.

I can't imagine what he would be paying today. And it's not as if we all of the sudden have an amazing new formulation of insulin that allows you to use a third or a quarter of a half. So, it would justify an increase in price. This is not the case.

You can't cure Type I diabetes. You can't get more exercise or change your diet or lose weight. It used to make him crazy. Well, if you just ate few cookies. No. This is an autoimmune disorder and the only way you stay alive, the only way you stop your kidneys failing, going blind, losing a limb, is by using insulin.

And you shouldn't have to face those complications, a shortened life because the price has gotten too high. As I say, I could accept it if all of the sudden this was an amazing new, improved version. It's the same drug. It's been around for 100 years. Biosynthetic insulin has been around since 1982.

We mandate lots of things and I know I oppose some of them, my party does. But as far as I'm concerned, this is something that we need to do. Because it not only saves lives it saves money. Those people who don't go blind, who don't need dialysis, who don't lose a limb, who are able to remain productive, healthy members of society and we need to make that happen.

So, I am in strong support of this bill. I thank you for raising it. I'm happy to take questions and let's do this. Thank you.

REP. SCANLON (98TH): Thank you, Representative and thank you for being here today and sharing that story about your family and for joining us at the press conference a few weeks back. One of the most important things about this bill that I think is important to me is just how bipartisan it is.

Right, this isn't -- we see a lot of partisan things in this building but working together to make sure people can afford insulin that they need to survive should not be one of those things and I appreciate you joining us in that effort. I'm going to open up to the questions and I'll reserve mine for other folks. Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you, Mr. Chairman. I was just wondering, you had mentioned

that the price had doubled. I wonder if you could give us those figures and did you say between --

REP. CHEESEMAN (37TH): 2012 and 2016. I think the figures I saw from the Non-Profit Healthcare Cost Institute. It went from, I think, $2600 to $5700. And I think that between another statistic I saw in -- in fact, in the last 10 years, insulin distributed by the major manufacturers some of the versions had tripled in price.

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

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman and thank you, Representative Cheeseman for your testimony, it was really touching. Just curious, during the period that you were getting the insulin for your husband, how did the -- your out of pocket costs change? Did they change dramatically over that term?

REP. CHEESEMAN (37TH): They went up but not to the extent, I mean, he was diagnosed in 1988 and died in 2012. And there was an increase in cost but it wasn't unsupportable, it wasn't astronomical. It might, you know, it might have gone from $20 to $30 or from, you know, the test strips might have gone from $25 to $50 which was a lot. But it wasn't a huge, unsupportable burden.

And thank God it never got to the point where, you know, well we're going to cut back on this. Because if you live with a Type I diabetic you know keeping that blood sugar controlled is key. And the way you keep that good control is through frequent testing. And, you know, I'm pleased that you include those testing supplies because you may be testing 8 or 10

times a day. So yes, there were increases but not to the point where we thought, you know, what are we going to give up so we can afford the drug.

REP. DATHAN (142ND): Did your insurance cover all the testing equipment as well?

REP. CHEESEMAN (37TH): It -- it -- it did, you know, with a copay. But yes, the test strip, the meter, syringes and the insulin itself. And, you know, there are a number of different kinds of insulin you may use. You know, there are quick acting ones that you will take before a meal. There are longer acting ones like Lantus that will go for, you know 10 or 12 hours or a day.

So, it's a very fine process. And every diabetic is different and it can vary from day to day. I know it's very frustrating, Type I diabetics, when your ill your blood sugar may be 400 or 500. You haven't eaten anything. But because of the way the body works and the stress on the system.

So, it's a challenge every day if you're a Type I diabetic to keep your blood sugar in check to avoid the highs and lows. And the last thing you want is to think, oh my gosh, you know, I'm not able to afford the insulin. I can afford, I know I should be testing more but I have to make this bottle of test strips last for a week.

REP. DATHAN (142ND): I mean, that's another huge concern. I know someone that went into diabetic ketoacidosis as a result of, you know, not having as much testing as she probably should have because her doctor didn't think it was as huge of a risk. So, I really think it's important that we focus in on the

testing and with that also keeps the insulin in check. Thank you so much for your testimony.

REP. CHEESEMAN (37TH): And it is, you know, when -- when you work at it, when you're able to succeed at keeping your blood sugar under control, you have a normal -- as normal a life as you can. You avoid those terrible complications.

I have a dear friend who was diagnosed as a child. And she's now in her 50s. She's had one tiny eye treatment but she, you know, she has an insulin pump. She's absolutely religious about keeping good control. And she's had two children, she's a grandmother.

You can have, you know, as healthy a life as you can as a chronic, you know, someone with a chronic disease. But it only happens because you have access and affordable access to the insulin and the test strips and the equipment you need.

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

REP. SCANLON (98TH): Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you, Representative Cheeseman for your testimony. And again, as Chairman Scanlon said as well for standing with us in that bipartisan press conference a couple weeks ago.

And I think your testimony underscores why this is so important. First of all, I'm sorry for your loss and this sounds like an incredibly difficult healthcare journey. But it also underscores why, you know, even when healthcare, health insurance covers diabetes management.

Managing Type I is still very difficult. It's still -- when everything goes right it can still be a difficult time consuming and stressful thing to do. And that's why when we hear stories later on today from folks who don't have health insurance or have major barriers in affordability it just makes it that much more challenging. Folks who have to -- who can't afford lifesaving insulin that they need to -- to stay alive. So, I just wanted to thank you for your testimony and I look forward to working with you to get this important piece of legislation passed into law.

REP. CHEESEMAN (37TH): Thank you.

REP. SCANLON (98TH): Any further questions? If not, Representative, thank you so much for joining us in this effort. Next up, Deputy Commissioner Hershman. He's going to be followed by John Carbone from Access Health unless Senator Fasano walks into the room first.

MR. HERSHMAN: Good morning Representative Scanlon.

REP. SCANLON (98TH): Good morning.

MR. HERSHMAN: Senator Lesser, Ranking Members and members of the Real Estate and Insurance Commission. My name is Josh Hershman. I'm the Deputy Commissioner of the Insurance Department. I'm here for three of our six raised bills. You have my testimony in front of you. I can read it into the record if you'd like or we can --

REP. SCANLON (98TH): All right.

MR. HERSHMAN: I'll go for it. We have three raised bills --

REP. SCANLON (98TH): Deputy Commissioner, if you don't mind, maybe my nod was just [crosstalk].

MR. HERSHMAN: Oh, okay, all right. I have three bills. We have one bill for AN ACT CONCERNING THE GENETIC TESTING which deals with whether or not companies will require or can require on the life insurance side a genetic test. And we are saying that the bill would prohibit that.

The other bill is related to our bail bonds act. It is, I think, the seventh year that we've presented this bill in front of this Committee. We feel as though it is very important. It -- it standardizes the bail bonds process and allows us to do a better job of auditing the bail bondsmen.

And the final bill that's in front of you has two, well three components to it. The first component is mirroring what we currently have on cancellation of non-renewal for commercial insurance for homeowner's insurance.

And the second component has to deal with a -- a loss ratio for credit for reinsurance. Connecticut happens to be in a completely different arena. Our loss ratio for the credit for reinsurance is somewhere around 23 percent. Most other states are somewhere around 50 percent. We should really be working on trying to bring us into the same standard as most other states.

So, those are the gist of our bills that are in front of you today. I'd be more than happy to answer any questions about them.

REP. SCANLON (98TH): Thank you, Deputy Commissioner. On the genetic testing, that is something that is becoming more and more prevalent

in our society. Does the Department feel like it is important for us to take a look at regulating that and making sure that nobody is being --

MR. HERSHMAN: Yeah. I mean, I think that really what's going on is that we're seeing accelerated underwriting processes taking place. And we just wanted to make sure that through those automatic processes and in traditional processes that those pieces of information aren't being collected to the detriment of the consumer.

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

MR. HERSHMAN: Thank you.

REP. SCANLON (98TH): John Carbone from Access Health followed by Senator Derek Slap.

MR. CARBONE: Good morning Chairmen Lesser, Scanlon, Ranking Members Kelly and Pavalock-D'Amato and the distinguished members of the Insurance and Real Estate Committee. My name is John Carbone. I'm the director of small business for Access Health CT, the Connecticut Health Insurance Exchange. Thank you for this opportunity to allow me to give testimony before your Committee this morning in favor of S.B. 206.

The Connecticut Health Insurance Exchange doing business as Access Health CT operates the marketplace for small business health insurance coverage, Medicaid, CHIP enrollment as well as individual health coverage for the State of Connecticut and has expertise in these markets. Currently, the Small Business Health Option Program

offers some qualifying health plans to the small businesses here in Connecticut.

Access Health CT believes that by offering all the Small Business Health Options program on a common platform would be beneficial to the consumers, small businesses, brokers and carriers.

The purpose of this legislation is to require certain health insurers that deliver, issue for deliver, renew, amend or continue certain group health insurance coverage polices in the state to offer and sell all their portfolio small business plans on and off the Connecticut Health Insurance Exchange.

This will provide small businesses with under 50 employees a range of plans that may meet their needs. Access to the small business federal tax credit for those who qualify which right now can only be offered on the Access Health's small business platform, year round enrollment for small businesses.

Access Health provides many benefits for health insurance plans including year round enrollment, flexible online enrollment platforms, a dedicated team to ensure seamless enrollment and renewals. I think it's important to note that in this legislation that all small business plans would be offered by the carriers on the exchange as well as off the exchange.

Access Health CT recommends that any legislation that is passed requires certain health insurance issuers to offer plans through Access Health SHOP specifying that all those plans must meet the ACA requirements and the Access Health Certification

requirements for qualified health plans to be offered on exchange. I'd like to thank you for your time and if you have any questions, I'd be more than happy to answer.

REP. SCANLON (98TH): Thank you, John. Any questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Yes. I just wanted to see if you wanted to expand a little bit. I understand that for the first time the Exchange is engaging in silver loading this year. Can you expand on that?

MR. CARBONE: That's mostly on the individual side and on the group side so I'd have to get back to you on for that.

SENATOR LESSER (9TH): And what are the statistics on the small group side in terms of growth?

MR. CARBONE: Currently right now, we have about 308 groups in there with over 1500 members. We only have 14 plans and 2 carriers currently in the platform.

SENATOR LESSER (9TH): And I understand that -- that growing that CHOP size is a priority for the -- the Exchange. But it sounds like it's still relatively small. Do you have projections or goals for the year?

MR. CARBONE: So, currently right now in the first quarter we have grown over 21 percent and we're hoping to continue that trend throughout the year.

SENATOR LESSER (9TH): Okay thank you.

REP. SCANLON (98TH): Any further questions. If not, thank you, John. Appreciate you being here today.

MR. CARBONE: Thank you.

REP. SCANLON (98TH): I know that Senator Slap is not in the building yet so we'll postpone him. But I see Representative Jesse MacLachlan was here a moment ago. Did he step out? All right, I don't see Senator Looney. How about Ted Doolittle from the Office of the Healthcare Advocate. And following Mr. Doolittle, we will move onto the public part of this process starting with Dr. Steve Thornquist.

MR. DOOLITTLE: Good morning, Representative Scanlon, Senator Lesser, Senator Kelly and Representative Pavalock-D'Amato and members of the Committee. Thank you for hearing me this morning. My name is Ted Doolittle. I'm the head of an independent state agency called the Office of the Healthcare Advocate.

And just for the benefit of everybody in the room, the Office of the Healthcare Advocate has a staff of nurses, attorneys, paralegals and others that can help you with health insurance coverage. So, if you've got a coverage denial, you're having questions about whether you're covered under your plan, please come to us, we can help you for free.

I come forth today to speak in support of several bills, I'll name them. S.B. No. 1 and H.B. 5175 and also, we filed testimony in support of Senate bills 202, 206 and 209. I just briefly want to comment on the first bills I mentioned, S.B. 1 and H.B. 5175. This is the bill concerning insulin.

A couple of -- you're going to hear a lot of rich testimony today and I don't want to add to that. But I will mention that putting -- putting these

expenses in front of the deductible, in other words, having the insurance company pay them before your deductible is wise policy. It was recently adopted at the federal level as an option for health savings account eligible high deductible plans.

And what that tells -- should tell this Committee is that this is a smart investment. It's been determined by the federal departments of Internal Revenue Service, HHS and Department of Labor that this is a form of value based insurance design.

It's a smart investment to get people to take their -- have and take their insulin so that the health system is spared from dramatic expenses when they don't. So, it's a smart thing to do, it's a form of value based insurance design.

I want to draw your attention to one aspect of my written testimony which is that well, for the reasons I stated, the Office of Healthcare Advocates strongly supports this. Remember that what this is doing is this is moving the high price of insulin away from the members and onto the healthcare plans. That will raise premiums. And that's a good thing for the reasons that I stated. It's the right place to put that risk instead of hoisting it onto the individual families that suffer from diabetes and are less able to pay it.

They're our brothers and sisters. It's our community. The community should be paying so the cost should be spread as widely as possible. However, this Committee should consider strengthening the bill or having some type of separate legislation that actually goes toward the high price of insulin. The high price of insulin is what's driving all of this. Why is insulin so high

and that is a question for -- for this -- for this body to take up.

We suggested several measures that could be added that would address the high price of insulin or at least cause transparency. I will really briefly run through them just so you have them in your mind and then I'll yield the floor to others.

But our first suggestion is to require that providers or pharmacists certify that they're aware of and have taken into account lower cost alternatives before they prescribe a particular drug, especially a high priced one. Along with that is we need a mechanism to provide those providers and those pharmacists with the real time price information.

So, that if I'm covered by United Healthcare, I go to the pharmacy and I need my insulin or a I go to the doctor and I need my insulin, we need that doctor to be able to know what the United Healthcare price for that insulin is. And we're starting to have those capabilities with the All Payor Claims database and others. So, that's part two.

Second, or third rather, we can consider allowing reimportation of -- of drugs from other countries where they're cheaper. And we've had discussions on that in this Committee before. That is something that should be looked at.

The fourth suggestion is to include insulin and diabetic products in the new healthcare benchmark program that is being set up in the Office of Health Strategies. They're being charged with -- with examining the price and projecting the price and tracking price increases. Add this specifically,

because of the important to your constituents and/or healthcare system of the diabetes cost.

Fifth, would be to require the health -- the state's health information technology officer or the new -- newly forming health information exchange to track providers who disproportionately prescribe the most expensive types of insulin. To examine why those providers are -- are disproportionately compared to their colleagues prescribing insulin.

And either provide education or even take some type of action like requiring that in the state paid health programs like the state employee program or Medicaid and HUSKY, that those providers be not eligible to participate in those programs.

I also somewhat in the same line, our last proposal would be to add insulin and insulin analogs to the list of drugs whose costs is currently newly required to be tracked and reported under Public Act 18-41. That's the bill that passed this House in 2018 that requires that carriers annually report on the cost of certain outpatient drugs.

I believe you'll remember that it's limited to the top 25 drugs. Why not add this specifically again, because of the importance of this, the prevalence of it and the amount of expense that's experienced.

So, I just wanted to draw your attention to that aspect of it. Fully support the bill but think it could be strengthened by adding some measures that go to the actual cost, underlying costs of insulin. Thank you for your time, happy to take any questions.

REP. SCANLON (98TH): Thank you, Ted, for being here today. And I think a lot of those suggestions are

things that Senator Lesser and I have certainly been thinking about and this Committee will definitely consider as part of our overall effort to reign in the cost of not just this drug but all drugs.

I know Senator Lesser has some questions so I'll defer to him to start us off. One other thing is I did not see your testimony on the system for this bill. So, if you can just make sure the clerk has a copy of that. It might be on another bill and we'll make sure to have it.

MR. DOOLITTLE: It was just filed this morning so it may not quite be up yet. But I'll make sure you have it.

REP. SCANLON (98TH): Okay great, thank you.

SENATOR LESSER (9TH): Thank you so much, Mr. Doolittle, appreciate your testimony. I have a bunch of questions because I think we're trying to get this bill right and make sure that we -- we cover as many folks and we do it in a way that we don’t want to have to come back next year to have fixture bill. We want to get this bill done right this year.

And so, one of the many questions, as you know, one of the limitations we have, the General Assembly are self-insured plans. And they are outside of our scope to regulate because of federal law that preempts our action. And so, folks who have plans that we regulate we can help but sometimes it's difficult for us to help people with self-insured plans.

And so, one of the things that we're sort of wrestling with is, okay, so if there are folks that have high deductible health plans who don't

affordable access to insulin but they're not regulated by the State of Connecticut, what -- what can we do. And one of the things that we're -- we're contemplating but don't have answers to right now is perhaps leveraging low cost insulin available via the 340(b) program at community health centers.

And I just wanted to see if that was an option or if there are other options that you're aware of where we might be able to go in and directly assist people with self-insured plans where we can't, you know, pass direct legislation impacting them.

MR. DOOLITTLE: So, that's -- that's something worth considering, I think. The 340(b) program, of course, is complicated, I'm not an expert on it. I don't know what -- what all the requirements are to make sure that a hospital's 340(b) eligibility is maintained. But as long as it can be done within maintaining the 340(b) eligibility, I would support that.

SENATOR LESSER (9TH): Thank you. You've mentioned your support of reimportation. My understanding of the federal law on this and, you know, we can -- defy federal law, some states have done. But our resisting proposal is to not to that is to go to the Department of Health and Human Services and ask for a waiver to allow us to import safe, affordable prescription drugs from Canada.

My understanding under the federal waiver process is that as currently drafted, it excludes biologics like insulin. And so that that would -- although you could get safe affordable insulin from Canada in theory and people can and do drive up and do that.

Under the terms of the federal waiver process, that would not be something that the federal government would be likely to approve for insulin. They would approve it potentially for other drugs but not for insulin. Does that -- does that sound right or what would you suggest we do in that regard?

MR. DOOLITTLE: You may have more information than I do on this based on your recent research. I certainly -- what you say, that does sound right.

SENATOR LESSER (9TH): Okay thank you. And then -- and then I -- I'm very interested in this new guidance that we've gotten from the IRS. That says that for people in high deductible health plans, they can allow first dollar in coverage for insulin and for other chronic conditions. So, that you could get access to insulin without first meeting your deductible.

In terms of mandating coverage of that which is something that this bill currently seeks to do. Certainly, one of the things that we're -- we're sort of considering is how that changes the actuarial value of plans offered via the exchange. And I just wanted to know if you could sort of discuss some of the policy consideration.

To me, that seems like a no brainer. This is, you know, the idea that somebody should have to wait until December meanwhile paying, you know, $2500 a month for insulin and supplies is just a mind boggling policy. But I just wanted to see if you could sort of talk through some of the policy considerations that we might -- we might be facing as, you know, as we seek to compel rather than just allow high deductible plans to meet that new IRS guidance.

MR. DOOLITTLE: Yeah. So, every year in the Access Health board and their subcommittees, there is discussion about how to make sure the plans comply with the actuarial value. And there's a careful balance of what can be paid for with the deductibles and not with the deductible's tradeoffs do have to be made. And -- and, you know, if it comes before that body, I know they deliberate. I'm on that subcommittee, in fact, and deliberates quite carefully.

There's no obstacle from an actuarial value perspective. It is -- if you squeeze one thing, maybe something else does have to drop off, that is -- that is true. But at the end of the day by managing the design of the plans the actuarial value can be maintained.

SENATOR LESSER (9TH): Now would you suggest that we just with regard to exchange plans, would you suggest that we apply this to all exchange plans or maybe to some but not all on allowing, you know, skimpier plans that don't have that coverage to be accessible? Do you have thoughts on that one way or the other?

MR. DOOLITTLE: Yeah. I mean, in an ideal world, this would apply to all plans at the state and federal level. And, in fact, to the extent that this body has any ability to work with our congressional delegation to urge them to advocate for inclusion in the self-funded plans. I think, you know, that would be -- that would be good.

My main point is only that -- that -- that -- that we should -- this -- the list, the IRS list that you mentioned is carefully vetted to choose products and services that are going to save the healthcare

system money over time. First among that list of 14 services are the diabetic drugs and supplies, in my view. So, it's a smart investment. So, to me this should be as wide spread as possible for that reason. Because in the long run, it's going to save the healthcare system money.

SENATOR LESSER (9TH): Thank you, that's an excellent point. And I will note that although oftentimes we're at [inaudible - 00:48:31] the Association of Health Plans actually testified in support of S.B. 1, the insulin bill. Because, I think, they -- they recognize that this also saves money.

So, my hope is on a voluntary basis, even if we can't compel them to cover the self-insured plans, you would expect to see people moving in that direction. I think you're seeing that to some extent in the private marketplace already. Obviously, we're legislators, we like to legislate but I think is also good dollars and cents as well.

MR. DOOLITTLE: Yeah. I certainly think this is a good example of where, perhaps some jawboning might -- might be helpful. If policy leaders in the state up to and including leaders at this assembly or the Governor were to sit down with the CEO's and others of the insurance companies and say, this is the right thing to do, we can't force you to do it.

But maybe we can, as a group, agree to do this so that nobody feels like they're a competitive disadvantage by one -- one insurer doing this and others not. Perhaps we could all grab hands and jump off the cliff together.

SENATOR LESSER (9TH): Thank you.

REP. SCANLON (98TH): Representative Dathan followed by Senator Anwar.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman and thank you so much for your testimony today. Just curious, I know your -- I've sent my constituents to you and you've been very helpful at resolving some of their issues. If you were to break down the sort of drug issues you have for your office, where would you put insulin, insulin supplies in your consumer claims that people have and having issues with -- on their insurance?

MR. DOOLITTLE: It's one we see frequently. I would have to say it's probably in the top 10.

REP. DATHAN (142ND): If you could also let me know what other drugs that might be of a concern. Because I feel like insulin is a huge issue but there are drugs that we need to be keeping. Anecdotally, I can say I've had constituents talk to me about blood pressure medication. But would love to hear your view on other drugs that you're having an issue with.

MR. DOOLITTLE: No, that would be -- that would be the other area that -- that -- to keep an eye on where clearly, it's the right thing to do and it saves money over time and we do get a fair number of complaints. Our complaints are -- are largely driven too by probably I would say when a drug is commonly prescribed, the statins and so forth, we will see a number of those complaints just because there's a high volume of them.

REP. DATHAN (142ND): Do you have a list of those top 10 issues that you have? Anywhere on your website so just out of curiosity could refer to?

MR. DOOLITTLE: No, I -- I don't think we do. But my staff is -- is with me here. We'll make a note to -- to see what we're able to produce and get back to you. And if there's something that we can put up on our website we certainly will do that.

REP. DATHAN (142ND): Great. Thank you so much for your testimony today.

MR. DOOLITTLE: Thank you.

REP. SCANLON (98TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Along the same lines, I would just add actually respiratory illnesses. COPD, asthma, those inhalers are -- are out of control as well.

I think what's happening is the pharmaceutical industry's definition of pricing is based on what the market is able to pay not at their cost. And that’s part of the challenge that we are seeing is that this model is not sustainable. So, we have a perfect storm that's brewing and insulin need with the diabetics is probably in the center of it right now. But there are a lot of illnesses and the entire healthcare challenges that we have are all around it.

The cost which is increased in an exponential manner every year is part of the challenge. But the second part is the -- the insurance industry is actually working on the deductibles in such a manner that right now on an average, our deductibles go up. They used to be an average worker was paying the deductible to the middle of February. Now to the end or 19th of May as of last year the average American is paying their deductible.

So, half the year we have no insurance and the remaining half is being increased by 15 percent premium increase every year. So, this is not a sustainable model in any shape or form. And I think we will have to have a broader look at this. Approaching this from a disease base is a -- is a good way to approach this. But we will have to go beyond that ultimately because this gives us an insight into the abuses that have been happening.

And -- and as you were talking about looking at how the cost is -- is increasing in the pharmaceutical end, I was thinking in my mind, how do you legislate protection against greed? And then that's going to be a challenge but we have to figure that out. This -- this -- this malignant greed is -- is getting out of control.

If you have models against that [clapping] --

REP. SCANLON (98TH): Senator Anwar, as much as I may agree or disagree with the applause that we may get sometimes in this room, I just ask everyone to not -- refrain from outburst and applause in moments of support or opposition just so everyone feels comfortable in the room if they have opposing viewpoints. So, please continue Senator Anwar.

SENATOR ANWAR (3RD): Thank you. So -- so the part that we have to look at is if there are models to be able to assess this, I would like to learn more about them offline as well. But we have to identify those.

This was more of my comments but I would love to hear if there are other states that you have looked at which have been able to identify ways of

protection against the pharma as well as from insurance.

MR. DOOLITTLE: Yeah. Well, thank you very much, Senator Anwar and Dr. Anwar for your comments. I will mention that I've referred several times to the new IRS list of working treatments. And inhaled corticosteroids for asthma, in fact, are on there. So, they've been identified by the federal regulators as another smart investment to put in front of the deductible.

I'll also mention that I do share your concern about high deductibles. I'll restate my point that the high deductibles and the high premiums are caused by the underlying health -- by the underlying costs of the healthcare services and drugs and so forth. And that's to your point too.

I will mention to this Committee that this morning we transmitted, the Office of Healthcare Advocate, transmitted to this Committee as was our charge under the budget bill last year, the high deductible health plan task force report. And you will see some thoughts in there that were recommended for -- for -- for consideration by this Committee.

There are some - some suggestions that were considered and not -- not recommended. But at the end of the day, you're exactly right. We need to get into the business of focusing not so much on squeezing the balloon and it pops out somewhere else but on figuring out how to -- how to get these costs under control.

That's why I'm so encouraged, frankly, by the Governor's executive orders 5 and 6 that created the healthcare cost benchmarking for the state. Where

the healthcare costs for the state are projected out a couple years. And if providers exceed that they at least might have to explain why they had to exceed that.

That's a baby step but it's a step in the right direction. I think these bills here, 5175 and S.B. 1 are also baby steps in the right direction. Let's get these -- let's get these needed and smart investment medicines before the deductible so it's not coming out of pocket, so we increase the compliance.

And then let's take a hard look at what tools we might have to just start this journey which the United States alone among all the developed countries has not been on with trying to keep the costs down. You know as well as I do, Dr. Anwar, that -- that this country costs literally twice as much for quality that may or may not be as good as -- as the other great economies of the earth. And we need to -- we need to turn that around. And I think there's no better place to do that than here in Connecticut in the insurance capital of the world.

SENATOR ANWAR (3RD): Thank you for your comments and thank you for your response. One more question or comment I wanted to make was when you look at the -- the prescribers in trying to identify the higher cost prescribers. I assume you're going to separate out the endocrinologists completely. Because comparing an endocrinologist who uses insulin far more than a primary care would skew the numbers. So, I assume that's a given.

MR. DOOLITTLE: I -- that is a given. My perspective on this comes from my time as a senior official in Medicare where I was the deputy director

of the program in the anti-fraud division. Which spent a lot of time trying to figure out who the allies were but then taking the second step of some outliers are perfectly legitimate, right. And you have to be able to winnow those out. You're exactly right.

So, it's not an easy thing to do. You can't just simply say the highest prescribers of opioids, the highest prescribers of -- of costly insulin, you know, are going to be hammered. You can't do that. You have to -- it's -- it's harder than that. It's harder than that and it takes a lot more analysis than that.

SENATOR ANWAR (3RD): Thank you so much for your -- for your help. Thank you.

REP. SCANLON (98TH): Any other questions from the Committee? If not, Mr. Doolittle, thank you again for your testimony and please make sure we get a copy of it so we can put it on the system again.

MR. DOOLITTLE: Great, thank you.

REP. SCANLON (98TH): Thank you so much. We've been joined by Senator Looney and Senator Fasano so in deference to them, we'd like to go back to the elected officials and start with Senator Looney.

SENATOR LOONEY (11TH): Good afternoon, Senator Lesser, Representative Scanlon and distinguished members of the Insurance and Real Estate Committee. My name is Martin Looney. I'm the state Senator for the 11th district representing New Haven, Hamden and North Haven. And I'm here to testify today in favor of three bills on your agenda. S.B. 1, S.B. 206 and H.B. 5251.

S.B. 1, of course, is AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTHCARE PLANS. And I think all of us here in this room and throughout the state know at least one friend or relative who is suffering and struggling with diabetes in their lives.

And that is because approximately 355,000 people in Connecticut or 11.4 percent of the adult population has diabetes. In addition, another, almost another million people in our state or about 36.5 percent of the adult population have prediabetes with blood glucose levels that are higher than normal but not yet high enough to be diagnosed as diabetes.

Every year, an estimated 18,000 people in Connecticut are diagnosed with diabetes. And the prevalence of diagnosed diabetes in the U.S. is growing rapidly. Studies have shown an increase of 382 percent from 1988 to 2014. In addition, African Americans and Latinos are over 50 percent more likely to have diabetes than non-Hispanic whites.

These diagnoses make access to insulin and to related medical supplies a matter of life and death. In 2015, diabetes was ranked as the seventh leading cause of death in our nation, killing more Americans than AIDS and breast cancer combined.

Neither of the forces of supply and demand nor competition in the private market is working to control cost as economists often predict that the market would be self-regulating.

Insulin has been around since the 1920s. But when the inventor generously sold the patent for $1 with the intent that it would be available to save as

many lives as possible. He had a sense as a public spirited citizen to benefit the public health.

But the prices of the most widely used insulin has tripled between 2002 and 2013, and costs continue to rise despite the expiration of patents for human insulin formulation. Type I diabetes patients who generally inject themselves every day, paid an average of $5705 for insulin in 2016. And between 2006 and 2013, average out of pocket costs per insulin user among Medicare part D enrollees increased by 10 percent per year for all insulin types.

The mean price per milliliter of insulin increased almost 200 percent from $4.34 per milliliter in 2002 to $12.92 per milliliter in 2013. And the annual retail price of Humulin-R increased from $2487 at the end of 2005 to $15,860 by the end of 2015. This is, of course, not sustainable.

Costs are rising at an alarming rate and the culprit is greed and a broken system that ignores the human cost of unconscionable price gauging. There are only three insulin manufacturers serving the U.S. market. Eli Lily, Novo Nordisk and Sanofi.

A class action complaint filed in Massachusetts in January of 2017 stated that "in 13 instances since 2009, Sanofi and Novo Nordisk raised the benchmark prices of their long acting analog insulins Lantus and Levemir in tandem". Taking the same price increase down to the decimal point within a few days of each other. Eli Lily and Novo Nordisk have engaged in the same large step behavior with respect to their rapid acting analog insulins.

With no competition outside of these three manufacturers, costs will continue to rise without government intervention. And given the cost of insulin today, 1 in 4 Americans with diabetes is now skipping or using reduced amounts of life saving doses. And this often can be so damaging and even fatal.

This is not the kind of medication that there is any real discretion about you need to take it every day in the precise amount prescribed without other you're putting yourself at terrible risk. There may be some other medications that you can stretch a dosage or skip a dosage and just as long as you're not doing it for too long to compromise your health, you may be able to get by until the next regular prescription refill comes up or something like that. But that's not the case with insulin for diabetes.

Every day is a life and death situation. And it doesn't have to be this way and there is no justification to allow prices to continue to spike as they have.

Last year, Cigna announced a program that would cap the price of the 30 day supply of insulin to $25 thus showcasing the viability of what S.B. 1 seeks to achieve. And that is, affordable care for diabetics. This bill comes at a critical time and I strongly support capping the monthly out of pocket costs to insulin, delivery services and other drugs used to treat diabetes for insured individuals.

Additionally, no person should die simply because he or she does not have immediate access to a prescription for insulin. And section three of the bill authorizing pharmacists to distribute emergency insulin would literally save lives. This is a

critical bill and I know there is bipartisan interest in this. And I'm pleased that this is one of the times where we can rise above partisan divides that often separate us and do something in common for the good of the people of our state.

Two other bills that I mentioned, S.B. 206 would require the health insurers that offer plans in Connecticut must also offer at least one plan on the Health Insurance Exchange. This legislation would increase the plan options for people who buy their insurance on the Exchange, thus increasing competition in the health insurance marketplace. If an insurer is profiting by selling plans in our state, it should also offer plans on the Exchange.

H.B. 5255 would prevent various types of insurers from discriminating against a person of the basis of that person being a living organ donor. While health insurers cannot discriminate on the basis of a pre-existing condition, there is no such prohibition regarding life insurance, long term care insurance or disability income protection.

Living organ donors are brave and generous people. As I know very well, being the beneficiary of an organ donation from Superior Court Judge Brian Fisher, more than three years ago. And those brave and generous people should not suffer discrimination for their courageous choices. So, I thank the Committee so much for raising these bills.

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

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you, Senator Looney. For those of you who don't spend a ton of time in this building, Senator

Looney is the President of the State Senate. And, you know, there are an awful lot of bills that are introduced in this building every single year. But this bill has been designated, the insulin bill has been designated S.B. 1. Which is an indication that it is our caucus, the State Senate's top priority in 2020.

And I think it's a sign of the seriousness with which you understand this issue and just how important it is and how it will go a long way towards saving lives. I think there's no higher purpose. There's nothing more important that we can focus on in this building and I just am grateful for your leadership in designating that this bill is S.B. No. 1.

I also want to thank you for your testimony in support of the other two bills as -- as a living organ recipient. Certainly, we're excited to work with our colleagues, Representative Exum and Senator Slap in finding ways to ease barriers to organ donation and make sure that we're promoting that.

Senator Looney, my understanding is that S.B. 1 has a number of different components. You mentioned, of course, the cost cap, the out of pocket cost cap also tempting to come up with funds to help people who are uninsured or underinsured access those supplies.

And that last part that you mentioned which is emergency access to insulin. I just didn't know if you had anything you wanted to expand on why that is also so important. I think in other states it's been called Kevin's law. I wanted to see if you wanted to expand on that.

SENATOR LOOENY (11TH): Yes. So, just to add to that, as we know, there are -- because it is -- every day is an emergency regarding diabetes care and access to insulin. So, sometimes people may be -- may be traveling or may -- maybe forget to bring their insulin with them or maybe suffer a mishap or drop it or have it damaged or have it stolen or whatever. And suddenly someone is without the insulin at a critical time and needs to be able to access it on an emergency basis when they're not near their own local pharmacy from whom they normally get it.

SENATOR LESSER (9TH): Thank you very much.

REP. SCANLON (98TH): Other questions from the Committee of Senator Looney? If not, Senator, I will just echo what Senator Lesser said in thanking the Senate for making this S.B. 1. And it is a sure sign of a commitment from your leadership and your body and your caucus that this is a high priority.

It's a caucus priority for my caucus as well and I know that the other two caucuses in this building also support this bill which I think is a very big sign. That the State of Connecticut takes seriously the notion that nobody should ever have to worry about affording the drug they need to survive. So, thank you very much for your leadership on this.

SENATOR LOONEY (11TH): Thank you, Mr. Chairman. And I want to thank Senator Lesser, Representative Scanlon and the members of this Committee for doing such important work every single year. If you look at some of the most important bills that we have passed over the last 5 or 6 years, I think have come from this Committee.

And those that have had the most -- the greatest benefit in terms of healthcare, consumer protection for the people of this state have been the product of this Committee in many ways. So, I want to thank you again and congratulate you.

REP. SCANLON (98TH): Thank you, Senator. Next up, we have the distinguished Republican leader of the Senate, Senator Leonard Fasano.

SENATOR FASANO (34TH): Thank you, Mr. Chairman. Senator Lesser, Representative Scanlon, Senator Kelly, members of the Committee. First of all, I want to echo the wonderful things that our counterpart on the other side of the aisle in the Senate talked about with the insulin bill. And the bipartisan product that has come out of that, I think, is going to see its way clear through this general assembly and that's terrific.

But I want to talk about another bill which is S.B. 201 which is this task force study to health insurance about care in equity in the state. I've got to tell you, to me, this is an extraordinarily important bill. And task forces, I know, are looked at sometimes in this building as okay, let's just push that aside.

But to start a serious discussion on the inequity of healthcare in this state begins with knowledge of facts of what that would look like. And you can't start that discussion until you look at issues.

When you look at the Connecticut Health Foundation that released a study and found that babies born to black mothers are four times as likely to die before their first birthday as opposed to those born to a

white family, a white mother. That's an incredible, equally disgusting statistic.

And the Connecticut Voices for Children released a study that said black and Latino residents are more likely than white residents to be uninsured, dying before reaching adulthood and are reported in poorer health. That's another factor.

So, I applaud the task force. If I could make some suggestions. Number one, generally we allow leaders and others to appoint people in their mind that they see fit. I think you may want to look at having people who are doctors in urban areas who deal with this issue.

I think you want to look to have people on this Committee or this task force that would have experience in healthcare. The blocking of getting insurance, what the different avenues.

I think you want urban environmental concerns raised at the table because I think those are factors. And there's also social factors that are unrelated to environmental, unrelated to money and I think you need some expertise in that area.

As a final note on the bill, I believe it talks about January 1, 2021. Can I make the following suggestion? I think the report should be done by December 1st because we start session sometime after that January 1st to give it some time.

Number two, I would also add that I think not only should they have findings and recommendations but I think they should have concepts that can be divvied to the chairs and ranks by way of a letter to be raised as concepts that may be fertile grounds for a bill. So, have the report, then have concepts that

could be raised for a public hearing and then from there, get a bill.

I think that gets a jump start to the process. So, that in January and February, each committee and I'm sure a lot of it will fall here as well as public health, can get a jump with the necessary background. Those are the suggestions I would make to this bill.

I think it's a great idea and I think this is going to be very eye opening and a new direction for the State of Connecticut that bipartisanly we can lead into the future. So, I want to thank you all for your time.

REP. SCANLON (98TH): I want to thank you, Senator, for coming here today. I think we can both agree and everyone on this Committee should agree that nobody should have a different healthcare system based on the zip code that they live in. Certainly, not for babies and children.

So, I think I speak for everyone when I say, we're -- we're looking forward to taking this up. And certainly, we'll take your considerations into account here. I see Senator Kelly is looking to say something and then I know Senator Lesser will too.

SENATOR KELLY (21ST): Thank you, Mr. Chairman. Thank you, Senator Fasano, for being here. I thank you for your insight and comments so that we can turn the results of the task force into action next session. I think that's what's important is not just to have a task force to study something but to actually get action on this issue.

I think the other part of those statistics isn't just that these -- these populations have this

experience but you have even within the populations, the same insurance but different health outcomes. I think that's another one of the issues that's a problem. So, thank you very much for your comments and for your time this morning. Thank you.

SENATOR FASANO (11TH): Thank you.

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

SENATOR LESSER (9TH): Thank you, Mr. Chairman, and thank you, Senator Fasano for your testimony. I was asked knowing that this bill was coming yesterday by the chairman of the health equity caucus what I thought was important that we were dealing with. And I listed this bill as one of the things that I thought was just an important to conversation to have about how we can start having a serious conversation about health equity in this state is probably a couple hundred years too late. But I'm eager to have that conversation and appreciate you working across the party lines to make sure that this happens.

I would urge you to come, if you're available. The BPRC is holding a public hearing this evening to discuss potential priorities. And if you're available, this might be an important conversation to have with that caucus as well to figure out how we can move forward quickly and deliberately in terms of addressing health equity in this state. But thank you very much for raising the idea and I think it's important. Look forward to working with you.

SENATOR FASANO (11TH): Thank you.

REP. SCANLON (98TH): Any further questions from the Committee? Seeing none, thank you Senator Fasano.

SENATOR FASANO (11TH): I thank you all for your time. Have a great day.

REP. SCANLON (98TH): Next is Representative Jesse MacLachlan. And then again, I apologize to the people who have been waiting here but that will conclude the elected official portion of this and we will proceed to Dr. Steve Thornquist.

REP. MACLACLAN (35TH): Thank you, Chairs Scanlon, Lesser, Ranking Members Kelly and Pavalock D'Amato and the good members of the Insurance and Real Estate Committee. I appreciate the opportunity to testify in support of H.B. 5175 and S.B. 1. And also, I'd like to thank Chairs and Ranking Member on your leadership in pushing this issue through.

The rise in cost of prescription medication is an issue facing the entire country. States are pushing back against big pharma and the opioid trade, in particular, and the predatory disclosures that have ruined thousands of lives and created a reverse opium war here at home in this country.

But I came here to talk about insulin. And this bill is an outstanding measure to address a deeply affected people group who are being taken advantage of and it's shameful.

I've heard from parents in my district whose children live with Type I diabetes and they go to great lengths to pay for their children's insulin. To hold down their jobs, working multiple jobs to maintain insurance to offset the ridiculous costs that they're paying. They're not asking for handouts they're asking for fairness.

No one should have to ration their insulin in the United States in 2020. We all want to make Connecticut a more affordable place to live and this bill is a meaningful step forward and an opportunity to do so in a bipartisan way. I look forward to partnering with you all. I look forward to co-sponsoring these bills and I look forward to its passage into law. Thank you again for the time.

REP. SCANLON (98TH): Thank you, Representative. Any questions for Representative MacLachlan? Seeing none, we just echo what I said to Representative Cheeseman, we really appreciate your work and your help with us on this and the fact that it's bipartisan I think makes our constituents know that this is of vital importance to them and therefore us. So, thank you.

REP. MACLACHLAN (35TH): Thank you, Mr. Chair.

REP. SCANLON (98TH): All right. First up, Dr. Steve Thornquist and he to be followed by Tom Swan.

DR. THORNQUIST: Good morning, Senator Lesser, Senator Kelly, Representative Scanlon and Pavalock-D'Amato and the distinguished members of this Committee. I'm Steven Thornquist, I'm a physician.

I'm a board certified ophthalmologist and I'm the legislative chair of the Connecticut Society of Eye Physicians. And I come before you today on behalf of those physicians and the physicians in training who are members of a number of societies. The dermatological society, the ENT society and also the urological society, representing over 1000 Connecticut physicians.

I want to thank you for the opportunity to testify in support of S.B. 1. I want to thank this

Committee for bringing this important bill to a public hearing. This bill focuses on two enormous public health problems. One, the escalating costs of medicine for chronically ill patients. Specifically, in this case with regard to insulin. And the gargantuan problem of high deductible plans.

Chronically ill patients such as diabetics face enormous challenges in life, one of those should not be the cost of their medicines. In a *U.S. News* article from last year, the head of the Diabetes Patient Advocacy Coalition has Type I diabetes Christel Marchand Aprigliano, and she needs insulin to survive.

She testified in 2011, she paid $40 for a copay for that essential vial of insulin at the end of the year. The very next month when she went to pick up the same insulin vial from the same pharmacy, the cost was $1269 because her family had switched to a high deductible health plan.

More recently, her husband was unexpectedly laid off from his job. She applied for a patient assistant program from the insulin manufacturer but was denied based on her past income, not her current zero income. She appealed and they told her they could get back to her in 4 to 6 weeks despite not being able to afford the insulin every day that she needed to stay alive.

There are more -- there are more than just the immediate physical concerns for her. She worries that she'll have insurance from month to month or if she can afford the insulin even with her insurance. She describes it as psychological torture.

Unfortunately, her story is not unique. Physicians hear stories like this every day. Our patients have to choose from pay check to pay check whether or not the rent gets paid, whether they get the medication they need to save their life and vision or whether they can feed their kids.

Here are some facts to consider for this bill. The leading cause of blindness of working class individuals is diabetic retinopathy. Diabetes related blindness costs the nation about $500 million annually according to the CDC.

Blindness from diabetic retinopathy can usually be prevented by tight control of their diabetes with insulin and other medications. And diabetic retinopathy surgery is virtually non-existent in Canada where diabetics have reliable access to insulin.

Time will not allow me to talk about all of the problems that physicians are also facing with high deductible bills and the cash flow management problems that ensue and that how that is the biggest challenge for many medical practices. But I have appended our testimony from last year on a similar bill for your perusal.

Nobody chooses to get diabetes. Insulin should not be considered a luxury, all right? According to the *Hartford Current*, it costs $5 to make a 10 milliliter vial of an analog insulin. And that vial retails from between $350 and $1100. Pharma deserves to make a profit, this is America. Everyone deserves to make a profit. But people are dying here and Pharma is making a killing.

REP. SCANLON (98TH): Thank you, doctor, I appreciate your testimony and obviously it was very powerful. I appreciate you -- you sharing that with all of us. Are there questions from the Committee? Senator Anwar.

SENATOR ANWAR (3RD): I just want to thank you for your testimony. It's very moving and much important. Especially because you're seeing the complication and the cost of the complication is something that's unsustainable for us as a society. So, thank you for that. Can I make a comment, Mr. Chair?

Just a thought, because of the topic that we are dealing with and the number of people who are here, maybe it would be worth exploring to have the diabetic patients speak first because it's lunch time and there's a -- some may go hypoglycemic. Just thinking aloud but I will leave that up to your discretion. Thank you.

REP. SCANLON (98TH): Senator Kelly just said that's the benefit of having a doctor on the Committee. Yes, I do. But I have a feeling that there's probably a lot of people in this room that want to testify about that bill that that applies to.

So, maybe take your suggestion into consideration. And if there's anybody that's feeling that way or that would like to move up their testimony, they can come up to the clerk and the clerk will notify me and we'll do the best to get you up there as quickly as possible. But again, just want to see if there's any other questions for Dr. Thornquist. Seeing none, doctor, thank you so much.

DR. THORNQUIST: Thank you.

REP. SCANLON (98TH): Tom Swan followed by Anna Doroghazi from AARP.

MR. SWAN: Good afternoon, Senator Lesser, Representative Scanlon, other members of the Insurance and Real Estate Committee. My name is Tom Swan and I'm the executive director of the Connecticut Citizen Action Group. I am diabetic but Type II as opposed to Type I so I might qualify.

The -- on behalf of our thousands of members, I want to thank you for raising S.B. 1, H.B. 5175 AN ACT CONCERNING DIABETES AND HIGH DEDUCTABLE HEALTH PLANS. And also, for raising H.B. 5251 AN ACT ESTABLISHING A TASK FORCE TO STUDY INSURANCE FOR UNDOCUMENTED IMMIGRANTS and urge passage.

Insulin was first developed decades ago. The formula has not changed much at all. A person with Type I diabetes incurred annual insulin costs in 2016 of approximately $5700 and the average cost in 2012 was roughly half that, $2864. In the mid-'90s, it was about $260 a year.

The formula for making this drug has not drastically changed. A report cited by public citizen last year from the Right Care Alliance, reported that Eli Lilly, Sanofi, Novo Nordisk, the three major manufacturers of insulin in the U.S. currently mark up the price of their insulin product by as much as 5000 percent over the cost of production.

The outrageous price of insulin is clearly impacting people. You hear it from your constituents. It's having people ration their insulin. It's driving up our healthcare costs all across the board and it's causing people to die.

The only reason that this is happening is greed. And I applaud you all for taking this first step here today to really begin to try to address this and to make sure that those of us that have this health condition can have access to the support and drug.

I also want to touch base on the portion of the bill pertaining to high deductible plans. It's a good start. But there should be no high deductible plans. These are an industry creative mechanism to push costs onto patients and to turn doctors' offices into collection agencies. They don't serve a public purpose in terms of really controlling costs.

Because yeah, people do not get care that they need because of the high deductibles and their inability to pay for them. But it's going to drive up our long term costs across the board. What you're proposing here is a positive first step but we really just have to get rid of these. They serve no real social purpose.

And finally, I want to offer up strong support for 5251 AN ACT CONCERNING ESTABLISHING AS TASK FORCE TO STUDY HEALTHCARE COVERAGE FOR UNDOCUMENTED. This is not only the morally correct thing to do, it's a smart thing to do. How many of us really feel good knowing that there are people walking around our streets as we're worried about a Coronavirus pandemic in the United States not having access to care.

It is not only the morally correct thing to do, it is the smart thing to do. Thank you for raising these bills today and we look forward to working with you to pass them.

REP. SCANLON (98TH): Perfect timing. Thank you so much. Any questions from the Committee? Seeing none, thank you very much for coming today. Next up is Anna Doroghazi followed by Dr. Bismruta Misra.

MS. DOROGHAZI: Good afternoon, Senator Lesser, Representative Scanlon, Senator Kelly, member of the Committee. AARP is here today to support S.B. 1 and H.B. 5175 because we believe that out of pocket caps on insulin, non-insulin diabetes drugs and diabetes equipment and supplies will relieve consumers financial burdens, improve drug adherence and ultimately save lives.

I want to echo some of the comments that folks made earlier when they came up saying that this is a good first step. And that these efforts to limit out of pocket costs should be implemented in conjunction with additional policy changes to lower prescription drug list prices and increase competition within the pharmaceutical industry.

The rising cost of insulin optimizes a much bigger problem. The deaths and adverse health outcomes that we've seen from insulin rationing and insulin non-adherence are not inevitable. In 2018, there was a study in which the authors found that a year's supply of biosimilar insulin could be sold for $71. A year's supply. And that a year's supply of analog insulin could be produced for $133 per person and the companies producing them could still make a profit.

Instead, the average annual per person cost of insulin for Type I diabetes is just under $6000 a year. It's been mentioned before but companies are entitled to make a profit. But the average profit margins of the world's 25 largest drug companies

which include insulin producers Eli Lilly, Novo Nordisk and Sanofi. Those profit margins fluctuate between 15 and 20 percent per year.

At the same time, the profit margins for the world's 500 largest non-drug companies are in the range of 4 to 9 percent. In response to a growing affordability crisis, the pharmaceutical industry has enjoyed healthy product while demonstrating an inability or unwillingness to lower insulin prices.

Older Connecticut residents and all Connecticut residents need relief in the face of their inaction. H.B. 5175 and S.B. would provide some of this relief.

I also want to note that insulin is not the only high priced drug used for the treatment of diabetes. According for the Centers for Disease Control and Prevention, an overwhelming majority of the 21.4 percent of adults age 65 and over who have been diagnosed with Type II diabetes. Most are Type II rather than Type I.

And medications used to treat Type II diabetes such as Januvia, ozempic these can sell for in the range of $500 to $800 for a 30 day supply. So, we also support the provisions of S.B. 1 that would place a $50 cost cap on these non-insulin diabetes medications.

I think it's important to note also that this legislation is not uncharted territory. Last year, Colorado enacted legislation to limit the amount the consumers pay for insulin. At least three other states plus D.C. have previously passed similar laws that limit the amount consumers in private health

plans pay for 30 day supplies of high priced specialty tier prescription drugs.

Delaware, for example, limits insured individuals' copays and coinsurance for specialty tier drugs to $150 a month for a 30 day supply. Other states impose annual caps on out of pocket expenses. Vermont, for example caps individual out of pocket expenses a $1300, $2600 for families.

Thank you. We hope this Committee will take action on S.B.1 and H.B. 5175. And additionally, consider legislation to increase competition and address the practices replacing profits over people. Thank you.

REP. SCANLON (98TH): Thank you for your testimony. Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Ms. Doroghazi for your testimony and for AARP's strong support on this and other efforts to lower the cost of prescription drugs. You know, I -- I talk to people who are surprised that this -- this bill would be a priority of AARP's.

But I recall a meeting a I had with one the three manufacturers and, you know, I'm not going to mention their name so you can guess which one it might be that makes insulin in the United States. And they, you know, they -- they argued that we didn't need to act on this issue because there are patient assistance programs that are available to take care of people who do need insulin and other glucose lowering agents.

And I asked them about that question, does this actually cover everyone. And they we were going through and they said well, there's actually a big population that we actually don't help and those are

seniors in the donut hole who do need access to insulin.

Well, that is a big population, that's an important population. That's a population that certainly AARP seeks to serve. And so, for those folks out there who argue that this legislation may not be necessary because there are patient assistance programs. Well, that doesn't help if you don’t qualify and certainly people in the -- in the donut hole are certainly are large -- a large important population. So, thank you for your advocacy on -- on this and other prescription drug reform proposals.

MS. DOROGHAZI: Thank you.

REP. SCANLON (98TH): And further questions? Seeing none, thanks very much.

MS. DOROGHAZI: Thank you.

REP. SCANLON (98TH): Next up is Dr. Bismruta Misra followed by Nathan Tinker.

DR. MISRA: Good afternoon Chairman Lesser and Chairman Scanlon, Vice Chair Hartley and Vice Chair Dathan, Ranking Member Kelly and Ranking Member Pavalock-D'Amato and distinguished members of the Insurance and Real Estate Committee.

My name is dr. Bismruta Misra and I'm the division director of endocrinology at Stanford Health which strongly supports the provisions of S.B. 1 and H.B. 5175 that limits the out of pocket costs for patients with diabetes access to drugs, equipment and supplies. You have my written testimony so I'll focus my comments on the impact of the cost of treatments for patients.

It sounds like a cliché but I chose to become a doctor and specifically an endocrinologist because I wanted to help people live longer, healthier lives and indeed I have. I am proud to say that I and my fellow staff and colleagues at Stanford Health Diabetes and Endocrine Center have made a real difference in the lives of countless Connecticut residents in the 10 and a half years since I started my career.

There is nothing more gratifying than to help bring a patient back to good health or to even save a patient's life. What I never could have predicted when I started out in 2010 though is how the medication payment landscape would shift under our feet. On the one hand, industry has seen some helpful innovation in the form of improved forms of insulin, new medications and monitoring equipment.

Unfortunately, most of them are prohibitively expensive. Even to the point where some of my patients with diabetes are having to make a choice between life's necessities such as paying rent or staying compliant with their medication.

On a fundamental level, a physician is supposed to prescribe the best drug for their patient, carry full stock, end of story. Instead, because of sky high costs, I am forced to perform an exceedingly difficult balancing act. Trying to identify the drug that is most efficacious and that my patient can afford.

As a background, patients with Type I diabetes will die without insulin. While patients with Type II diabetes can take other drugs or insulin. Poor diabetic control is the number one contributor to

heart disease, blindness and kidney failure in the U.S.

These diabetic complications are financially burdensome to the healthcare system and more expensive than the medications that could have prevented them. Patients with diabetes have died because they couldn’t afford their insulin.

In Minnesota, Alex Smith, a 27 year old with Type I had a high deductible healthcare plan and was paying $1000 a month for insulin and diabetic supplies. To save money, he rationed his insulin which ultimately lead to his untimely death from diabetic ketoacidosis. In Haiti, Type I diabetes is considered a death sentence. I never thought I would hear stories like this in this country.

None of my patients have died from rationing, at least not so far. However, there are many stories I could share with you about patients who put their health at risk every day because of the cost associated with managing their disease.

We have many treatment options for patients with Type II diabetes but of the top three medication choices that outline by current treatment guidelines, only one is generic. The cost of these brand name medications are too high so many simply choose to stop taking the drug.

There has been amazing progress in the treatment of diabetes over the last decade. From the artificial pancreas to other technology that makes the disease so much easier to manage. Instead of optimism, my patients despair that their condition will be a lifelong financial burden.

End of the day, we feel that these bills will help to ease the financial burden for patients with diabetes and help our patients focus on their health where it should be. Thank you.

REP. SCANLON (98TH): Thank you, doctor. Something that you said was very striking to me. You said, at least not yet none of them have died and that's a very powerful statement for you to make. So, I appreciate you being here today. Representative Dathan.

REP. DATHAN (142ND): Thank you very much, doctor, for your testimony. One thing that you had mentioned in your testimony was that there are three separate diabetes insulin drugs. When you are working with your patients, do you have to choose which drug to use based on the patient's insurance and are there some -- do you feel like that's causing adverse effects choosing a specific one based on what their insurance would cover.

DR. MISRA: So, absolutely. I actually was just talking about this to someone outside. 2010 I would write the prescription for the best insulin for the patient, end of story. I'd give them a prescription, they'd go to the pharmacy. Now instead, I discuss with the patients and I say, before I give you a prescription, let's research your insurance plan, let's find out what's tier 1, tier 2, tier 3 even though I might feel that the tier 3 drug might be best for the patient and we research it together.

We have a case manager who's with us full time. And so, a week later, I get back to them usually with information saying this is an insulin that your insurance is the cheapest which is still not cheap,

especially in some of these high deductible plans. So, it's not an easy thing. I used to be able to just give a prescription. I can't do that anymore.

REP. DATHAN (142ND): So, do you feel that we, not just your time is -- is valuable here, you could be dealing with other patients that need your help. But in terms of do you feel like patients might be at risk for having to go down one brand name versus another?

DR. MISRA: Some. There are some differences between the different type of long acting and short acting insulins. And sometimes we find that one might work better for another. We always try to pick the most, you know, sort of the most affordable. But the most affordable may not always be the best for the patient.

REP. DATHAN (142ND): Got it, thank you. I -- I still am shocked that, you know, Penicillin has been around for almost longer than insulin but we have a generic for that but yet we don't have a generic for insulin. And so, we really are held at mercy of, you know, three drug companies for this. And it's just shocking that in today's society we have this issue. So, thank you so much for your testimony today.

DR. MISRA: Thank you.

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

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

SENATOR LESSER (9TH): Yes. Thank you, Mr. Chairman and thank you, doctor for your -- for your

testimony. I have a question for you but before I do, I just appreciate you telling the story of -- of Alex Smith, the -- the young 26 year old who died rationing insulin in Minnesota.

I happen to know his mother Nicole who was just an incredible advocate to try to address this issue nationally and in her home state. And, you know, my hope is that we won't have to have any Nicole's in Connecticut, that that’s something that we can address today or this -- this year in this session.

One of the things I've heard in conversations with patients with Type I is that they're often due to issues with their insurance, given less effective or less appropriate insulins. That they have different effects on different people that obviously everybody's physiology is different. And that sometimes when you have to switch from type of insulin to another because of affordability, that can be difficult for the body to process. And I just didn't know if you could speak to that a little bit more as one of the challenges of Type I.

DR. MISRA: I can give sort of a brief thing that I've had to do recently with many of my patients. So, typically a Type I is on a combination of long acting and short acting insulin. And the short actin insulin that take three times a day. And the long acting insulin have made a long -- I mean, they have improved significantly with choices like Lantus and Levemir which are sort of standard of care. And also, the delivery systems make it much easier for the patients to use. We have insulin pens and insulin needles.

What we've been finding with the costs is that I'm having to change patients from those insulin pens

and, you know, sort of better forms of insulin to vials of insulin, vials of NPH. Which is not a bad insulin per se and will probably keep my patient alive but is more often associated with low blood sugars which can be just as dangerous as high blood sugar. And it's more difficult to use. It's drawing up insulin from a round syringe. It's sort of 1970s technology that we have to continue to use because of cost.

I can send them to Walmart and they can get rely on insulin bottles for cheaper. And so, we sort of make do if what they can afford. I will tell you, in every case, the patient's diabetic control has slipped but they are alive. So, I think of it as what we have to do in the meantime.

SENATOR LESSER (9TH): And the switching from one to insulin, I assume switching from one insulin to another because of cost that that is something that's often difficult to adjust. Is that something you can just easily do or can't?

DR. MISRA: I mean, we --

SENATOR LESSER (9TH): It's better than not adjusting, yeah.

DR. MISRA: It's better -- it's better than nothing. It's very distressing to the patient who has been doing really well on their regimen. And, you know, I -- I -- it's very upsetting and it is time consuming. But again, it's sort of the choice that, you know, if somebody is paying close to $700 a month for their testing supplies which they need in order give the appropriate amount of insulin, you know, all of the costs are adding up to thousands a month. They, you know, going for a $20 vial of

insulin, they're willing to do. Even though it comes sometimes with the cost of the control slipping. I mean, I would say for in my case, all of the time.

SENATOR LESSER (9TH): Thank you very much.

REP. SCANLON (98TH): Thank you, doctor. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, doctor for your testimony. I wanted to ask from another angle, how much of staff time is being used to get the medicines authorized? How many people have to be hired and what time is it taking for that to happen?

DR. MISRA: That's a great point. I'm not going to lie, I've been very blessed to work at Stanford Health. We have a full time case manager who dedicates herself to our diabetic patients. If we didn't have her, before we had her I was staying in the office after hours two to three hours dealing with the calls and getting prior authorizations and things like that and probably would have left endocrinology. But we were lucky to have her. But I frankly find it ridiculous that we have to have someone who's full time on the phone to get, you know, the right medicines for patients.

SENATOR ANWAR (3RD): So, what I hear from many of the clinicians is that they have literally one staff person holding for hours to have somebody up pick from the insurance company to authorize that prescription which is the most basic prescription. And that's at the cost of the healthcare personnel.

DR. MISRA: Absolutely.

SENATOR ANWAR (3RD): And -- and if we were to pass this bill, that would actually improve that challenge at least for this particular medicine.

DR. MISRA: For my field, yes, absolutely.

SENATOR ANWAR (3RD): Okay good. Let's save as many as we can. Thank you so much.

DR. MISRA: Thank you.

REP. SCANLON (98TH): Yes, Representative O'Neill.

REP. O'NEILL (69TH): At one point in your testimony you said that of the top three medications that were used or recommended for treating the diabetes only one of them was a generic. Is that the -- and a little later the Vice Chair said that there is no generic substitute or no generic available. And I'm just -- was that a non-insulin medication?

DR. MISRA: Yes. So, these are the medicines used for Type II diabetes. The American Association of Clinical Endocrinologists have sort of a treatment algorithm. And the first top three non-insulin medications that are recommended for Type II diabetes, only one is generic and the other two are brand name.

And there is a long list, it sort of goes in order. Luckily the number one is generic but number two, number three and actually number four are all brand name medications. And -- and in a high deductible plan, none of them are affordable. I'm happy to give the treatment algorithm. I can circle the few meds that are generic on that list.

REP. O'NEILL (69TH): But just so I'm clear, the ones you were referring to were not insulin.

DR. MISRA: They were not insulin.

REP. O'NEILL (69TH): Okay.

DR. MISRA: And that's an aspect of this bill that I think is -- is really sort of innovative and different than some of the bills that have been across the country that only address insulin. Because Type II diabetes is -- is even more predominant and we have very good non-insulin treatment options for them.

REP. O'NEILL (69TH): Okay. And one other thing, the -- the thing you mentioned, the $20 vial at Walmart, I assume that's a generic?

DR. MISRA: It -- it is actually technically not a generic. It's NPH insulin and I -- I -- forgive me, I don’t remember which company makes it off the top of my head. But it's the same company that would make the other insulin pens. They just happen to offer it and you can -- you can get the vials. It's called Relion inulin. $20 a vial older insulin that you can get through a regular pharmacy also in a pen form but it would be much more expensive. It is not generic insulin.

REP. O'NEILL (9TH): Okay and -- and what would -- because the comment was made that well insulin has been around for roughly the same time as penicillin and there's no -- there's a generic for penicillin but there's no generic for insulin. Is it that the insulin isn't available or the delivery mechanism is the big difference?

DR. MISRA: I -- I think both. The delivery -- the delivery mechanism of the insulin pens is what most diabetics want to use and it makes it easier to use. The compliance is better than the insulin vials and

syringe. But we are able to get the -- the, you know, the vials which is the older technology. And the drug company has sort of made this, they -- they call it sort of the gift that oh, this is acceptable insulin, you can get it at this one place. It's only at Walmart. You cannot get it anywhere else.

REP. O'NEILL (69TH): And I'm just trying to understand more clearly what the -- all of the factors are that are in play here. So, I'm not that familiar with this field so I'm trying to -- so if someone were to say to me that this bill isn't necessary because you can get the $20 Walmart insulin, or you can get another drug that's really inexpensive. It's this is like an older technology that's not as effective? Is that a fair characterization?

DR. MISRA: Yeah. So, it's an older form of insulin. It is versus insulins like Lantus and Levemir which are the long acting insulin which you would maybe only have to inject once a day. The insulin vials you have to inject twice a day. They may not last the full day so there are periods where your blood sugar could be very high. They may peak at a time which is not beneficial so it can lead to a low blood sugar.

So, what we found with these older forms of insulin is that the blood sugars are more widely fluctuating and the timing is very important. So, there is really no flexibility with using them. And the other thing too, in terms of using the vial and syringe, you -- you have to -- it's not something you -- people want to do in public.

A pen you can do a little bit more discretely. This is where you bring a big vial, you have to bring a

big insulin syringe with a longer needle, draw up the insulin and then inject. And -- and it was a barrier to patients taking it long ago because it was hard to use.

But like I said, it is an older option but the patients are not also willing to use it. It's very difficult to use. And they don't feel -- they don't feel that good on it because their sugars are fluctuating. But if it's a case where they need insulin, they need insulin. It's better probably than nothing.

REP. O'NEILL (69TH): Okay, thank you.

DR. MISRA: Thank you.

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

DR. MISRA: Thank you.

REP. SCANLON (98TH): Nathan Tinker followed by Kristen Whitney Daniels.

MR. TINKER: Good afternoon Chairman Scanlon and members of the Committee. I am Nathan Tinker, CEO of the Connecticut Pharmacists Association. CPA represents thousands of pharmacists, technicians and students across all of the pharmacy profession in Connecticut and we appreciate the time you have already taken to discuss this bill with us and work on some of the issues that we have.

We believe that with thoughtful revision, this bill can be helpful in ensuring insulin access and affordability for patients and we apricate the opportunity to comment.

Section 3 of S.B. 1 H.B. 5175 requires licensed pharmacists to dispense insulin equipment, insulin, equipment and supplies without a prescription in certain circumstances. But in order for this to be successful to both serve the needs of the patients and protect the pharmacists who dispense the drug. And there are several details for pharmacists that should be considered as we move forward.

As already mentioned by several people, there are five different classes of insulin, more than 20 brand names and a range of delivery systems. It will be necessary to identify and -- and figure out how each of these would be eligible for emergency disbursement and what would constitute a minimum supply.

Two, would pharmacists be required to maintain a special stockpile of insulin for such emergencies. If so, would this include all the various types of insulin on the market or would it be limited to certain brands or styles or classifications?

Three, without a valid prescription, pharmacies generally cannot make a reimbursement claim to a payor for any drug. In the case of the present proposal, if a patient has insurance, commercial or otherwise, the payor should be required to fully reimburse such claims regardless of other factors. But if a patient has no insurance, there must be an established process for reimbursing the pharmacy's considerable upfront investment.

Four, there is an ongoing insulin shortage which can make it difficult for some pharmacies, especially small, independent ones, to keep certain insulins affected by the shortage in stock. This could be

further exacerbated by stockpiling requirements and should be considered as we move forward.

There should be provisions to minimize fraud and abuse. There is already a broad and active black market for insulin of all types and unscrupulous individuals could potentially utilize the emergency insulin system to access product possibly from multiple pharmacies over a short period of time and illegally resell it.

And finally, a pharmacist's liability must be considered. Insulin is considered a high-risk medication and can cause among other things, hypoglycemia which can be life threatening. Pharmacists should be fully and completely protected from any liability associated with the transaction including adverse reactions.

We are currently working on, as you had requested, some language to address many of these issues and I thank you for the opportunity to testify today.

REP. SCANLON (98TH): Thank you very much and thank you for the conversation the other day when we talked about this. I think you're raising some really interesting questions that we have to find the solutions to. But one that I'd like to sort of discuss with you probably because for the sake of other people that are going to testify, is what that appropriate dose might be. I know you had suggested to me that it could 50 milliliters, is that correct?

MR. TINKER: Well, in general, pharmacies, retail pharmacies dispense insulin in 10 milliliter vials or 5 pen packs. Each of those pens has a 3 millimeter dose. If you think about Relion which has been discussed a couple of times, Relion is sold

in those 10 milliliter vials over the counter without -- basically without the need of a prescription. It's behind the counter but it still doesn't require a prescription.

That one vial is probably the -- the easiest way to get that minimum requirement. That said, different patients have different responses and dosage needs and so forth. And doctors, I think, would need to work through that a little bit.

REP. SCANLON (98TH): And how long would, again, I know it differs based on the age and a lot of different factors. But how long would that 10 milliliters last the average person?

MR. TINKER: So, I believe and there are people in here with more expert on this. I believe that four vials and if I say this wrong, I know I'm going to say -- are about a months' worth of -- of -- of insulin for an average. And I may be wrong on that but that's my understanding.

REP. SCANLON (98TH): Thank you. And then on the pen side of it, they come in packs of five, correct?

MR. TINKER: Yes.

REP. SCANLON (98TH): And what we discussed that day is that it's not so easy that a pharmacist could maybe break off one of those pens and just hand it to somebody. That's not sort of something that you're able to do, correct?

MR. TINKER: Well, you can do it but it causes ancillary problems especially in -- in terms of reimbursement and in terms of keeping things in stock. Simply because that package now has been reopened. The expiratory date is in effect in a

different sort of way and so forth and you can't really hand out separate pieces. You couldn't for instance take that broken open pack and sell the other four to someone who was coming in for their regular prescription.

REP. SCANLON (98TH): Got it. And on the insulin shortage, how often is that something that your members are reporting to you is a thing that's happening to them on a weekly basis?

MR. TINKER: Relatively often. And it -- and it can depend on the brand name, it can depend on -- on the season. There's -- there's a variety of issues at hand but it is not unusual and especially for the smaller and independent pharmacies.

REP. SCANLON (98TH): Thank you. I don't have any further questions but I see Representative Vail does.

REP. VAIL (52ND): Thank you, Mr. Chairman, good afternoon. Doctor, what group do you represent again?

MR. TINKER: The Connecticut Pharmacists Association.

REP. VAIL (52ND): Okay. And how many pharmacists are a member of that group?

MR. TINKER: We have over a thousand pharmacists in that group, yeah.

REP. VAIL (52ND): Over a thousand. Are you the only group like that in the State of Connecticut?

MR. TINKER: There's a hospital pharmacy association as well as well as an ASKAP which is generic and long term pharmacy issues.

REP. VAIL (52ND): Okay. And so, you recognize that we have a problem with this issue in Connecticut. You generally support it though you have some concerns about parts of this bill, is that correct?

MR. TINKER: Yes, absolutely.

REP. VAIL (52ND): And I'm encouraged to hear that you talked to the, you know, to the Committee chairman about this issue. But when were you guys kind of brought in to get your opinion on this? Recently or in the past to help kind of figure out the best way to go forward with this bill or is it just something recently that you were asked to partake in?

MR. TINKER: The meeting was recent but our people have been talking with Representative Scanlon for a while.

REP. VAIL (52ND): Okay that's very encouraging. Thank you.

REP. SCANLON (98TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you for your testimony. What is happening in New York City area, do you know? My understanding is anybody can go to a pharmacy and get insulin.

MR. TINKER: That I don't know off the top of my head.

SENATOR ANWAR (3RD): Okay.

MR. TINKER: I know that in the past, insulin did not require a prescription at all and for a long time, it didn't. When you move towards analog and other formulations, of course, you have different sorts of problems.

SENATOR ANWAR (3RD): And -- and do you know, some of the others states where a similar has passed, what is happening there?

MR. TINKER: I don't have a good -- I can find that out.

SENATOR ANWAR (3RD): Okay. That may be -- because I think that the issues would be similar for the pharmacists over there as well in some respect. I think the challenge we're trying to -- our intention is to make sure that people are not without insulin because of the -- the logistics of getting the insulin and that's the whole purpose.

And I can recognize and respect the protection around the pharmacists. That's just fixing the words a little bit so that should be easy enough. But I think this is something that's already being done in many places so this should not necessarily be a hurdle in any shape or form for moving forward for us. Thank you.

REP. SCANLON (98TH): Any further questions? If not, I just want to thank you. We -- we sort of agree on the three or four things that we have to figure out here. I think we can get there and I appreciate your willingness to work with us on this. Thank you.

MR. TINKER: Thank you.

REP. SCANLON (98TH): Next up is Kristen Whitney Daniels followed by Kathryn Nagel.

MS. DANIELS: Good afternoon Chairman Lesser, Ranking Member, well we'll just state the Real Estate and Insurance Committee. Thank you so much for having me here today. My name is Kristen

Whitney Daniels. I am a Type I diabetic from Shelton. I'm also the chapter leader of Connecticut Insulin for All.

And for those who don't know what the group is, we're a group of volunteer advocates fighting for affordable access to insulin and diabetes related supplies. We do not take any industry money that would influence our voice and we have 34 chapters across the United States.

I'm testifying today in support of S.B. 1 and H.B. 5175. I support these bills because it's a very personal experience for me. You'll hear a lot about rationing and you have already. The statistic is is that one in four Type I diabetics are rationing their insulin. For me, I am that 1 in four.

At the age of 26 after I aged off my insurance, I had a high deductible health plan. I knew I wouldn't be able to afford my insulin and I knew I would be able to afford my diabetes supplies. So, I started hoarding, I started reusing my supplies and I started cutting back on my prescribed insulin.

For nearly five months, I watched my supply dwindle as I ran my blood sugars dangerously high with no solutions in sight. As I approached my last drop of insulin, I attempted to pick up my prescription but it came to a total of $2400 and it wasn't even my full months' supply. That equaled more than my months' salary.

People with diabetes do not have the luxury to say no to insulin. So, I researched every solution and called for hours. Have you ever had to plead for the one thing that's keeping you alive? Do you know what it's like to beg for your medication at the

pharmacy? It is demeaning, it is embarrassing and it is shameful that any human has to go through this.

Yet I had to beg manufacturers, my insurance company, pharmacy benefit managers and all the rebate cards people love to tell as solutions. And each time I was turned away because I had health insurance. I'm one of the lucky ones. You've heard the stories of those who have been -- who have not survived. I was able to go to a federally qualified health center and get my insulin for $14 a month. It's a huge discrepancy.

No one should ever have to beg for their insulin, a medication that's been on the market for nearly 100 years. No one should ever have to ration their insulin, not when it costs between $3 and $6 to produce a single vial. An no one should ever have to jump through hoops or patient assistance programs, not when they force patients to work through all of the red tape and are often met with denials in the end.

These bills represent a great first step to addressing the rise in out of pocket costs and reducing the barriers to accessing insulin. I ask that the Committee also consider finding an immediate solution for those who are rationing and are paying the list price.

I was within a day of dying from rationing my insulin. I had no insulin left when I went to the federally qualified health center. There are diabetics today who are rationing their insulin and don't have a day to wait. So, while we appreciate the study and we hope that the study could show

other solutions that the state could find, we can't wait for a study.

We also hope the Committee will consider legislation that will address the list prices, the root cause of the insulin pricing crisis. Thank you to the Insurance and Real Estate Committee. We appreciate you hearing out our voices.

REP. SCANLON (98TH): Thank you, Kristen, for joining us today and more broadly for all of your incredible activism on this issue. You and I have probably done 10 or 15 roundtables together from New Canaan to Canaan, Connecticut. We've done a little bit of a road show and the state, I think, is better off because of your advocacy. And I know that everyone around here is shaking their heads because you're -- you're the leader on this and we thank you for that so thank you.

I want to go back to the dialogue that I was just having with the preceding witness before you about what the proper amount would be. Do you have thoughts on what the -- what that amount should be to dispense with?

MS. DANIELS: Yes, I have a lot of thoughts.

REP. SCANLON (98TH): By all means, share them.

MS. DANIELS: [laughter] So, Kevin's Law as this is typically referred to is based off of Kevin Houdeshell who passed away from being unable to access his insulin. You'll hear later, a report from his father who has helped to pass this law in, I think, at least 14 states and there are many other states that are considering this.

There's a gold standard. And the gold standard is a 30 day supply for those who need it. And that would offset the current law that Connecticut has in the books which is to get an emergency refill for 72 hours. Insulin does not come in a 72 hour dose, inhalers do not come in a 72 hour does, neither does EpiPen's, all lifesaving medications that Connecticut residents need. And we hope that it would also be that people can access this bill multiple times a year.

REP. SCANLON (98TH): So, what would the milliliter amount of a 30 day supply be for the average person? I know it -- it differs.

MS. DANIELS: Yeah. I don't know the milliliters off the top of my head but we're hoping that it would go off a previous prescription that somebody already have. So, that it would offset some of the concerns for pharmacists in terms of concerns about where this insulin is going.

REP. SCANLON (98TH): So, the man or woman would walk in the pharmacy and say hey, something fell through her, which is the intent and I've talked to Kevin's parents and I know you have too. I have a prescription, you know me by my first name, I come here every month but something fell through, just give me the -- the normal 30 day supply that you usually give me. Right, that's the impact?

MS. DANIELS: Exactly.

REP. SCANLON (98TH): Okay. Any questions from the Committee? Seeing none, I just want to thank you again for all your hard work in helping us with this bill. Thank you, Kristen. Oh, Senator Lesser's

here. Looks like he's got an eggplant parm here too.

SENATOR LESSER (9TH): Yes, thank you, Mr. Chairman, and I do recommend the specials today in the cafeteria. No, I want to apologize, Kristen, for missing your testimony. I was out of the room as the Chairman pointed out. But I just want to thank you. You've been all over the state on this issue, one roundtable after another just elevating the issue. And I think we wouldn't be here if it weren't for the committed advocacy of Type I advocates all across the state.

But you yourself have been really awe inspiring in terms of your dedication to raising this issue. So, I want to thank you. I look forward to continuing to work with you. Let's get this thing done.

MS. DANIELS: Thank you.

REP. SCANLON (98TH): Next up is Kathryn Nagel followed by Eli Terris. As a general rule, if I mispronounce your name, please do not be offended. Just correct me.

DR. NAGEL: That was correct.

REP. SCANLON (98TH): Okay.

DR. NAGEL: Good afternoon to the members of the Committee and thank you for hearing my testimony. I'm testifying in support of S.B. 1 and H.B. 5175. My name is Kathryn Nagel. I'm from New Haven and I'm the policy lead for the Connecticut Insulin4all chapter.

I'm also a resident physician in internal medicine and pediatrics and have been a Type I diabetic myself for the past 28 years. I was diagnosed at 18

months. I've always been humbled by the fact that if I were born when my grandmother was in 1919, I would not have made it to see age 2.

This is because insulin was not discovered until 1921. We've now had it for almost a century but we are being priced out of access. So, I've been lucky to remain with good health insurance. Over the last several years, I've personally run into more issues with access and drug costs. I've had middle supply companies drop me from their plans with no notice. I've been chased by a debt collection agency due to poor communication and ridiculous billing practices.

I've been turned away time and again at the pharmacy because my doctor wrote a prescription for a particular brand that my insurance company no longer covers. It's hard to describe the helplessness, rage and frustration I feel when these things happen.

This past month, I have been working on a pediatric floor in the hospital. In the past two weeks, I've had six patients admitted to that floor with new onset diabetes. These patients have ranged in age from 6 to 15 years old. I teach these children and their families how to measure their blood sugar, count carbohydrates and dose insulin.

But I do not tell them about the second battle that they will have to fight. The battle for access to the things we are telling them they need that they must take. These young diabetics, unfortunately, will learn about the second battle sooner than they should have to and I will treat them then too.

I treat the patients who come to clinic desperately asking for a solution because they can't find a way

to afford their medications. The ones who have turned to black markets or other countries to try to get supplies. The ones who end up hospitalized because they were rationing.

I became a doctor because I wanted to help people with diabetes master this disease so that they can live fulfilling and productive lives. I have worked tirelessly to understand the nuances of the disease and its management but I've hit a wall.

At my hospital, one in four adult patients with diabetes ration insulin due to cost. I cannot help people manage a disease when they cannot access the basics supplies required to do so. This is why I'm here now.

As American healthcare consolidates and becomes increasingly controlled by large companies with minimal patient contact, we have seen the realities of what unchecked corporate greed can do. These realities are measured in the cost of the most valuable of currencies, human lives.

We can petition, we can plead, we can bring the ashes of those lost in this battle to the headquarters of Eli Lilly but it appears to make no difference. The only avenue it seems that might be able to save us is this one right here. This is why I'm here and this is what I'm asking of you.

S.B. 1 and H.B. 5175 are a step in the right direction. They're not perfect but they protect thousands of diabetics in this state. We need your help now. Our lives are on the line.

REP. SCANLON (98TH): Thank you, doctor for your testimony and for being here today. Any questions

form the Committee? Seeing none, if not, thank you for your testimony. Oh, Senator Lesser.

SENATOR LESSER (9TH): Thank you, doctor, and, you know, it's this is a broken record but it's obviously incredibly distressing. That in the wealthiest state by many measures in the wealthiest country on earth, 25 percent of your patients are rationing their insulin. That is shocking and unacceptable and intolerable. And hopefully that will end with this bill.

I just wanted to know if you had specific -- you've obviously taken a lot of time to look at the proposed legislation and if you had thoughts about the holes that we have or the things that we should really focus on going forward.

DR. NAGEL: Yeah, I do and thank you for that question. I think, so for the Kevin's Law portion of the bill, that's the part that it's looking at pharmacy access in emergency situations. I think one thing that is absolutely critical is that there's an insurance mandate for that. So, that when individuals do show up and emergency access is granted, that insurance will cover that access. Because otherwise it's sort of useless, the prices are too high to get it.

And I'll just reiterate, I think other people here have said this but it's kind of common sense. Insurance companies should be paying for preventative supplies and necessary supplies like insulin and testing supplies and all of the ancillary equipment that is very necessary to treat this disease properly.

If they don’t, those patients will end up in emergency rooms and that cost is much higher than the insulin. They'll end up in hospitals, they'll end up in ICUs, and down the line, they'll end up with complications which we've heard about, including kidney failure, blindness, et cetera. So, that is super important.

I would also iterate that I think it's very important that we cover -- that we create a fund to cover uninsured and underinsured individuals. Because a lot of the provisions of the bill, the price cap which is excellent, doesn't cover everyone. And people who don’t have insurance or don't have appropriate insurance will still suffer and it will still cost us a huge amount and that can't be.

So, if we're going to move forward in a meaningful and substantial way, that portion of the bill needs to be flushed out. And, I think it's great to look into the issue but we need to do more than just look into it, we need to create a fund for it.

REP. SCANLON (98TH): Yes, I will get to Representative Vail in one second but I wanted to tell you I agree with you 100 percent. And at the risk of saying something that I shouldn’t say in front of the public and my friends on the other side of aisle, our intention is to try to figure this out by the end of this session. I don't know that we can figure it out by the end of our deadline to draft this bill. But this is a bipartisan bill as people have heard and we are working closely with our Ranking Members to try to see if we can figure that out. But as is drafted right now, it is to study it but we hope to actually do it.

DR. NAGEL: Thank you.

REP. SCANLON (98TH): Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. You just mentioned creating a fund. Do you have any suggestions on what the funding source might be?

DR. NAGEL: That I don't know offhand. But I do think it's important that -- I think that the cost that we will incur if we are not covering for patients to get their insulin is significantly higher if you're looking in a long scale way.

REP. VAIL (52ND): Okay thanks.

REP. SCANLON (98TH): Any further questions? Seeing none, thank you so much. Eli Terris followed by Kathleen Kirrane.

SENATOR LESSER (9TH): Is Eli here? Well, then we will move on to Kathleen Kirrane followed by Madeline DelGreco.

MS. KIRRANE: Dear member of the Insurance and Real Estate Committee. My name is Kathleen Kirrane, I live in Newtown and I'm here with the Connecticut Insulin4all chapter to speak to you in support of S.B. 1 and H.B. 5175.

As a Type I diabetic, insulin to me is as vital as oxygen and water and without it, I die. It is for this reason that I believe access to insulin is a human right and these bills are a small step towards achieving this goal of affordable Insulin4all Connecticut residents. Because no one should have to worry about having access to insulin, to life sustaining medications in this state.

I say small step because these bills do not solve the crisis of the skyrocketing prices of insulin that has been occurring over the past two decades. The production cost of a vial of insulin is around $3 to $6. But the list price for analog insulin is over $300. And while the copay caps limit the out of pocket expenses for those on a limited number of insurance plans, about 29 percent of the plans in Connecticut, it does not help those who are uninsured or underinsured.

In the United States, one in four Type I diabetics have had to ration their insulin due to the costs. And this number is even higher for those aged 18 to 25 at about 43 percent. Rationing insulin is a dangerous game that leads to ER visits, hospital stays, potential for complications that lead to disability and ultimately death if insulin is withheld for too long.

This leads to increased healthcare costs that can be avoided if insulin was affordable. So, I support this bill as a small step in the right direction. More needs to be done to be able to cover all Connecticut residents.

Another important aspect of this bill that I want to touch on is the emergency access portion, especially in regards to diabetes supplies. There have been times over the last 12 and a half years when my prescription has lapsed due to prior authorizations taking longer than expected on my glucose test strips. This has caused me to ration them for a weekend because I was almost out and the script wouldn’t be authorized until Monday morning.

These strips can be purchased over the counter at pharmacies but they cost over a dollar per strip and

I use 7 to 10 a day just to make sure I'm safely dosing my insulin. So, with the emergency access, I would be able to receive a 30 day supply while waiting for my prescription to be fully renewed.

As a newly licensed nurse here in Connecticut, I want to live and work in a state where I no longer will have patients end up on my unit because they're not able to afford their insulin. I also want to no longer have to worry about how I'm going to pay for my insulin if for some reason I'd lose my job, end up on a high deductible or whatever the circumstance.

I want to live in a state that is the leader on fighting for affordable insulin and it is my hope that we can work on this together to tackle the crisis with S.B. 1 and H.B. 5175 being the first of many steps. So, I thank you for your support on this bill and hope to continue working with you on this issue.

SENATOR LESSER (9TH): Thank you so much for your testimony and for your advocacy. And 43 percent of young people rationing is shocking. Are there questions or comments from members of the Committee? If not, thank you very much for your testimony. Next up we have Madeline DelGreco followed by Jill Zorn. Good afternoon, Madeline.

MS. DELGRECO: Hi, Insurance and Real Estate Committee Chairs and members. I am here today strongly in favor of S.B. 1 and H.B. 5175.

SENATOR LESSER (9TH): I'm sorry, can you -- I know your name but could you please just state it for the record.

MS. DELGRECO: Yes, let's get there. My name is Madeline DelGreco. I'm a Type I diabetic from Farmington and I'm here with the Connecticut Chapter of Insulin for All. Since the 1990s, the cost of insulin has increased over 1200 percent. One in four diabetics ration or have rationed their insulin due to price hikes. Rationing insulin is extremely risky for the health of a Type I diabetic and has resulted in death.

The insulin costs have made this life saving medication inaccessible to many people. Currently the retail price for the three vials of Humalog analog insulin that I use per month is over $900. These vials cost about $6.16 to produce at most.

You've heard many of these facts already today and that's because it's just ridiculous. There are people rationing and struggling to afford their insulin in Connecticut today. We are in a crisis. I feel that I am not guaranteed a future and that might life is not safe should things remain the way they are now.

We must do something to increase access to affordable insulin and diabetes supplies in Connecticut. Insulin is as necessary to a Type I diabetic as oxygen. Without insulin, a Type I diabetic is guaranteed to die in just a few days. And this makes access to affordable insulin a human right.

I strongly support S.B. 1 and H.B. 5175. The passage of these bills would make a huge difference for my life and the lives of many diabetics in Connecticut. Thank you for your time.

SENATOR LESSER (9TH): Thank you so much. And did I hear you say that your -- that the insulin that you take is -- cost $900 a month?

MS. DELGRECO: I take three vials a month. I'm on the insulin pump so that means I'm on one type of insulin, Humalog. And I get a basal rate of about 48 units a day and I take about 30 units a day for bolusing. And so, I use about three vials a month and they're a little over $300 per vial. So overall, the retail price is over $900.

SENATOR LESSER (9TH): That's something. Now is that -- so that's the retail price. Is that the price that you actually pay or is that the amount that you pay some months?

MS. DELGRECO: I don't pay that amount because my insurance pays most of it. But if I was underinsured or uninsured than I would have to pay that amount. I'm in a very lucky situation where I do not have to pay that full amount.

SENATOR LESSER (9TH): Great, thank you very much. Yes, Representative Hughes.

REP. HUGHES (135TH): Thank you, Mr. Chairman. I'm just curious in terms of your cohort of age group when you first found out that this was your diagnosis. What was kind of the -- what was the norm, you know, either from the medical community or from other young people in terms of accepting this like basically dependency on an outrageous inaccessible cost?

MS. DELGRECO: So, when I was first diagnosed, I was in 5th grade, I was 10 years old. I really thought for many, many years that this state and this country would never let me not have access to my

insulin and that was a totally outrageous thought to me. It was around when I went to college that I realized oh yeah, they will and I could die. And I want to make a change because I thought that was unacceptable that I had to do my part to make the change.

REP. HUGHES (135TH): So, are there -- through you Mr. Chair, are there other peers in college that aren't on their parent's insurance or aren't covered that you've run into?

MS. DELGRECO: Not personally. I have met people that are rationing their inulin although they've usually been older over the age of 26.

REP. HUGHES (135TH): 26 yeah, okay. Yeah, so I am just interested in that you've come of age in a cohort where this is the norm and acceptable. And you're suddenly questioning that as we all are like how did we get here to just accept that the actual impact of these barriers. Like on a weekend or, you know, something has happened and you don't have access to those. You know, how life threatening and preventable that emergency is.

MS. DELGRECO: Right.

REP. HUGHES (135TH): Interesting. Thank you.

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

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. You mentioned that the price of insulin has gone up 1200 percent since the '90s, is that correct?

MS. DELGRECCO: Yes.

REP. VAIL (52ND): Can you site that statistic? I'm very data driven so I'd like to know if you -- if you don't have that, I don’t mean to put you on the spot. But if you do have that information where I could find that statistic and if you don't, if you could get it to me at some point following the meeting.

MS. DELGRECCO: Yeah. I don't have it with me at the moment but I'll definitely get it to you after the meeting.

REP. VAIL (52ND): And I see some motioning in the background. So, maybe someone who is testifying later on might be able to provide me with that information. Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions or comments from members of the Committee? If not, thank you so much for your testimony. Next up we have Jill Zorn followed by Joshua Levin. Good afternoon.

MS. ZORN: Good afternoon. Thank you to the co-chairs and Committee members for the opportunity to speak in support of S.B. 1 and H.B. 5175. I am senior policy officer at Universal Health Care Foundation of Connecticut and my name is Jill Zorn as you said.

And I do know the source for that. If you go to the T1 International website, they are full of statistics. Those living with diabetes face medical expenditures that are two times higher than the medical expenses of people without the disease.

As the price of insulin continues to rise, and more and more people in our state are covered by high deductible health plans, this financial burden is

increasingly difficult to manage for more and more people of our state.

I wanted to talk about a few of the different provisions in the bill. One is to have -- provide emergency access to insulin as we've talked about, also known as Kevin's Law. And that has been passed by at least 13 other states. So, I know if other states have figured it out, I'm sure that we can too. And we should definitely add our name to that growing list of states.

It would be great to see that our bill provided a 30 day supply so we wouldn't have to get so hung up on different people in the abyss or that. And that people could access it, a minimum of once a year.

Another important provision of -- of these bills is the setting out of -- setting out of pocket monthly caps for both 30 day supplies of insulin and non-insulin drugs. And it's really great that this bill includes 30 days' supply of medically necessary diabetes equipment and supplies. And that the bill sets a monthly maximum for all of that. That is really important.

Colorado passed their bill and they realized they had made a mistake and they're going back and trying to fix it because of the people are on multiple drugs as -- as we've heard. So, I think it's great that it has a maximum monthly out of pocket cap too.

And then I wanted to talk about the fund and we have had that discussion already. That it's a shame we have to have a study and we'd like to see, you know, people need help immediately. And also, people that have testified today have pointed out that part of

the problem is the huge and rising cost of these drugs.

So, why shouldn't we follow what Minnesota is trying to pass where they've actually tasked the manufacturers of these drugs to help support a fund like this. It's the monopoly pricing of insulin that is causing this crisis. The companies responsible for these indefensible high prices should be responsible for helping low income residents gain affordable access to life saving medications and supplies.

We'd like to see -- the Foundation would like to see out of pocket protections like those proposed in these bills expanded to cover all prescription drugs. And we'd also like to see that manufactures be held accountable for these outrageous prices. Please improve and pass S.B. 1 and H.B. 5175.

SENATOR LESSER (9TH): Thank you so much, Jill, for your testimony and for the work of the Universal Health Care Foundation. You know, I do want to point out that there is a provision with regard to the Alex Smith Law from Minnesota.

The funding mechanism that we're looking at that's outlined in this bill is through a program that's administered by DSS. And we're exploring right now if that's a viable funding mechanism and certainly there could be others that come along if that does not pan out. But we're looking at that right now. So, thank you for your testimony. Are there other comments or questions from members of the Committee?

Okay, well I just leave you also noting that obviously this is not the only prescription drug

that we're concerned about. We may have other hearings on other proposals in the future.

MS. ZORN: Looking forward to it. Thank you.

SENATOR LESSER (9TH): Maybe next week. Next up Joshua Levin followed by Campbell Mitchell.

MR. LEVIN: Hello, co-chairs and Committee members. My name is Joshua Levin and I represent the Universal Health Care Foundation of Connecticut as well as the Houdeshell family of Avon Lake, Ohio and especially their son Kevin.

I and the Houdeshell family are in full support of S.B. 1 and H.B. 5175. It is a well-publicized story that Kevin died in January of 2014 after not being able to get a supply of insulin from an expired prescription. This began on New Year's Eve on 2013 and continued over an extended holiday period when he could not reach his doctor or the office.

Kevin died on January 8, 2014 from diabetic ketoacidosis. DKA was the cause of his death. However, we believe it is because the State's laws governing emergency prescription refills are inefficient and outdated. Kevin died at age 36 and except for dealing with diabetes daily, he was in excellent shape and healthy.

In my research, Connecticut laws that was effective in 2018 falls short of being effective and able to save lives. It states, prescriptions may be refilled once pursuant to this subsection for a quantity of drug, not to exceed a 72 hour supply.

The issue with this is the packaging which restricts a pharmacist to dispense that small of a quantity. For example, insulin comes in pens and vials. COPD

meds in puffers, albuterol in vials, medications in blister packs, and others that cannot be broken into this amount.

Until five years ago, most states had these same laws but after Ohio's law changed, many more states updated their refill laws when I doctor cannot be contacted to approve that refill. Under current laws, if the pharmacist extends their professionalism to help a patient and send a vial to the patient in need, that pharmacist could lose their license. When upgraded, the law will help the pharmacist as well as the patients. Pharmacists are very well educated to do their job and they should be allowed to do so to help their patients.

What happened to Kevin happens more often than people realize. The patients end up in the ER or ICU which becomes even more costly than providing an emergency vial of insulin rather than a prescription that can be authorized. Kevin's Law is a movement across the United States and is needed in all 50 states.

Legislators have called it a common sense law that improves quality of life and saves lives at no cost to the state. In the states that have passed this law, it was done totally bipartisan with little or no opposition. Several states in 2019 took Kevin's Law to the next level, you can call it Kevin's Law 2.0. Ohio currently has an updated version in legislation.

No person should die because they cannot get a refill because their doctor is not available. Type I diabetes waits for no one. The effects of lack of insulin are immediate. Make some positive from your tragedies, struggles and difficulties. We are

capable of making that choice and incredible things can happen. Respectfully, Joshua Levin on behalf of Danny Houdeshell, the Houdeshell family and in memory of their son Kevin, who was taken way too early.

SENATOR LESSER (9TH): Thank you. Thank you very much, Joshua. Are there comments or questions from members of the Committee? If not, thank you for sharing that testimony and for being here. Next up we have Campbell Mitchell followed by John Kleinhans.

MR. MITCHELL: My name is Campbell Mitchell. I'm a Ridgefield resident and a social sciences major at Western Connecticut State University. I've had Type I diabetes since I was 9 years old. Today I'm here to share my story in support of S.B. 1 and H.B. 5175.

My fellow students and even my professors are frequently shocked to hear that I spend on insulin that I spend on tuition. And unlike tuition, I will be paying for insulin for as long as a live. This leaves me in a difficult position. The risk of losing my insurance coverage if I try to start a new job or start my own business is one of life and death. And there is no sane, responsible course here.

Even if I get new insurance, the cost of my insulin and other supplies might become so burdensome that I go bankrupt or die from rationing. I know other students have died because either they couldn't get insurance or their insurance didn't cover what they needed or because even with insurance, they can't pay a few thousand dollars a month for insulin that costs $2 in Australia.

When I was 9 years old, my doctors mistook my initial symptoms. And so, I got to live through what it feels like to be deprived of insulin right up until the moment before it kills. As some people have said that insulin is as essential to a person with Type I as oxygen. Personally, I think this is an understatement. Diabetic ketoacidosis is far worse than suffocation. Without insulin to allow the body to process sugar and energy, the body starves, eating its own tissues to stay alive.

At the same time, the body's survival efforts cause a buildup of highly acidic ketone bodies. Without insulin, blood pH level plummets, to where it is impossible for the organs to function. The pain of starving to death, being eaten alive, having my organs fail, and being burned by acid from the inside out, was worse than anything I could have imagined at 9 years old and more excruciating than words can describe. And when other people have mentioned rationing, this is the experience they're talking about.

I am exceedingly lucky to be alive today and luckier still that I survived without serious brain or organ damage from going without insulin for so long. Today, I am studying at Westconn in the hope that despite my disability, I can with hard work, contribute positively to my community and my country. But if something goes sideways with my insurance, and it comes back to a question of paying tuition or paying for insulin, I can't put my life at risk again.

My capacity to participate in and contribute to society depends on sane restrictions on insulin prices so that I and my fellow people with Type I

can make rational, informed and responsible choices about our futures. It depends on measures like S.B. 1. Thank you for your time.

SENATOR LESSER (9TH): Thank you so much for your testimony. It's just shocking that you spend more on tuition -- on insulin than you do on tuition. Wow. I'm glad that you are here. I'm glad that you've been able to tell your story and hopefully your story will help open hearts and minds and allow us to do the right thing here. So, I just want thank you. It was incredible testimony and wish you the best of luck with your studies as well. Are there questions or comments from members of the Committee? Thank you very much. John Kleinhans followed by -- by Michell Cheney.

MR. KLEINHANS: Good afternoon.

SENATOR LESSER (9TH): Good afternoon.

MR. KLEINHANS: Today I'm here to support S.B. 1 and H.B. 5751 AN ACT CONCERNING DIABETES AND THE HIGH DEDUCTABLE HEALTHPLANS. And I want to thank Senator Lesser, Representative Scanlon, Senator Kelly and Representative Pavalock-D'Amato for the opportunity and for your leadership on this.

SENATOR LESSER (9TH): John, I don't mean to interrupt you. I know who you are but could you just please state your name for the record.

MR. KLEINHANS: John Kleinhans, Niantic, Connecticut. I'm on the board of directors for JDRF and their advocacy chair. But today, I don't speak in that capacity, I speak as a Type I diabetic.

In 1995, I was diagnosed with Type 1 diabetes. This life altering news at five years old completely

changed the day to day and minute to minute operation of my daily routine. I remember sitting in the emergency room and my mom being absolutely devastated. I was confused, as most kindergarteners would be, and why my mom was mad at me for having this disease.

And she wasn't. She was terrified of the fact that there was no time outs and no breaks from diabetes. She was nervous for my future childhood of five shots a day, over a dozen finger pricks a day and the constant battle of keeping my blood sugar in a range that would allow me to live a normal life and do normal things like normal kid should do. Like play sports, go to college, get married, have children and just live.

In the time between diagnosed and turning 13 when I first on an insulin pump, I gave myself over 15,000 shots of insulin. Just think of that for a second. 15,000 shots of insulin before I was a teenager I self-administered. From 13 to 30 which is where I am today, the hairline is a little aggressive right now, I've been on an insulin pump which consists of injections, modifications and constant management of a small machine in my pocket. All these tools that are fueled by a simple drug that has not changed, called insulin.

The bottom line is that my pancreas does not produce insulin that keeps you and I alive. Most people don't really understand that. But if I stop taking this drug, I die. Simple, I die.

The average price of insulin nearly tripled between 2002 and 2013 in the United States according to an ADA study recently. Let other countries pay significantly less. And you've heard from so many

different advocates across so many different spectrums, these numbers. That the end of the day, I've had diabetes for 25 years.

And you as legislators, the most impactful thing that you can do, you can raise taxes, you can create environments to have business come to Connecticut and things like that. But this legislation here will help kids survive and people live. And I think that's the most important thing. So, thank you so much for hearing my testimony.

SENATOR LESSER (9TH): Thank you so much, John, and I know you have been interested in this issue and -- and Type I advocacy for a long, long time. And I appreciate, although you're not testifying in that capacity, the important work that JDRF does as well in this community. I have a hunch that my co-chair has a couple questions.

REP. SCANLON (98TH): Well, I just want to reiterate what Matt just said which is that, you know, thank you for your leadership on this and for helping us to organize people. Because I think I -- I'm just so struck by what Campbell just testified about. I mean it's just unfathomable to me.

I'm a new dad and I just can't imagine what is going through somebody's mind when they're spending more on a drug they need to survive than their college education. That just is staggering to me. So, it just is a stark reminder on why we're here and I want to thank you for helping us with this.

MR. KLEINHANS: Thank you.

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

REP. VAIL (52ND): Thank you, Mr. Chairman, good afternoon, John. So, you mentioned between 2002 and 2013 the prices have tripled.

MR. KLEINHANS: Mm-hmm.

REP. VAIL (52ND): And someone earlier had mentioned it went up 12 percent since the '90s to now. Again, can you site where you got that information, number one.

MR. KLEINHANS: Yeah. So, I got that information from the American Diabetes Association, right on their website.

REP. VAIL (52ND): Thank you very much.

MR. KLEINHANS: Yup.

REP. VAIL (52ND): And do you know why, is there any explanation as to why the prices have gone up? Has anyone -- there's no data as to what would have driven the cost up so exponentially for something that hasn't really changed.

MR. KLEINHANS: I've been taking literally the same -- I've been taking Humalog since I was 5 years old. The same exact drug. So, I don't have -- that's not profession in terms of actually developing those drugs. But I've literally, today I've been looking at that same vial since I was in kindergarten and the drug hasn't changed.

REP. VAIL (52ND): And I understand that's not your profession. I just ask because I know there's a lot of people in here who have done a lot of research. I was just curious if you had that information.

MR. KLEINHANS: Nope.

REP. VAIL (52ND): I'm curious as to find out why so thank you.

MR. KLEINHANS: Thank you.

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

MR. KLEINHANS: Thank you.

SENATOR LESSER (9TH): Next up, we have Michell Cheney followed by Tom Dykas.

MS. CHENEY: Thank you, Committee members. My name is Michell Cheney and I am here in support of S.B. 1 H.B. 5175 AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALHTPLANS. I'm here with Connecticut Insulin4all and I'm also one of the admins of the Connecticut Type I parents' website.

I live in Watertown and I have an 8 year old Type I diabetic daughter named Kira. She has been diabetic since she was 3 years old. A lot of people have spoken, and I want to clarify, I'm fully in support of this bill.

A lot of people have spoken about the dangers of not having insulin and about the costs so I don't want to reiterate what they've already talked about even though it's in my testimony.

I want to point out that these things that we are trying to are for our collective future. That we are trying to prevent some of the complications that uncontrolled diabetes and the lack of insulin can create. My daughter has a non-diabetic A1C because we have her on such tight control with the equipment and the insulin that we're able to afford right now as long as nothing changes. And if it does, I'm

going to have to choose between keeping her somewhat safe and paying bills. So, you know, that's one of the most important things that we're dealing with here.

I know that people have spoken about the Relion insulin. I want to address that. That won't work for this kind of control. This will just keep you above water, as you were. It won't prevent complications. I know someone who is on this insulin. They're an older Type I diabetic, they've been taking it for a long time. And at least three times, the ambulance has been called to her house, had to break down her door once because she was so low, she was in danger of dying. So, that isn't a solution. It's just a cheap way to not die.

Also, advocating more specifically to the portion of Kevin's Law. As I understand it, the 72 hours is an issue. They don't really sell 72 hours' worth so I think that’s an important point to look at. And I think what other states are doing is -- is -- is helpful but I think even if -- even if they weren't Connecticut is ready and willing to make a difference. And I think that with your help, we can be at the forefront of saving a lot of lives. Thank you.

SENATOR LESSER (9TH): Thank you very much. Thank you for your testimony and for your suggestions about how to strengthen it and for your passion and concern for your child. We're going to do the very best we can and I just am mindful of what my Senate leader, Senate Looney said a few hours ago. Which is our goal this year to make sure that no one in Connecticut has to die because they can't afford insulin or other diabetic management supplies.

MS. CHENEY: Thank you.

SENATOR LESSER (9TH): Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you for your testimony. Can you just go over the 72 hour provision? You were saying about that.

MS. CHENEY: The provision -- there's a provision, Kevin's Law for the 72 hours emergency supply of medication. It's not really a thing that insulin comes in. You can't get, you know, four pills for your next dose. It doesn't work that way. And it's so variable, like other people have mentioned getting your -- your last prescription filled amount as your emergency supply is probably more accurate.

Because what one diabetic, if my daughter took what another diabetic took, it could kill her because it'd be too much. So, it's all dependent on the person.

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

MS. CHENEY: Thank you.

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

MS. CHENEY: Thank you.

SENATOR LESSER (9TH): Next up is Thomas Dykas followed by Kathleen McKinnon. Good afternoon.

MR. DYKAS: Good afternoon Chairman Lesser and Ranking Member Pavalock D'Amato and distinguished members of the Insurance and Real Estate Committee.

Thank you for allowing me the opportunity today to speak briefly regarding my support for S.B. 1 and also H.B. 5175.

My name is Thomas E. Dykas. I am a constituent who resides in Groton, Connecticut. I also have been living with Type I diabetes since 1993 at age 7. I am also a member and advocate for the Connecticut Insulin4all chapter.

Since my diagnosis in '93, I have endured over 27 years' worth of financial, mental and physical damage. I've come to expect that as most of that is permanent now. It makes me sick when I think about how much healthier I could have been today if my insulin was just made readily available and affordable to me. But it's just something I have to live with now and it's just hindsight.

But my worse experience by far happened over these past holidays. I was expecting to pick up my routine refill for my insulin. Come to find out, I was three days too soon to refill it. In order to receive my refill, I had to call the doctor, wait for an authorization, wait for the pharmacy to call me back. I did not have time to do that.

In the meantime, my blood sugar was rising rapidly, resulting in diabetic ketoacidosis. The symptoms at first are very similar to the flu but in reality, your brain and body are shutting down. Mentally and physically, you cannot make the clear and urgent decisions to get that immediate care needed.

Without any recollection, somehow, I made it to the emergency room with minutes to spare. I was very lucky. That same exotic topic happened to Kevin Houdeshell over the 2013 holiday. Unfortunately,

Kevin wasn't so lucky to have made it. I know exactly how he was feeling and what he was going through in those final hours.

Since then, Kevin's parents have fought endlessly to put a stop to conflict surrounding their insulin refills. Parents like Nicole Smith-Holt has joined the fight as well.

As a result, states like Ohio adopted Kevin's Law with more states on board every legislative session to follow. Remember, these parents are not out there fighting for their children's future anymore, they're doing this all for us now.

They started social media groups, they're creating movements now to honor their late children. As a result, they have never taken a day off from reliving those final tragic moments of their children's lives.

I no longer dream of having children anymore. I'm sorry, I cannot take the risk of having a child living with Type I diabetes even if genetics are not the option. I saw the pain that my mother went through and read all of this. If I could please have a couple more minutes, I have some important points.

SENATOR LESSER (9TH): Yes.

MR. DYKAS: Please, thank you, I appreciate it. I understand that this is very tough for somebody who's not living with diabetes to fully understand what we are going through. That's why we're here today. We ask that you would give us a chance to work with you on writing a bill that will follow through what it's intended to do.

We know the words that have to be in the bills but we need you on this one to really make sure that it's worded correctly. Together, we can build something truly lifesaving. And keep in mind, we're not just people living with diabetes, we're voters living with diabetes. We elected you guys to help us and we have confidence that you will emphasize with us to help improve our daily lives.

One thing I just wanted to make clear. Regular insulin, NPH insulin are not a good enough option. Good enough is not an option at all. It's pretty much the same as rationing your insulin. If you're not - if you're not adjusting the right dosages, your blood sugar is erratically rising and dropping, same outcome in the end. I highly recommend that you find out how your body works with these insulins because everybody is different. My cat was diabetic and was prescribed NPH insulin. This is not an option.

SENATOR LESSER (9TH): I don't mean to cut you off but you are over your time.

MR. DYKAS: I understand. I -- I just wanted to thank you all for your time and the opportunity to let me speak. And I really urge you guys to work hard on this to support S.B. 1 and H.B. 5175. And I am available for any questions you may have now or after this hearing.

SENATOR LESSER (9TH): Thank you very much.

MR. DYKAS: Thank you for the extra time, by the way.

SENATOR LESSER (9TH): My pleasure. Don't tell anybody. I can see Representative Vail has a

question. I just have a comment after him. Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. When you -- when you get your prescription for insulin, how long can they do your prescription? Does it have to be 30 days, can they go out 90 days, can they go out a year?

I think it depends on -- I know on some drugs or medicines that some they have to do like every 30 days and there's requirements. Some of it can go out a little bit further. I was just curious where insulin fell on that.

MR. DYKAS: That was actually another issue I -- I have had. Because the box of insulin pens, there's five in a box. Sometimes you may get -- you may have a precise prescription written by the doctor where, you know, one box or two boxes may last you 45 days or 70 days. I've -- I've these experiences before when I didn't know when -- when it was time to -- to refill again. It wasn't really made clear to me.

REP. VAIL (52ND): Okay. I just was curious about that. That's why I mentioned it earlier. Thank you.

SENATOR LESSER (9TH): Thank you, Representative. I just wanted to thank you, Thomas. You told your story at the press conference as well and I know that it's probably a miracle of modern medicine and through the grace of God that you're here today. And I'm just so grateful that you are, that you're here to tell your story and to advocate for other people who are uninsured or underinsured in fighting to take control and manage Type I diabetes. So,

you're a real inspiration and I'm just very grateful for you telling your story.

MR. DYKAS: Thank you. I also wanted to thank Representative Cheeseman for coming up here with her testimony. For a non-diabetic to dedicate that much care for us is -- is -- is beyond words to me. It does mean a lot to us that people care like that.

SENATOR LESSER (9TH): I'm assure you we'll get to Representative Cheeseman and she's a great advocate on this issue as well so thank you.

MR. DYKAS: Thank you.

SENATOR LESSER (9TH): All right, next up we have Kathleen McKinnon followed by John Orfino.

MS. MCKINNON: Hello Connecticut Legislature, Senators and Representatives and members of the Insurance and Real Estate Committee. My name is Kit McKinnon. I reside in Haddam, Connecticut. I am a member of the Connecticut Insulin4all group. I am also a registered nurse and a certified diabetes educator for the past 30 years.

I have been the manager of the Middlesex Health diabetes care program, Center for Chronic Care Management for the past 20 years. I am not actively speaking for the hospital as a spokesperson. My comments today are my own based on my experience educating and supporting people with both Type I and Type II diabetes during my 40 year nursing career.

I support S.B. 1 H.B. 5175 AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS. Because I believe the benefits of passing this legislation will accrue not only to individuals with diabetes but to society in general.

The upfront expense spent to control out of pocket costs for insulin and diabetes testing supplies is more wisely invested in ensuring that people with diabetes have what they need at a reasonable cost to stay healthy, safe, working and going to school.

So, practically on a weekly basis, I told you I work in a hospital. I see a variety of downstream effects of the high cost of insulin. Men and women, young and old, working and retired people being admitted to Middlesex Hospital with dangerously high blood sugar because they ran out of insulin and test strips because they can't afford to pick up the prescription at the pharmacy.

I would also like to say that this is a change. People talk about like, you know, when did this happen. I would say probably over the past three years, what I've really seen is people in the hospital telling me that they gave up trying to figure it out. And they asked their family member to basically bring them to the hospital for help.

This is discouraging. Adults -- as adults, we have agency and the fact that we have people that basically think that the hospital is the only place to get help is really a crisis to me.

Again, to finish up, inpatient care is the most expensive diabetes care that there is. And thank you for considering my experience with the trust cost of society of keeping the way things are, expensive and unaffordable insulin and diabetes supplies. And if you pass this legislation, I do believe that whatever you pass is going got relive some of this economic stress and worry that I see every day at the hospital. Thank you.

SENATOR LESSER (9TH): Thank you so much and thank you for sharing your stories of experiences that you've seen at the hospital that's in my community. As a Middletown resident, I'm very grateful for the work done at Middlesex Hospital and so thank you for that. And we're mindful of the larger cost of untreated and unmanaged diabetes, so thank you very much.

MS. MCKINNON: Thank you.

SENATOR LESSER (9TH): Are there questions or comments from members of the Committee? If not, thank you very much. Next up, John Orfino followed by Misty Lewis.

MR. ORFINO: All right, well good morning Chairman Lesser, Chairman Scanlon, distinguished members of the Committee. I think I must have hit a lunch or something. My name is John Orfino, I live in West Hartford and I'm here with Insulin4all in support of S.B. 1 and H.B. 5175. I just want to thank you for raising the bills and scheduling today's public hearing to hear our testimony.

Some of you may remember me from my time up here working with Speakers Annam and Sharkey. Of course, it's great to see you again, Senator Lesser. And again, I'm pleased that you're taking on the important issues addressing -- addressing the high cost of insulin and supplies, access to emergency insulin and creating a program for those who cannot afford their insulin and supplies.

Now I was diagnosed as a Type I diabetic only four and a half years ago. So, I'm relatively new as a diabetic but it's completely changed my life in many ways. First and foremost, I have to take insulin

multiple times a day to survive. If I don't have insulin within a few hours, my body will begin having uncontrollable high blood sugar that will result in diabetic ketoacidosis, eventually cause my death.

So, in a very short period of time, my health can spiral into an emergency crisis if I don't have access to insulin. In addition to having to take insulin, to make it easier to administer and monitor, I have an insulin pump which some people talked about. I don't know if you've actually seen this, and a continuous glucose monitor. And these are two items that I use every day and I have to pay for supplies for on a monthly basis.

Now with the pump, I can program how much insulin I need to take and administer it daily for myself. And with the continuous glucose monitor, it tells me exactly how much my -- my sugar is like whether it is high or low through the course of the day. Every five minutes it allows me to accurately give myself insulin.

Again, both of these are very expensive. The units themselves are several thousand dollars and the supplies cost about $2800 per year. That's in addition to insulin and other supplies as well.

I also have a team of doctors and specialists now that I have to see regularly to address many diabetic related issues that I have or I may have in the future. I have a primary doctor, endocrinologist, cardiologist, neurologist, ophthalmologist, a number of doctors that I have to see regularly. Occasionally, I've seen therapists who deal with the stress of dealing with a chronic illness as well.

So, all in all, it's a consuming condition, requires a lot of time, mental energy and money. And this past year, I spent approximately $12,000 on treatments and -- and visits and medications and tools and support.

So, I'll just finish up here. I'm one of the lucky ones. I've got a good job, I've got great insurance, I'm doing all right. The problem is is that the fees and the prices keep going up. When I first was diagnosed, I paid $20 a vial, now I'm paying $87 a vial for insulin.

The rates are unsustainable and the costs are definitely to contend with. And if I'm having trouble, I know others are having trouble. And again, I just want to thank you for taking up these issues, extremely important. I look forward to working with you on this further. Thanks so much.

SENATOR LESSER (9TH): Thank you so much, John. I appreciate your work on this issue. I should say for purposes of a conflict of interest, you and I were bowling a few days ago so I'm that doesn't [laughter] raise any ethical quandaries. You were better than I was. Are -- are there other questions or comments from member of the Committee? If not, thank you very much.

MR. ORFINO: Thank you.

SENATOR LESSER (9TH): Misty Lewis followed by Hobie Lewis.

MS. LEWIS: My name is Misty Lewis.

SENATOR LESSER (9TH): If you would like, you are under no obligation to but if you would like to testify together, we would allow, you know, we would

allow that. It's up to you. We might be able to pull up another chair. Is there a chair?

MS. LEWIS: My name is Misty Lewis and I live in Woodberry with my son and husband. I support S.B. 1 and H.B. 5175. Just after I graduated college and began my career, I was diagnosed with Type I diabetes. The diagnosis was stunning as I had no other relatives with diabetes and sobering as I was no longer free to pursue my dreams. I would have to be practical.

I'd have to work for a big company that offered good health benefits. Lucky for me, I did have health insurance. I worked hard to balance a complicated disease, a new job and young adulthood. I lived in constant fear of losing my job and more importantly, my health insurance.

Fourteen years after my diagnosis, my then six year old son would be diagnosed just as I -- just as he started first grade. It really upped the ante as now two of us depended on having good health insurance. Not to mention that now we had to pay for diabetes times two.

Each year, we pay thousands of dollars for that good health insurance and then we pay thousands of dollars in copays and deductibles on top of that to cover our insulin and diabetes supplies. I feel incredibly lucky that we can afford to pay for those lifesaving treatments.

However, little if any is left over for my son's college savings account or even an account for him to afford insulin when he's a young adult. I worry about our future. What happens if we are no longer able to access good insurance or couldn't afford it.

When my son becomes an adult and is no longer covered under our health insurance, how will he pay for insulin and supplies. Will he too have to sacrifice his dreams so that he can afford the insulin that keeps him alive.

It is extremely important that this bill includes both insulin and the delivery method to monitoring tools available for monitoring diabetes care. The technology that enables diabetics to improve their health outcomes cannot be overlooked.

Additionally, clear language is needed on Kevin's Law enabling patients to receive a 30 day supply of life saving insulin when needed. I ask you please to stand with us and support S.B. 1 and H.B. 5175 so that we can live more and worry less.

SENATOR LESSER (9TH): Hobie, do you have anything to add? Oh, you do, okay. Hobie, that was a classic fake out my friend. You sold me on the no.

MR. LEWIS: Hello, my name is Hobie Lewis. I live in Woodberry and I will be 10 years old next week exactly. I support S.B. 1 and H.B. 5175. I've been a Type I diabetic since I was six and a half. I want this to be a law because it is not fair to spends thousands of dollars on insulin and supplies just because one day my pancreas decided to stop working.

Last year, my insulin pump supplies cost more than $10,000. That doesn't even include my insulin and my test strips and I need those things too. Having Type I diabetes means that I have to think about so much more than my friends, like how many carbs I'm eating, how much insulin I need. And if my blood

sugar will be too high or if my blood sugar will get low and I'm playing outside.

Also, I'm really happy to have my insulin pump so that I don't have to take shots anymore. But seriously, the pump can be so frustrating. Imagine if you needed your phone or computer to keep you alive and every time it beeped or buzzed you had to stop everything and fix it or you might get really sick. I get frustrated with my pump every single day.

Please support me in this bill so that I can take care of myself and not have to think about how I will afford my insulin supplies when I become an adult. Thank you for listening.

SENATOR LESSER (9TH): Thank you. That was -- that was excellent. And I've got to tell you, Hobie, there are a lot of people who do this for a living, do what you're doing right now. They sit in that chair and they testify. And you -- and you did as good if not better a job than a lot of people who do this for a living.

So, congratulations and happy birthday, happy early birthday. You know, you mentioned that you spend $10,000 a year. Now that's a -- do you have a lemonade stand?

MR. LEWIS: No.

SENATOR LESSER (9TH): Well, we want to make sure that you don't have to do that. That's what we're hoping to do today is address that. So, your parents can put that money into a college fund, help make sure that you have other things you can do with that money so we're not just focused on the one thing that seems to take up an awful lot of both of

your lives which is managing Type I diabetes. And I just want to thank you for both for being here today. I think my co-chair, Representative Scanlon has a couple of things he wants to say as well.

REP. SCANLON (98TH): Yeah, Hobie, I just want to thank you for being here today and -- and telling your story. And, you know, I am saddened to hear that you're worried about this at 10 years old. Because I just became a dad and I hope that my son when he's 10 doesn't have to worry about this if he's diabetic.

MR. LEWIS: No.

REP. SCANLON (98TH): So, I want to thank you for being here because you're fighting for people that you don't even know exist so far and you're really brave and strong and you're the man. So, thank you for coming here today, okay?

MR. LEWIS: You're welcome. Thank you for having me.

SENATOR LESSER (9TH): And I'm hoping we can bring you back at some point. You can tell your -- tell your friends in school that you might have helped to had a little part of passing an important law. And that may be something you can -- you may be able to tell at some point. Anything else from members of the Committee? Yes, Representative Hughes.

REP. HUGHES (135TH): Thank you, Mr. Chair. Hobie, can you tell me, do you get to go to sleep away camp in the summer like some of your friends?

MR. LEWIS: Yes.

REP. HUGHES (135TH): And what kind of camp is that?

MR. LEWIS: It's actually a diabetes camp. It's Camp Joslyn. I've been going for two years now.

REP. HUGHES (135TH): Can you tell me about that?

MR. LEWIS: Well, it's pretty much a normal summer camp except it's diabetes only.

REP. HUGHES (135TH): Got it. So, people are -- are really there, the staff, the counselors, the nurses to help you with all of that in case that's a problem.

MR. LEWIS: Yeah. Like there's nurses everywhere and it's basically meant for Type I diabetics.

REP. HUGHES (135TH): Love that. Do you know of any other friends that maybe don't have that opportunity to go that have Type I diabetes?

MR. LEWIS: I have no idea.

REP. HUGHES (135TH): Okay. But one of the things that, as a former camp director, it's really hard for kids like you to just be able to do normal stuff like summer camp if it's not a specialty camp like that. And that's another barrier to just having a normal childhood. And I think that this law could go a long way towards granting normal childhood experiences for everybody who has Type I diabetes.

MR. LEWIS: Yeah.

REP. HUGHES (135TH): Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Anything else from members of the Committee? If not, thank you both, you've been terrific. Thank you. Next up we have Mitt Wallack followed Logan Merwin and Samantha Merwin who can go up separately or together as you would like. Good afternoon.

MR. WALLACK: Good afternoon. So, I've been here 5 hours and I'm rewarded by having to speak after Hobie.

SENATOR LESSER (9TH): Life isn't fair, I'm sorry.

MR. WALLACK: And I think I know who's going to be speaking after me. But in any event, I'm Milton Wallack, past president of the New Haven chapter of the Juvenile Diabetes Research Foundation, JDRF. I'm here today to express my strong support for S.B. 1 and H.B. 5175 and its intent to roll back prices for insulin and related supplies while increasing emergency access from a pharmacy.

This is critically important legislation. And as indicated by Aaron Kowalski who is the president and CEO of JDRF when he noted that no one should suffer or die for a lack of insulin.

Unfortunately, people are dying due to rationing of insulin or because of its total lack of availability. USA Today, for example, reported on December 10, 2019 and you've heard some of this story before. It's the story of Alex who when he turned 26, died because he was faced with the need to ration his insulin.

This was because after his 26th birthday, he was no longer eligible to be covered by his parent's insurance. The pharmacist whom he dealt with said he would have to pay $1300 for his insulin and supplies which he could not afford, thus causing him to ration his insulin.

Within a month, Alex's parents received a call that no parent wants to get. That Alex, who was a loving, caring, goofy, compassionate, adventurous, generous young man was gone. His mother notes that

his hugs are one of the things that she misses the most.

Alex unfortunately is not alone in this dire circumstance. Others who are poorly managed are faced with damage to their heart, kidneys, eyes and nerves that result in heart attacks, strokes, kidney failure, blindness, crippling neuropathy and amputations.

According to a study at Yale, many patients who are currently using insulin do so with a less than prescribed amount because of its high cost. There is no reason for this to be happening other than for the greed and Representative Vail, you asked about why, other than for the greed of the manufacturers of these companies such as Eli Lilly, Novo Nordisk and Sanofi.

These three manufacturers are already the targets of investigations in several other states including California. And a law suit has been filed that accuses them of conspiring to drive prices higher. Perhaps we in Connecticut in concern with the attorney general's office should pursue similar actions.

Insulin was first developed nearly 100 years ago so there is no research and development costs. Today, the costs of producing a month's supply of insulin is $15. Despite this, in the past decade alone, the price of insulin has risen more than 240 percent. Individuals are now forced to pay between 600 to 700 per month for insulin or between $7000 and $85 per year plus the cost of their supplies.

There is absolutely no reason for these excessive costs, especially when insulin supplies are

available in Canada for just a small fraction of the cost in Connecticut. The only reason for the huge price differential between the United States and Canada is that Canada holds down prices with legislation.

This is exactly what you have the opportunity to also do and is why I strongly support S.B. 1 and H.B. 5175 and urge passage of this bill. Thank you for creating this legislation and for accepting the challenge to save lives. Thank you.

SENATOR LESSER (9TH): Thank you so much, Milton, for your testimony and for the work of JDRF. It's important. You mentioned the three insulin manufacturers that control the U.S. market. You know, I mentioned this at the press conference we held a couple weeks ago.

But the price of -- Sanofi is a French company. You can walk into any drug store in France, you can walk out of their headquarters and go to a drug store and a five pack of Lantus pens costs about $50 give or take on the exchange rate. You walk into a Price Shopper in the State of Connecticut and the retail price as of today is $566 for the exact same pack of five insulin pens.

That is tenfold for the exact same pharmaceutical product for sale in one country and we are paying the highest prices in the world. So, it's a really important point and thank you for your testimony. I see that Representative Vail has a question.

REP. VAIL (52ND): Thank you again, Mr. Chairman. Good afternoon. You mentioned the three manufacturers. Is there anyone else that manufactures?

MR. WALLACK: Not that I'm aware of.

REP. VAIL (52ND): Okay. So, they -- so the law suit that you mentioned is -- that accuses them of kind of controlling the price.

MR. WALLACK: Exactly.

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

MR. WALLACK: Thank you. And by the way, Senator Lesser, in Canada it's about 10 percent of what it is in the United States even as big a differential.

SENATOR LESSER (9TH): I met earlier with a representative of the Canadian government. They complained that they pay the third highest prescription drug prices in the world after us, we're number one. But if they're paying 10 percent less than we are than number three is still a heck of an improvement. But it really puts things into perspective so absolutely. Any other questions from members of the Committee? Representative Scanlon.

REP. SCANLON (98TH): I was just waiting but I will just add thank you, Mr. Wallack and to your wife as well. You're always here on a number of issues and we appreciate you being here today for this, so thank you. And apologies for your very difficult slot in the batting order. That's outside of my control.

SENATOR LESSER (9TH): Next up, we have a star familiar to many of us, Mr. Logan Merwin and his mom, Samantha. Unless you want to -- do you want to --

MS. MERWIN: [Off mic].

SENATOR LESSER (9TH): I -- I -- I remember there was a point in my life I felt that way. You're on, Logan.

MR. MERWIN: Good afternoon Senator Lesser, Representative Scanlon and members of the Committee. Hi, my name is Logan Merwin. I'm 13 years old and live in Haddam, Connecticut. I'm here to submit testimony for S.B. 1 and H.B. No. 5175.

Eleven and a half years ago, my 17 month old self got the fateful news, you have Type I diabetes. That meant having to get insulin and other supplies for the rest of my life or a die. We didn't know at the time but those five words meant a lifetime of ups and downs and endless fields of supplies which come for an extremely high cost.

I support the insulin and supply cap part of this bill because many times our family paid over $700 for insulin for a one month's supply. That's just the insulin. It's not like the rest of the supplies are free. That $700 could have been a plane ticket to Alaska to go gold mining. But instead, it was spent on buying liquid gold from the pharmacy.

I was selected to go to JDRF's children's congress this past summer to talk about insulin pricing and research funding. I haven't seen any action taken yet. Maybe if Connecticut passes legislation, the government in D.C. will want to pass legislation on it too so it helps everyone.

I worry sometimes about when I'm an adult on my own with not a lot of money. How am I going to be able to get insulin? Well, I have the answer to that question, this legislation. This bill would solve

the problem because I could pay $150 much easier than thousands.

I support the Kevin's Law part of the bill too. Because if I was in an emergency, it would be crucial to my survival. If I was in between jobs than I could get an emergency refill for insulin because of Kevin's Law.

I shouldn't be thinking in these situations but I am. Because without this bill, I might be in a situation where I have to ask another Type I for insulin because I can't afford the copay at the pharmacy. This isn't just me. It impacts my friends and over 2500 kids all over the state. If this bill gets passed, we can help change thousands of lives in Connecticut. Thank you.

SENATOR LESSER (9TH): Thank you. And I want to thank you because what you're doing here today and what you did at the press conference is going to make a difference for those 2500 other kids who are in the exact same position but who couldn't take time off to be here today. So, thank you, you are really inspiring and it means a lot. Representative Lucy Dathan.

REP. DATHAN (142ND): Thank you so much for presentation and your testimony today. It really, you're very eloquent and light years ahead of your age. One thing that I was thinking about, I have three kids. Luckily nobody has diabetes.

But I was thinking about when one of the doctor's earlier was testifying about using the syringe with a vial versus the pen. And I was thinking how difficult that would be for a young person to have to administer that sort of drug themselves.

I'm wondering, in your experience, are you able to be pretty self-sufficient with your testing products and your pens?

MR. MERWIN: Well, I actually use an insulin pump too so it administers every five minutes. But I am able to take care and change my insulin pump site and dexcoms on my own. Like if one fails at school, then I am able to do that.

REP. DATHAN (142ND): That's wonderful. I mean, that's taking a huge amount of responsibility and you should be really proud of your -- yourself for doing that. So, thank you so much and thank you, Mr. Chairman.

MR. MERWIN: Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other comments or questions from members of the Committee? If not, thank you. You've been great as always. Next up, Samantha Merwin followed by Laura Nally.

MS. MERWIN: Members of the Committee, I'm here to submit testimony in support of S.B. 1 H.B. 5175. My name is Samantha Merwin and I live in Haddam, Connecticut. My child Logan, who you just heard from, has been living with Type I diabetes for almost 12 years. And for most of his life, we have been impacted by the cost of insulin and diabetes supplies.

He was diagnosed in 2008 and every year we spend between $5000 and $9000 on keeping him alive. This doesn't include the monthly premium cost of our insurance which brings that number up. Our total out of pocket medical costs annually are $10,000 to $15,000 a year before last year.

I support the price cap for insulin and assistance for Type I patients on high deductible plans. The Type I community has been held hostage for years by the insane cost of insulin, which is why rationing occurs and people die.

It's important for all of you to know that we have no choice but to buy insulin. Logan will die without it. All of these people here that are Type I will die without insulin. Type I diabetes is unique in that there is no generic alternative to other treatment available. Logan has other diseases like asthma. We have options for inhalers, we have options for a cheaper inhaler. We have options for a generic EpiPen. I have no option for insulin, I just pay for Novolog.

Our family has been on a high deductible plan for most years. In January 2018, as Logan mentioned, we paid over $700 for a one month supply of insulin. By May, my total was $2492.20 just for insulin alone, for nothing else, May 2018.

Luckily, that was actually a good year. That didn’t include any other item we needed but we met our out of pocket maximum that summer which was $7500. Some years our deductibles and out of pocket maximums were higher, some years they were lower.

I also support the price cap for diabetes supplies. But I think that the language in the bill needs to make it clear that it should also include continuous glucose monitoring supplies as well. The price of a continuous glucose monitor continues to rise and keep it -- and makes it out of reach for many families.

A CGM protects the person with Type I, as you've heard in other testimony, because it avoids costly emergency room visits and it should be accessible to all. In many years, I began paying for the first shipment of pump and CGM supplies in January, only to pay it off in December to have it start over again the following January. It's a vicious cycle.

I'm very passionate about supporting the language in the legislation for Kevin's Law. Pharmacists should be allowed to dispense a 30 day supply of insulin if the prescription has expired. And the language should be really clear about the fact that it should be a one month's supply as there have been issues under the current 72 hour legislation.

I know you've heard many stories about Kevin himself but I want to tell you a story about your own constituent in Connecticut who ran out of insulin on October 10, 2017. And we heard from a relative of his that was in another state and Logan and I met him in a parking lot to give him some of our emergency supply of insulin to help -- to help keep him alive for another day.

He had no choice. His alternative was to incur more debt and go to the emergency room for treatment or prepare for death. So, that night on 10/10/17 had a huge impact on me because we never wanted that to be Logan. I brought him with me and in turn this is, you know, this is why him and I advocate.

Every single one of you knows somebody impacted by Type I. It's your constituents, it's your friends, it's your neighbors. So, please support this legislation to help them. I want to just note that it's important, while you're hearing consistent messages from us and the Type I community, we aren't

asking for anything for free. We're asking for fair, fair, not free. Thank you for your time today and your support of this bill.

SENATOR LESSER (9TH): Thank you for your testimony and for coming up and being a stalwart advocate. And it's just mind boggling that this is the system we have that people have to meet in dark parking lots to exchange lifesaving medication. So, thank you for your testimony and for being Logan's mom. Are there questions or comments from members of the Committee? If not, thank you very much. Next up we have Laura Nally followed by Jesus Morales-Sanchez.

DR. NALLY: Okay. That may be my continuous glucose monitor alerting me that my blood sugars are a little bit high probably because I'm nervous. It may continue to go off but that's okay we're just going to roll.

SENATOR LESSER (9TH): There may be a few continuous glucose monitors in the room, it's unclear.

DR. NALLY: There's quite a few in the room, yes. So, thank you all for having me here today. My name is Laura Nally and I wear many hats. So, I not only have had Type I diabetes for the past 30 years but I am also the outreach leader for the Connecticut chapter of Insulin4all, co-founder along with Kristen Whitney Daniels and Dr. Kathryn Nagel. And I am also a pediatric endocrinologist.

So, I am here today in support of testimony or writing this testimony in support of S.B. 1 and H.B. 5175 that helps my friends, my family and patients in Connecticut who are struggling to afford the necessary insulin and supplies to manage diabetes and stay healthy.

So, we all know that insulin used to be cheaper. So, I was actually a teenager when the cost of the current insulins that we still use today was only about $20 a vial. I do remember this actually because I had to go to a pharmacy after I dropped a bottle on accident and I remember that we paid out of pocket, $20. I do have a good memory, it serves me well in my career.

Then there's also plenty of evidence in the literature as well to show us this. And so, I'm happy to provide you with the T1 health analytics that was published in the *Washington Post* that shows that the price of insulin used to be $20. But those of us who have been practicing for a long time or who have had diabetes a long time actually remember when it was.

So, I -- I'm a physician and I have good health insurance. However, just because I have health insurance does not mean that I can always access affordable insulin when I need it. So, recently when I was at my cousin's wedding, my insulin pump came disconnected from my body. Basically, I require a continuous infusion of insulin to be going into my body at all times. And when it becomes disconnected, I can get sick very quickly.

I use a rapid acting insulin that can wear off within a few hours. So, by the time I noticed that my insulin pump had fallen off and this can happen because you're sweating more than usual or your skin is just oily, it -- it had been about two hours and I was starting to feel sick. I was with my family, we were able to call my doctor and get refill sent over to the local pharmacy within about an hour. But unfortunately, I was not due for a refill and

had to pay $369 out of pocket for one vial of insulin.

I didn't have a choice so I took the insulin immediately. And unfortunately, even though I was able to take it within a few hours of noticing that my insulin pump had been disconnected, I became very ill. I returned to the wedding and was vomiting on the floor of the bathroom for about an hour. And in between vomiting episodes was falling asleep and my mom had to sit there with me and basically wake me up and make sure that I was okay.

Essentially, I was going into diabetic ketoacidosis because I hadn't -- I had been without insulin and it had only been about three or four hours since I had last had my infusion set giving me insulin.

So, I did fine, obviously I'm here and I was definitely very lucky that I was able to pay for the insulin out of pocket. I was lucky that I didn't have to -- that I had my family with me to help me. And I didn't have time to call manufacturers for support. I didn't have time to figure out how to get an insulin coupon online like the insulin manufacturers have proposed is a solution. And I didn't have to worry about whether or not I could afford the insulin.

And so, the message I want to send is we don't have time to -- to argue over this issue or to figure out, well we need affordable insulin now and it's basically a matter of life and death. I did have a couple other things that I just wanted to say briefly.

SENATOR LESSER (9TH): Dr. Nally, your time is expired.

DR. NALLY: Okay.

SENATOR LESSER (9TH): But I'm going to ask -- but I'm going to ask you what the two other things you wanted to say are.

DR. NALLY: Okay. I just -- I have a really nice analogy but -- but I just wanted you to think about what it would be like if you didn't have access to water. And for some reason, water cost you $600 to $1200 a month. And if that affected your child or someone that you loved, how would you manage to do that.

And if your doctor, for some reason, had to prescribe you water and let's say your doctor prescribed the wrong amount and weren't due for your water just yet, how would you end up surviving. That's basically what it's like for us with Type I diabetes. So, thank you so much for hearing my comments.

SENATOR LESSER (9TH): All right, thank you so much for your comments. And if you were given how difficult it was to respond to that ketoacidosis shock being a pediatric endocrinologist, I can only imagine how much more challenging that might be for people who don't have the skills and credentials, the know-how that you, you know, accumulated over your lifetime. So, I'm grateful for your advocacy and for being here today and glad -- glad you're okay.

DR. NALLY: Thank you.

SENATOR LESSER (9TH): Are there questions or comments from members of the Committee? Well, you got off easy. Thank you.

DR. NALLY: I'm -- I'm more than happy to meet, answer questions and whatever you guys would like to chat about. Anyways, thank you.

SENATOR LESSER (9TH): Thank you very much. Next up, we have Jesus Morales Sanchez followed by Keerti Murari.

MR. SANCHEZ: Hi. Good afternoon at this point.

SENATOR LESSER (9TH): It's been afternoon for a while.

MR. SANCHEZ: I know. I'm like, I'm still thinking that it's like, you know, 11 o'clock for some reason. But so, my name is Jesus Morales Sanchez. I'm here in support of not only S.B. No. 1 and H.B. 5175 but also H.B. 5251.

As you said, my name is Jesus Morales Sanchez. Some of you have seen me before. I'm a usual face in here. As of today though, it has been 508 days since the worst day of my life. It's been 508 days since the day that I was diagnosed as a Type I diabetic. And while I'm no stranger to diabetes, being the oldest child of an immigrant family, it was me who interpreted for my mother's doctors' appointments for the last ten years. And it was also me who taught her how to inject insulin 10 years ago at the age of 15.

I knew that I had this history of diabetes in my family, more specifically, Type II diabetes. I did not know of anyone else in my family with Type I. So, it was a bit of a surprise when I was diagnosed two weeks before my 24th birthday.

I attached to my testimony and I don't know if you all have it but, I mean, I have a copy here. There

are two pictures. They're taken 10 months apart from each other. In the top picture, it was basically December of 2017. I was 235 pounds. Ten months later, I was 130 pounds.

This disease had gone undiagnosed for about 10 months. It had literally been shutting down my body. It crossed my mind that I needed to see a doctor when I started to lose all that weight. However, even though I was employed full time, my employer did not provide benefits.

Early in 2018, I had to pay out of pocket a wisdom teeth extraction which destabilized a lot of my financial responsibilities. So, the idea of me going to the doctor even for a regular checkup was nerve wracking because I knew that I could not afford it. Months passed and my health continued to deteriorate. And it was through friends and, you know, through personal favors, I was able to schedule an appointment at the Fair Haven Clinic in New Haven.

Life has been hard. I was uninsured and the cost of insulin and supplies terrifies me. I was lucky that there's a program, the 340(b) which a few folks have like mentioned before. I was able to get quick access to -- to -- to -- to insulin for relatively cheap.

In the meantime, I was also trying to keep enrolled Husky D. Because of my unemployment status, I was able to qualify for Husky D. And later on, I was able to apply for a job that now provides me health benefits and allows me to pay for me -- for my insulin.

However, in between that stage, my mom's insurance actually ran out and in between her new insurance policy kicking in there was a gap where she fell uninsured. It was terrifying, it was paralyzing and ultimately what ended up happening is that, so that she would not have to run out of insulin, I had to share some of mine with her.

I'm part of like the very lucky, very privileged few. And here's also where my support for the other bill comes into play. I also come from a mixed status family. Many of my family members are undocumented and don’t have access to these medications. They don't have access to medical insurance.

Type I diabetes and Type II diabetes, there's some genetic components to it so I know that it was just a matter of luck and the irony of saying, I was lucky to be the one that got Type I diabetes and not any of my undocumented family members.

So, I'm sure that today you will hear a lot of these stories. Please listen to them and know that there's a lot more folks out there that could not afford coming today to this hearing. But we're coming here as a united front because we really need to save many more lives.

SENATOR LESSER (9TH): Thank you.

MR. SANCHEZ: Thank you.

SENATOR LESSER (9TH): And I know I'm going to kick it over to my co-chair who I think has a few questions for you. I just want to say how grateful I am that you're here. That you're okay, that you have health coverage now. I can only imagine how terrifying that must have been.

One of the things I've heard from -- from you but from also from other -- other people who have told their stories is how one of the critical safety net programs that we have are these health centers like Fair Haven where you got care and the 340(b) program.

What -- why aren't they -- what are the obstacles, I guess, for the folks out there who -- who either because of status issues, because of high deductible health plans, because of no insurance who aren't managing their diabetes. What are the obstacles to that being the solution? Why isn't that solution right now or what can we do to make it? Maybe you could sort of -- did you not know about it? What was the -- just sort of I'm trying to get my head around why -- why that isn't itself solving the problem.

MR. SANCHEZ: I certainly did not know about it. As I said, it was at the time that I was -- before my diagnosis, I was uninsured. I thought that even a regular checkup at my community clinic would just throw my like financial responsibilities off balance the same way that that wisdom tooth extraction did.

I have friends in here that are -- probably can attest to that, how difficult it was for me to like schedule that appointment because I knew that I could not afford it. And actually, it's unfortunate that Senator Anwar is not present because I actually met him like a month before my diagnosis and he saw me at a -- at a protest. He took a photo op in which he was like testing my battles and what not. And I was like a bag of -- of -- of skin and bones.

Yeah, a lot of times it has to do with there's no -- I didn't -- we didn't know that that was an option

but that was like something that I could tap into and that those resources were available. The other one is that those appointments take time. I had that appointment that I'd made in which I was diagnosed took over a month of waiting time.

Had I waited another month, had I made that call a month later, I probably would not be sitting right here. And as I said, I'm a 6 foot tall guy and this is my normal complexion. 130 pounds is not a healthy weight. I was almost not making out of that situation. So, it -- it was a combination of like different factors and -- and -- and misinformation for sure.

SENATOR LESSER (9TH): one other thing I've heard and I haven't verified this is that the 340(b) program currently covers insulin, it does not cover the diabetic supplies. Is that something that you experienced?

MR. SANCHEZ: Absolutely, absolutely. My supplies, test strips, glucose monitor, a lot of those, I had to pay out of pocket. And yeah, I mean, it's -- it's an expense while also while unemployed while unable to work, it was a huge burden. And, I mean, I did go more in detail in my written testimony. The only reason why I was also able to make it was because I also had my family with me.

I -- I'm still living at home. I still, you know, have my mom to, you know, rely on, my brother to rely on. He actually took on a lot of those financial responsibilities that I needed to take on. And the other reason why I was able to get back on my feet but had I -- had that been a different story, had that been a different kind of circumstances, I would not have made it.

SENATOR LESSER (9TH): Thank you. Representative Scanlon.

REP. SCANLON (98TH): Thank you, Jesus, for being here today. And I, you know, Senator Lesser asked some questions that I would have asked you. But I guess I'd just ask you one question. Throughout your story, you -- you hit on several different things that Senator Lesser and this Committee and I are all working on, right. Status, affordability of finding an option, struggles with qualifying for Medicaid and then coming off Medicaid and what that means and then sort of different insurances.

All of those things lead to one really bad thing though which is that people put off decisions about their health because they can't afford it. And we know and we've heard in this Committee from doctors that have testified that when you do that, you get sicker. And when you get sicker, caring for you costs more money.

So, I guess my question for you is, at all these different touch points in your life that you had to deal with our, let's just say, charitable crazy healthcare system, do you feel like it would have just been -- it would have been more affordable not just for you but for society in general to have just given you access to a quality and affordable insurance plan?

MR. SANCHEZ: Absolutely.

REP. SCANLON (98TH): That also then gave you insurance for a quality and affordable prescription drugs.

MR. SANCHEZ: Absolutely, absolutely. I mean, and I can tell you like right off the bat, as you said,

postponing that care makes matters worse. When I was diagnosed, I focused on the weight because that was kind of like the most visible symptom, right. However, there were like fears of other symptoms.

I do go into detail and just to give you some numbers, my A1C was 13.3. The A1C for those that don't know is kind of like a center measurement of where your blood sugar has been for the last three months. That is like roughly the equivalent, the average of my blood sugar was above 350 to 400 value. That's 3.5 to 4 times the value where it should be.

And at the time of diagnosis, my blood sugar levels were 453 milligrams over deciliters. So, that's 4.5 times the concentration of blood glucose that a person should have in their system approximately, but yeah.

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

REP. HUGHES (135TH): Thank you so much for your testimony, thank you, Mr. Chair. I just wanted to delve into the experience that you're describing of basically being a second class citizen because of the systemic barriers to access to life saving things.

Which actually, every had testified too. That everybody is either on the cusp of being that second class citizen, has been that second class citizen and that we've accepted that as a society as a norm. But certainly, marginalized communities that are like you're describing, mixed documented, undocumented have even more of a fear of being cast

into that permanent second class citizen. Can you talk a little bit about that?

MR. SANCHEZ: Yes. I mean, obviously a lot of it being an immigrant, coming from an immigrant family, just accessing information and understanding and navigating the healthcare system is super complicated. And it's something that I had to learn how to deal with from age 14 which is when my -- 15 when my family and I moved to the United States.

And with limited English, knowledge of the English language, going and navigating through those loops and hoops, people have talked about being on the phone for hours in trying to reach the right person. Now trying to do that in a different language it's a whole other set of issues. And not understanding the -- I can just try to go to the doctor and be like hey I -- I need medication.

It's a matter of also waiting for some days, sometimes weeks for a response from insurance companies. It's -- it's -- it's definitely a huge -- a huge burden. And that's only if you can afford or if you are eligible to be part of insurance or to be insured. Because again, in a mixed status family, that means that a lot of my relatives, they have to pay out of pocket. If they go out of -- if they fall ill, they have to rely on either charity or go back to home country a lot of times just to like die.

Has happened to my -- to my family. I had an aunt that chose to go back because she couldn't continue her leukemia treatment. Charity ran out basically. And with any other kind of like chronic illness, any other kind of illness that is like providing that, you know, the healthcare system right now is

unaffordable for pretty much anyone. Let alone for someone that cannot access the, you know, the brittle, social safety net that America has. It's -- it's -- it's -- simply makes matters like a lot more complicated for sure.

REP. HUGHES (135TH): Can you describe, you said your aunt went back.

MR. SANCHEZ: She passed away within a month.

REP. HUGHES (135TH): Within a month. And what was the access to those countries' healthcare like?

MR. SANCHEZ: Well, my family is from Mexico. There is like "social security" --

REP. HUGHES (135TH): Safety net.

MR. SANCHEZ: Safety net. However, being underfunded as well, she couldn't even really like make an appointment. By that time, she just decided to give up on the treatment.

REP. HUGHES (135TH): I was just sort of struck by the fact that we actually have a third world healthcare system that's being described here. So, you know, thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other comments or questions from members of the Committee? If not, thank you for being here.

MR. SANCHEZ: Thank you very much.

SENATOR LESSER (9TH): Next up we have Dr. Keerti Murari and then followed by Stephen Habbe. Hopefully I'm pronouncing everyone's names correctly. If not, please hold that against me. Good afternoon, doctor.

DR. MURARI: Good afternoon Chairs, and Committee members. My name is Keerti Murari and I'm an endocrinologist in training at the Yale School of Medicine. And I'm here today in support of S.B. 1 and H.B. 5175. As a member of Connecticut's chapter of Insulin4all.

As an endocrinologist, many of my patients have diabetes. And even though I've been a doctor for only five years, I have become all too familiar with many of the complications that my diabetic patients face. From ketoacidosis to amputated limbs, blindness and kidney failure requiring dialysis. These scenarios are frighteningly common and sadly preventable.

I try my hardest to work with my patients to find solutions to best help them manage their diabetes and minimize the risk of them developing these complications. In my work, I've come across many barriers to optimizing their health and today we actually have an opportunity to address some of these barriers. And that specifically the cost of and accessibility of insulin and diabetic supplies.

The caps proposed in these bills will help alleviate the financial burden of out of pocket expenses for many of my patients. Additionally, enabling pharmacies to provide emergency refills is a key measure in making sure our patients do not go without insulin or checking their blood sugars. This will help keep them safe and out of the hospital.

I also want to reiterate what has been stated about the need for providing a 30 day supply as opposed to a 72 hour supply. To give you an example, I have diabetic patients who may require maybe a total

daily dose of insulin whether it's their basal or bolus insulin of maybe 15 units a day. But then I have patients that require up to 300 units a day. So, in order to come up with a one vial that may be suited for all, that's not really an option.

That being said, $200 a month which is the cap proposed in this bill, remains a significant financial barrier for many people. Additionally, they may have other medical related expenses. There are many other conditions that go hand in hand with diabetes such as high blood pressure, high cholesterol and obesity. Those medications also are a financial burden for these people.

I would urge members of this Congress to do more for those who are uninsured and also despite the cap still may be unable to afford diabetic supplies and insulin. The study that's proposed in this bill does not provide a solution for people in these situations. And these individuals have a most immediate need.

We need to ensure that all people with diabetes have access to affordable insulin and diabetes -- diabetes supplies. This bill is timely, necessary and a step in the right direction. My colleague, Dr. Nally mentioned an analogy that she used. How would -- how would you feel if you could not go without water. And if someone were to tell you that the cost of water would be $600 a day.

The human body can actually go without water for three days. A patient with Type I diabetes cannot afford to go without insulin for a few hours or they will develop diabetic ketoacidosis.

And then, I was hoping also to maybe ask a question and clarify one particular part of the bill. And that is the $50 cap for non-insulin related medications for diabetes. Because currently, the language includes glucagon, glucose tablets and gels. But does this also include SGLT 2 inhibitors, GLT 1 analogs? These are also important medications. that are used in the care for our diabetic patients.

SENATOR LESSER (9TH): Well, thank you, doctor. Normally we ask the questions but happy to -- happy to put things. You know, I think we're -- we're still working on the language but I think the intent, and I just want to -- I think it also goes to something that you said earlier. You mentioned a $200 cap. You know, I think our intent is to have a $100 cap on both insulin and diabetic supplies. So, that would be a cap that covers all expenses for the month.

Now, the $50 cap would be for insulin and other glucose lowering agents for an individual prescription but up to $100 overall cap. So, there would be $100 -- that's, I think, the intent. But how we get there, I think we're still in the process of drafting that.

And while neither Representative Scanlon or myself have particular expertise in endocrinology, I know that you do and other folks in the room do and we'll be happy to work with you to see if we can get that language right. Are there other comments or questions from members of the Committee? If not, thank you very much for your testimony.

Now, I want to apologize. Actually, I had said that Stephen Habbe would be next. With his indulgence, I

do see Senator Slap in the room. And Senator Slap had been up earlier. I know you have a very tight timeframe so if it's okay, I'd love to sneak Senator Slap in and then go back to our regular scheduled order. Good afternoon.

SENATOR SLAP (5TH): Good afternoon. Good afternoon, Senator Lesser, Representative Scanlon, all the members of the Health Insurance Committee. Thank you and thank you for your indulgence for, you know, changing the order. I'll be very brief. I'm here in support of H.B. 5255. And also, two of my constituents, Diane Mack and Robin Gilmartin I know you heard from earlier today with Representative Exum.

I think this is really a critical issue of us helping to end the discriminatory practice that many folks who donate organs, which is something we want folks to do clearly in this state and there is a need. I think there's, what I have 1,250 folks who are waiting for -- for organ transplants in Connecticut. Across the country, obviously it's many, many more, it's about 114,000 folks.

And there are many people who come forward and do the good thing and do what, you know, right and heroic really. And to become whether it be a kidney donor or another type of organ donor. And then they have found, like my constituents have, that they aren't, you know, end up paying more for various type of insurance. When, in fact, if you look at some of the actuarial studies there's no reason for that.

That folks who -- who donate, let's say a kidney, or the screening process they go through, they're very healthy and they're no more likely to, you know, to

have a lot of extensive medical issues than -- than somebody else. Yet they find that their insurance premiums have increased.

So, one I would argue, I'm not an actuary but I would argue that they shouldn't increase in the first place. But if there were to be some kind of additional cost that ultimately that would be something that as a community, as a state, you know, it would make sense for us to have that distributed among all of us. As opposed to just a few people who are actually heroic in their actions and have helped to save lives.

So, other states have done this. I know you've -- you've heard this, you know, the list of New York and Maine and Idaho and Arkansas and I think there will be many more that are going to follow. So, I think it's -- it's the right thing to do, it's the fair thing to do and it's going to help save lives. And I'm just here to -- to argue for it, H.B. 5255. So, thanks very much for having me.

SENATOR LESSER (9TH): Thank you, Senator and you did an excellent job, although not quite as good as Representative Exum who was here earlier on the same issue. But no, I kid and I think it's an important issue and one we're looking forward to working with you on. Are there questions or comments from members of the Committee? If not, thank you. Thank you so much and we'll look forward to working with you and your constituents on this issue.

SENATOR SLAP(5TH): Thank you very much.

SENATOR LESSER (9TH): Okay. Back to the regular order of things. Stephen Habbe followed by Lauren Kelly Hamann.

MR. HABBE: Members of the Committee, thank you for the opportunity to testify on S.B. 1 and H.B. 5175. My name is Stephen Habbe and I'm speaking on behalf of the American Diabetes Association to convey our support for the bill, for these bills with the addition of some clarifying language. I'm -- I'm going to very much abbreviate my testimony which I've submitted in writing given so many of the people here today are very articulated, conveyed similar points.

The change needed for the Association's support of the legislation is to ensure that the caps listed in the bill are connected with the and. Currently it says there's multiple caps with the word or. We don’t want it to be an option where they're choosing to select one of the caps and not all the caps.

The Association urges your support for the bills, revised as I proposed, to help make diabetes care affordable. And thank you so much for your very clear interest in this very important issue.

SENATOR LESSER (9TH): Thank you very much and thank you for your brevity as well. [inaudible - 03:49:52] so I -- I really appreciate it and look forward to working with the American Diabetes Association to get the wording right.

MR. HABBE: Certainly. If there's any perspective that we can offer at any point in time happy to do so.

SENATOR LESSER (9TH): Thank you very much. Are there comments or questions from members of the Committee? If not, you got off light. Thank you. Next up we have Lauren Kelly Hamann followed by, I don’t know, I'm having trouble reading the

handwriting. Cathy, starts with an L. You'll have to help me with that. But I got one, I think.

MS. HAMANN: Hi. So, my name is Lauren Hamann. Most of my patients, colleagues and friends know me as Kelly. I am an RN CD here in Hartford. I work at St. Francis Hospital. However, my views today are my own, not representing St. Francis Hospital.

I have been living with Type I diabetes for greater than 20 years. I know we've heard lots of testimony today on life with Type I diabetes and the importance of insulin and maintaining that life with Type I diabetes. So, I'd like to spend a little time talking about Type II diabetes so thank you for your time today.

The CDC's most recent estimates show that over 30 million Americans have Type II diabetes. The vast majority -- or have diabetes. The vast majority of these individuals have Type II diabetes. Type II diabetes affects virtually everyone that any of us might know. It is a massive problem and it's growing exponentially day by day.

So, what do we need to do here? Capping the cost of insulin is incredibly important. And we've spent a lot of time today focusing on that. But we also need to figure out a way to decrease mortality, morbidity and complications that are impacting our healthcare delivery systems by managing the cost associated with other diabetes medications as well.

We've heard several adult endocrinologists talk about the ADA pathways and how we differentiate what medications we choose for our patients. The first drug of choice is always the same and it has a generic available. However, the next bifurcation in

the treatment algorithm are each classes of medications that are newer and only available in name brand forms. And each of these medications, if we select them as clinicians, we choose for a very good reason.

Either because there's data to show that they reduce cardiovascular complications. Or there's data to show that they reduce the progression of CKD or chronic kidney disease associated with diabetes. So, it's very important that we're not only focusing on insulin because the vast majority of patients who are treated for their diabetes do not take insulin. And that's the fact of the matter.

SENATOR LESSER (9TH): Thank you. And does the language, other glucose lowering agents, is that helpful?

MS. HAMANN: So, other glucose lowering agents would be helpful in this regard because these types of medications are other glucose lowering agents. We just want to be clear that we're not only identifying insulin and then things like glucagon and other rescue medications. All of these treatment components are integral to maintaining a healthy life with diabetes.

And the fact of the matter is, if we can keep our blood glucoses as close to control levels and I can help my patients keep their blood glucoses as close to controlled normal levels, then we can minimize complications and we can minimize any duress on the healthcare system.

SENATOR LESSER (9TH): I appreciate that. And I also just would note for the record that I think other legislation that we may be hearing about in a

little bit may also go some measure towards providing needed interventions that could benefit people either with or at risk of Type II diabetes as well. Because I understand that's a huge issue as well, so thank you for your testimony. Are there questions from members of the Committee? If not, thank you very much.

MS. HAMANN: Thanks.

SENATOR LESSER (9TH): I did have a chance to get some help in the -- during -- during Lauren's testimony. I think it's Cathy Labrecque, is that right?

MS. LABRECQUE: Yes.

SENATOR LESSER (9TH): Okay, good. I -- I -- wasn't sure on your handwriting, apologize. Followed by Douglas Schwan.

MS. LABRECQUE: Thank you very much, I was going to help you with the name.

SENATOR LESSER (9TH): Yes, thank you and good to see you again.

MS. LABRECQUE: Good to see you too. Thanks again for having me. So, I am Cathy LaBrecque and I'm from Simsbury and I'm here to talk on behalf of the H.B. 5175 S.B. 1 in support of that bill. I've been a diabetic for a number of years.

Throughout most of that time, I have been very fortunate to have insurance through my employer. And so, to be honest, the increase in cost of insulin was completely transparent to me for a very long time. Right up until the time that I found out I did have chronic kidney disease and I would need

to go on dialysis. And I got fairly sick and it became very challenging to be able to work.

So, I have to go and find alternate sources of insurance because even my Cobra was extraordinarily expensive. Because I was on dialysis, by federal law I also was able to be on Medicare. And so, I then was on Medicare with a supplemental plan.

So, the first time I realized the incredible rise in cost of insulin was when I went to the pharmacy the first time after I had left work and was on dialysis and was -- encountered a $700 bill. So, I didn't know really what was going on and I was already feeling pretty sick so I really wasn't really completely clear on how I was going to manage all of this.

And I did have also the expense of diabetic supplies because I am a huge advocate of innovation. And all of the advances that have been made to help people manage these chronic diseases, mine in particular being Type I diabetes.

So, as time passed, I learned how I was going to try and figure out how to manage all of this. I was on dialysis because I needed a kidney transplant. Through the generosity of my sister, I was very fortunate that I was only on dialysis for a year and a half and she gave me my Christmas present which was a kidney and I'm very, very thankful for that.

I then developed other complications from, it was a bit of a snowball effect. I then had a blood clot which required bypass surgery because it was arterial and that was a direct result of being diabetic and having a vascular issue. Not necessarily from the fact that I was recovering from

my transplant which was a bit of a controversy for a while.

But after I had my bypass surgery, I was told that I had lost blood supply from my knee down. But again, very fortunate, I only lost a toe to that and I was dangerously close to losing my leg. So, really the most I lost on that one was the ability to enjoy a nice pedicure which some people here will understand, some of you won't.

But it gave me a great sense of relief that when I went to the pharmacy, I can pay for my insulin and I can make accommodations for the supplies that are necessary. And I have an incredible support staff. Obviously, my family is very close. I again, have my sister's kidney so that's pretty great.

But I also know that there are a lot of costs associated with the care that I receive. And if I was able to stay in front of it and support the wellness activities that exist, I may not have had to endured all the things that I endured through the course of about a year and a half.

So, I support the bill so that many people can grow and have lives where they don't have to have all those complications and multiple procedures. Thank you.

SENATOR LESSER (9TH): Thank you so much, Cathy, for sharing your story with us. And if there's one thing I've been impressed upon today it's that if you think the cost of diabetes management supplies are expensive than the cost of complications are just that much more. So, I'm hoping that through your testimony that others won't have to go through what you've gone through. And I just appreciate the

strength you bring with us today. Are there comments or questions from members of the Committee? Well if not, thank you very much for your testimony.

MS. LABRECQUE: Thank you.

SENATOR LESSER (9TH): We have Douglas Schwan followed by Theresa Sanderson.

MR. SCHWAN: Hello everybody on the Committee, I appreciate your time here today. My name is Douglas Schwan. I'm a member of the Juvenile Diabetes Research Foundation board of the directors and a member of Insulin4all. My views and comments today are my own and my own only.

I am providing written and oral testimony today in favor, apprehensively because of the language in the bill at the moment, of S.B. 1 and H.B. 5175. Before I get into what I want to say, there was a couple of points the other Representatives and Senators had made that I think I can touch on that would answer some of your questions.

Number one, there are other insulin manufacturers in the world. The three that only affect the North American market are Eli Lilly's Humalog, Novo Nordisk and Sanofi. There is a new company in Poland, there's a new company in India. And I think maybe Brazil maybe there's another new one coming online because the populations in these other parts of the world are exploding with diabetics. Those insulins are not yet in this marketplace.

So, the bill is -- the bills as they are are not adequate and lack mechanisms related to the publicly stated intentions of the bill. I believe they're not strong enough and they're not protecting the

people they intended to serve. The poor, the working poor and frankly, the middle class.

The bills only affect a small subset of the population they're intended to serve. It's estimated only 26 percent of the population that these bills are targeted toward would actually be served with the language that they currently contain.

The second problem I have is that the burden of the lowering of insulin costs for diabetics is, in these bills, only being put on the backs of insurance companies and to a lesser degree, distributors. This is really backwards because the pricing mechanisms are allowed to run wild right now because the pharmaceutical companies are allowed to price things as they wish.

So, there's no mechanism in any of this to hold them accountable that I can see. I'm tremendously grateful to Eli Lilly, Novo Nordisk and Sanofi. We need them. Everyone in this room needs them whether you're diabetic or not. But the diabetics can't live without them.

I truly appreciate everything they've done but things are getting a little out of control. There's a couple of main points I want to make to finish. The market is really constrained because of evergreening patent laws. That is the biggest reason why insulin prices are allowed to explode with no limit.

The second reason is there's inelasticity of supply and demand in the market for diabetics. There's no supply in demand for diabetics. You need what you need and you only need what you need and that's

never going to change, okay. So, until those mechanisms are targeted in some way in a much broader sense, we're going to be back here again, guys. This is not going to solve a lot of things, I think. I hope that's not true.

So, I'm going to skip some other things because I want one last thing to show everybody in the room here. What I'm holding in my hand is a newspaper front page from the April 1, 1941 *Chicago Tribune*. You come down to the middle front page it says, insulin price fixing charged to three companies. Guess who they were? Eli Lilly, Merck and Squibb.

Okay, so what's old is new again. We have not changed our patterns and thinking's in terms of the corporate mindset with these things. And this is not like the first time we've been down this road. And I really think there can be more that we do with this bill.

SENATOR LESSER (9TH): Thank you for your testimony and I take that to heart. Some of the things that you mentioned, obviously are beyond the scope of the powers given to us in the State of Connecticut to address. We certainly don't have direct say over our nation's patent laws but there are things we can do to certainly strengthen the bill.

And would be willing to work with you and the organization that you're not representing but that you're apart of to make sure that we get there. Obviously one of the questions we've been asking in this Committee is that it's not just limited to insulin but it extends to the pharmaceutical marketplace in general. And one of them is the perception that there may be practices that inhibit full competition between market players.

So, I know the State of California, for example, recently passed legislation that prohibits what are called pay for delay agreements. Where one name brand company makes a payment to generics not to compete with them. Is that something that you've looked at and you think would potentially benefit the insulin marketplace? I'm sure if that's something [crosstalk].

MR. SCHWAN: I'm familiar with it in concept only. I don’t know enough about it to make a compare and contrast with what's going on with your legislation.

SENATOR LESSER (9TH): Well thank you. And I'd certainly be willing to work with you to figure out what we can to do try to strengthen this legislation. Yes, Representative Delnicki.

REP. DELNICKI (14TH): Yeah, thank you Chairman. And you made a comment pertaining to evergreen patent laws. Could you just expand on that for a moment? I realize it's out of our purview but with the duration that insulin has been around, I would have thought that every patent would have expired by now.

MR. SCHWAN: Evergreening, for people who don't know in the room, is a term that has been applied to -- and this happens in a lot of different industries. But it seems to really be rampant in pharmaceutical industry. Where you may make one minor variation that allows the continuation of a patent for a lot of things basically indefinitely. Because not only you are changing a molecular thing, you can then also apply it to other conditions and therefore, there's another patent.

I can't -- somebody at a group meeting I was at the other day, one of these insulins has now got like 35, 40 patents when initially there was one. So, it's those kinds of things where there is no end in sight to the patent manipulation with these things.

I want these companies to make money because I want them to keep developing drugs. But, you know, the NIH does all of the leg work with all of these things, okay. Since in 2010 to 2016, I think there was 210 new drugs that came onto market. Every one of those was funded by the NIH which us.

And then they pick up that at a bargain discount bottom rate and then make a huge drug which is great, we need these things. But the American taxpayer then ends up paying for this across the world for everybody else. We're being compensated for our tax dollars going back into these. Things like the NIH are being charged the highest prices in the world.

REP. DELNICKI (14TH): Well, that's a real eye opener for me. And for the record, my -- my adopted mom, my biological grandmother, I watched her live her life, the end of her life through the lens of having -- her having diabetes. And what I've heard today has brought back a lot of my memories and I appreciate everybody whose come forward to speak on this. Thank you.

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

REP. VAIL (52ND): Thank you, Mr. Chairman, good afternoon. Can I get your name please and who you represent again even if your opinions are your own?

MR. SCHWAN: Sure. I'm Douglas Schwan. I'm on the board of directors for the Juvenile Diabetes Research Foundation.

REP. VAIL (52ND): Can you spell your last name? I don't have a list of [crosstalk].

MR. SCHWAN: My testimony had not been submitted yet so that will be on when I get home.

REP. VAIL (52ND): And how do you spell your last name?

MR. SCHWAN: S-c-h-w-a-n.

REP. VAIL (52ND): And who are you with, what groups?

MR. SCHWAN: Juvenile Diabetes Research Foundation Connecticut chapter. I'm on the board of directors with them.

REP. VAIL (52ND): Okay.

MR. SCHWAN: And I also work with the folks over here at Insulin4all.

REP. VAIL (52ND): And so, your reading of this bill, from what I understood from what you said is that the real, like -- it seems to me the real culprit here is the pharmaceutical industry and we're kind of attacking the insurance industry. Would that be your perception?

MR. SCHWAN: Yes.

REP. VAIL (52ND): And I tend to agree with you on that. And again, maybe there's some limitations to what we can and can't do. But I certainly see that as being a major issue and I think they're the big reason why, obviously, they're the ones producing.

And why all the sudden have things gone up 120 percent or 3 percent over a 9 year period or whatever it is is still outrageous. We need to get to the bottom of why.

And sometimes when we -- when we spread things out in the insurance realm, they just put that cost back onto consumers and to businesses. And that's not always a solution that I can get behind. So, I'd be more than happy, I'd like to learn a little bit more if you could share some of your information with me and maybe we can meet offline sometime, I'd appreciate it.

MR. SCHWAN: Sure, be happy to do that.

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

MR. SCHWAN: Thank you.

SENATOR LESSER (9TH): And then next up is Theresa Sanderson. Theresa, he couldn't be here because he's a little under the weather but Representative Turco with whom I share the town of Newington advises me that you are a constituent. So, Representative Turco did want to extend his regret that he couldn't stay but he does need medical attention for himself. So, thank you very much for coming here today.

MS. SANDERSON: Thank you. I am Theresa Sanderson from Newington and I thank you for allowing me to testify in support of AN ACT CONCERNING DIABETES IN HIGH DEDUCTIBLE HEALTHCARE.

My support of this bill is stemming from two different directions. As an employer of more than

230 employees in West Hartford, I'm an administrator of West Hartford Health and Rehab. And there are 230 people who work there, many of whom have diabetes, mostly Type II. These folks are entrusted to care for our most fragile population and they make an average of $16 an hour.

I have heard anecdotal evidence from them over the years of having to walk away from the pharmacy because they can't afford their medication and they go without. I didn't understand fully the impact of this until five weeks ago when my daughter was diagnosed with Type I and went into a diabetic coma at the same time.

So, she was discharged from the hospital four weeks ago. And the first time I went to pick up her medication, I do have a high deductible plan and it was $400 for her first two pens of long acting, two pens of the short acting. So, apparently my pharmacy does split the boxes and that was $400 that went towards the deductible. That in the month that she's been home, I have spent $600 out of my own pocket and that's unsustainable.

So, a couple other reasons why is the prescription calls for finger stick testing three times a day. Well, as a newly diagnosed Type I, the reality is more like 12 to 20 times a day. Also, it's winter time. She cannot get blood from her finger to test and we -- we waste strip after strip. So, she's sitting there crying with five strips that we can't use trying to get a drop of blood out of her skinny little finger.

So, I have spent $600 out of pocket in supplies. I will not ration and yet she's already suggested perhaps she should start reusing her needles. And

I'm protecting her from that. There is no way. Also, she was discharged with the short acting insulin of which she required more. So, we have an endocrinology follow up visit for six weeks after discharge. She was discharged with a prescription for four weeks which lasted two.

So, I have been at the pharmacy every week begging, crying, pleading in a panic that I will not be able to take care of my daughter. I finally got the pharmacist to give me one pen of short acting while they worked out the insurance cost. And I felt like I won the lottery when I walked out of there with a pen that I temporarily didn't have to pay for. I went back the next day, it was $95 for one pen.

It is a fear. I fear for my daughter's future. She's 19, she's in college. She's going to remain on my health insurance but what if after that she doesn't have a job that has good insurance. What if she's one of these folks that does the rationing that is unable to afford it.

And diabetes is a life changing diagnosis. The amount of information we have coming at us is overwhelming and the learning curve is huge. We do not need to put the obstacles of insurance coverage and costs into this mix. So, thank you for letting me testify, please consider this bill so we'll allow the Connecticut residents to care for this disease.

SENATOR LESSER (9TH): Thank you so much for your testimony and for being here. And I think you, unfortunately, you sort of knit together a number of the different problems that we're trying to address with this issue.

One, the issue of high deductible health plans and whether or not insulin is a preventable drug that should be covered before people meet the deductible. What do you do when you need to get emergency access? What happens when people turn 26 and they fall off their parent's health insurance.

So, there are a lot of these issues we're working through right now and hopefully we can provide you with some of the peace of mind that as a mother it sounds like you are desperate for. And I can only imagine how stressful and difficult this must be. So, I want to thank you for being here and would open it up to any questions from members of the Committee. If not, thank you very much, I really appreciate it.

So, those are all of the speakers we have here who are scheduled to testify on -- on the insulin bills. We are proceeding through the bills. At the end of hearing, certainly we will have an opportunity for anybody who has not yet testified to sign up.

So, the next speaker we have scheduled on S.B. 197 is Michelle Rakebrand from CBIA. Following Michelle, we have Ken Ursaki from CAPIA on S.B. 200. Good afternoon, Michelle.

MICHELLE RAKEBRAND: Good afternoon. Thanks for having me. So, I'm here to testify as to what CBIA has done in the past as to all the mandates for the whole session and we are testifying more on the cost implications of these bills, not so much the substantive underlying message of the bill. First of all, I would like to thank the committee, the members here have really made controlling cost a priority, especially for the small group markets, so we do appreciate that. But we'd be remiss not to

testify on how mandates do affect premiums. Currently in the state, we have 68 mandates on the books and that contributes to $2085 dollars a year annually per enrollee's plan. And that number accounts for 23 percent of Connecticut's overall annual health expenditure per enrollee. And so, CBIA does concede that not all mandates are created equal. There are mandates that are definitely necessary and help a large portion of our population.

However, a really good way to determine that would be through doing a cost benefit analysis. So, currently, there is a Health Benefit Review Program in statute. However, that analysis hasn't been conducted since 2014. So, what we're really proposing that is -- if that analysis was done on a more frequent basis, you'd really get a better understanding on how these mandates affect premiums and which ones would be best serving for our community. I am happy to answer any questions. Thank you.

SEN LESSER (9TH): Thank you, Michelle. Certainly we pay a lot of attention to the proposed cost of any -- of any new mandates as well as potential savings because not always do mandates cost money as, you know, you've heard probably from the testimony this morning and this afternoon on insulin. The cost of not addressing, you know, Type 1 diabetes preventively can result in extremely expensive and serious complications if untreated. And I was wondering if the CBIA has done any analysis to address the potential cost shift to fit -- to workers to families if we were to repeal the existing insurance health benefits that are required under the Connecticut Statutes?

MICHELLE RAKEBRAND: So, I think it depends. If we did a cost benefit analysis which ones would be repealed because some of them cost on average $45 dollars per month, but some of them cost $0.10 cents a month. So, really it depended on which ones would be repealed.

SEN LESSER (9TH): But as I said, yeah, if we were to tell folks that, you know, we're no longer covering cancer treatment for example. Obviously, that's an example of a mandate I'm not sure that anybody would propose that. There would be obviously significant cost shifts to somebody who has insurance that no longer covers that, you know, interventions related to cancer treatment, right? If we were to repeal our existing mandates. So, in terms of the additional cost that would be borne by an employee in this state if their insurance no longer covered some of the essential health benefits that we've designated.

MICHELLE RAKEBRAND: So, we're not proposing any sort of cost shift. I mean right now employers cover about 76 percent on average of premiums for workers and the workers will pick up the remaining percent. We are not proposing a cost shift per se, we're just proposing that maybe taking a better look at these mandates could result in a cost savings for both employers and employees.

SEN LESSER (9TH): As long as the employee doesn't get sick. I -- yeah. Thank you. Representative Vail.

REP VAIL (52ND): Thank you, Mr. Chairman. I -- so you're here testifying on Senate Bill No. 197, I imagine you're not going to come up again as -- are there a list of Bills that are on the public hearing

today that you oppose and are there any that you support?

MICHELLE RAKEBRAND: So, we broadly oppose any mandates without a cost benefit analysis being conducted first, and the Bills on the agenda today are Senate Bill No. 197, 199, 203, and 204. But I will not testify every committee hearing on the mandates, so this is going to carry through for the whole session.

REP VAIL (52ND): Okay. Are there any Bills on here that you support?

MICHELLE RAKEBRAND: In terms of mandates, no.

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

SENATOR LESSER (9TH): Thank you. I'm sorry, Representative Pavalock-D'Amato.

REP PAVALOCK-D'AMOTO (77TH): Thank you, Mr. Chairman. Just to let you know, I did, with Representative Candelora, put in a Bill that does require analysis. I know one of the things that we looked at is, instead of having UCONN do it, which tends to be expensive, seeing if an outside company could do it and if it's cheaper. So, I don't think that's on the agenda for Thursday, but maybe the week after.

MICHELLE RAKEBRAND: Yeah, and we'd be supportive of that. Thank you.

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

SENATOR LESSER (9TH): Thank you and thank you Representative. Are there comments or questions from the members at this point? If not, thank you very much. Next up, is Ken Ursaki. Following Ken,

we will hear from Karen Siegel. If Ken is not around, we will go straight to Karen Siegel.

KAREN SIEGEL: Good afternoon Senator Lessor, Representative Scanlon, and esteemed members of the Committee. My name is Karen Siegel and I'm testifying today on behalf of Health Equity Solutions where I serve as the Director of Policy. Health Equity Solutions is a non-profit organization with a state-wide focus of promoting policies, programs and practices that result in equitable health care access delivery and outcomes for all people in Connecticut. We have submitted written testimony on S.B. No. 201, and H.B. No. 5251 and I'll just summarize both of those quickly.

In terms of S.B. No. 201, as you heard earlier, there are really dramatic disparities in health access and outcomes for people of color in our state. So, any effort to promote equity is something we support. We made a couple of recommendations about the Task Force, first to include consumers specifically and particularly people who experience those inequities so that there are no unintended negative consequences. The second was to consult with the reasonably large amount of research done in Connecticut on policy options for promoting equity in the state. In addition to the bills mentioned by Senator -- the papers mentioned by Senator Fasano earlier, he talked about the Connecticut Health Foundation paper, the Connecticut Voices for Children paper, which I in my previous role was the last paper I published there so I was glad to hear that. It has at least a dozen options in it. There's also work by the Child Health and Development Institute and the UCONN Health Disparities Institute; there's quite a lot of work

already done. So, you have a lot of options out there. So those were the two recommendations we made on that.

And then, regarding H.B. No. 5251, you're going to hear from a lot of other people who have really compelling stories and a lot of data. I just wanted to point out that from our perspective, this is a Health Equity Bill as well, because there are such large disparities in health insurance coverage in the state about -- there are about two times as large -- the rate of un-insurance is about two times as high for a black resident in Connecticut and three times as high for Latino residents as it is for white residents in the states, and since most of our -- about 70 percent of the folks in Connecticut who are without documentation, are from -- born in countries in Central and South America and in the Caribbean, there's quite a lot of overlap with that disparity and that population. So, a solution to health insurance access for folks who are undocumented is also a partial solution to the un-insurance gap. So, thank you for your time.

SENATOR LESSER (9TH): Thank you. I look forward to working with you on addressing potential options on what we can do to resolve the health equity gap. So, thank you. Are there comments or questions from the committee? If not, thank you.

Next up, moving right along, is Kathy Flaherty in the room? After Kathy we are going to -- the next big Bill, the conversation that I think a lot of you are waiting for about bariatric coverage, so that will be up following her, when the first speaker there will be Dr. Darren Tishler. Good afternoon, Kathy.

KATHY FLAHERTY: Good afternoon, Senator Lessor, Representative Scanlon, and members of the Committee. I actually submitted written testimony on a number of bills including the insulin bill. My mother-in-law is a type 1 diabetic, so, you know, that issue is very close to me personally and I encourage this committee to do everything you can to reign in those costs.

I'm here in support of S.B. No. 203, which is a mandate that would require health insurance coverage for motorized wheelchairs. I am the Executive Director of Connecticut, Legal Rights Project, also the Co-chair of Keep the Promise and in this perspective really here as a member of the Cross Disability Lifespan Alliance. Having access to wheelchairs provides mobility and freedom for people with disabilities who need it and the opportunity to participate in community life.

And I add my voice to those who are in support of H.B. No. 5251, we believe health is a human right. It should be not be dependent on one’s immigration status and I do think it's important that the Task Forces, if any are created, do include those people with that first handed experience, because they can give you the most valuable information. So, I'm happy to answer any questions, but that's it.

SENATOR LESSER (9TH): Thank you. Representative Dathan. Do you have a question?

REP DATHAN (142ND): That is my name.

SENATOR LESSER (9TH): No, I know it's your name, I didn't know if you had a question. [laughing]

REP DATHAN (142ND): [laughing] Yes, do you mind if I answer, or do you want to go first?

SENATOR LESSER (9TH): No, you go first.

REP DATHAN (142ND): Oh, okay, thank you. Thank you so much for your testimony. You've been a wonderful advocate up here and I've heard you in Appropriations, so thank you for everything you're doing. I really like this bill on the motorized wheelchairs because I do hear exactly what you're saying how it does give people more mobility, access to live their lives and it's wonderful. When looking at these wheelchairs, how long do they -- motorized wheelchairs -- how long do they typically last for and how much is someone paying out of pocket for a wheelchair like this?

KATHY FLAHERTY: I think the most responsible answer I can give you to that is, I will find out that information and get it back to you.

REP DATHAN (142ND): Okay, that's great. I just, you know, it seems like to me that this could be a good long-term investment for someone and the payback would be increased wages if they are out able to work and do things that are -- and also help with having to need extra care. So, thank you so much for your testimony and any answers you can provide I would appreciate it. Thank you very much. Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you, Representative. I'm shocked you thought I had forgotten your name. Other questions from members of the Committee? If not, thank you very much.

KATHY FLAHERTY: Thank you.

SENATOR LESSER (9TH): All right, Dr. Darren Tishler, followed by Burt Zaretsky. I want to thank folks for their patience today. There are a number

of big bills up for consideration and sometimes the wheels of the legislature proceed slowly.

DR. DARREN TISHLER: Senator Lessor, Representative Scanlon and other members of the Insurance and Real Estate Committee, I am Darren Tishler, I'm a resident of Glastonbury, Connecticut testifying in favor of S.B. No. 204, AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR CERTAIN SURGICAL PROCEDURES PERFORMED TO TREAT OBESITY. The views I express are my own and not of my employer or health care system. I am a bariatric surgeon who treats obesity. I'm the Chief of Metabolic and Bariatric Surgery at Hartford Health Care. I treat and often cure health problems likes diabetes, high blood pressure, arthritis, chronic pain and other obesity-related diseases. My career is incredibly rewarding because I improve the quality of life of those I treat and prolong their lives. Already, numerous colleagues have lost patients and others who suffer from obesity have submitted testimony. I would like you to also consider this testimony of your colleague Senator Eric Berthel, who himself has suffered from obesity and has seen incredible improvements in his life and quality of life and health conditions as a result of his bariatric surgery. He has been an incredible advocate for the treatment of obesity.

I also have the testimony in hand of one of our patients, Susan Millerick (phonetic) who had to leave to take care of her son, who does not have coverage for her surgery, and she is going to be tapping into her retirement account in order to pay for her surgery.

Last week, I had to inform a patient of mine, a hardworking mother, that her small business plan did

not cover bariatric surgery due to an exclusion. You see, if she was not working, she would qualify for HUSKY here in Connecticut and be able to get bariatric surgery. Unfortunately, I have this conversation every week in my practice. Twenty-three states have ACA required benchmark plans that include coverage for bariatric surgery. Connecticut is the only state in the northeast that does not have such coverage.

Obesity is a disease that affects all age groups, races, demographics, but disproportionately affects lower socioeconomic classes and minorities and often those most in need. Obesity causes more than 200 health conditions including cancer, diabetes, high blood pressure and leads to early death from stroke, heart attack and blood clots. More than 25 percent of Connecticut residents are affected by obesity and nearly 10 percent have type 2 diabetes. The health care costs for those with obesity are 42 percent higher. According to the office of legislative research work from last year, a 2011 study coordinated by the Connecticut Insurance Department estimated the cost of requiring commercial group health insurance policies to cover gastric bypass surgery was less than 0.2 percent of the premium. There is indeed a cost to provide this care for obesity, however, it is important to consider that this is an investment that can pay off in overall less cost of health care, increased productivity and a significantly improved quality of life.

A 2019 study of the cost effectiveness of bariatric surgery found that surgery is cost-effective for people with obesity who have type 2 diabetes. Additionally, the 2011, cost-effectiveness study reported that cost savings to employers may be

higher because of improvements in worker productive after bariatric surgery.

We often treat cancers that have a low chance of cure, not because it makes fiscal sense, but because it's the right thing to do. Mammograms find cancer early; we would never deny someone a mammogram because it was too costly. Interestingly, the cost to insurers with mandating coverage of bariatric surgery is on par with the cost of requiring coverage of mammograms.

As a physician, I have a responsibility to ask in a fiscally responsible manner but at the same time do what is right for my patients and offer them the most effective treatments available. One of the greatest satisfactions I have in practicing medicine is the fact that we do things because we have the compassionate things to do for our patients. Thank you.

SENATOR LESSER (9TH): Thank you so much Dr. Tishler for your testimony and certainly we've heard in the past and I'm sure my colleagues are familiar with stories from patients who view this intervention as something that saved their lives, so it's something that is deeply important to many of our -- to many of our constituents and to, as you mentioned, our colleague Senator Berthel. I had heard anecdotally that at least some insurance companies in Connecticut are sort of being mindful of what we heard earlier that this idea that we have to be careful about the cost effectiveness of interventions and mandates. But some insurance has recently decided to -- in Connecticut has recently started covering certain bariatric interventions on a voluntary basis because of a decision on its cost

effectiveness. Is that something that -- information [Crosstalk]

DR. TISHLER: I can't speak to their reasoning for increasing the coverage, but ConnectiCare, for example, increased coverage for a wider basis of people with type 2 diabetes in Connecticut. Also, several employers have expanded the coverage. Again, because of the cost effectiveness. My own corporation has expanded the coverage for our patients -- our employees I should say. Again, because of the cost effectiveness of the surgery.

SENATOR LESSER (9TH): And you said that this is something that is currently required in other neighboring states. Is that right?

DR. TISHLER: We are the only state from New York and New Jersey up, that does not have coverage for bariatric surgery through the Affordable Care Plan.

SENATOR LESSER (9TH): Thank you very much. Are there other questions or comments from members of the Committee? If not, thank you. Next up, Burt Zaretsky, followed by Richard Roberts.

BURT ZARETSKY: Good evening. Representative Scanlon, Senator Lessor, distinguished Committee Members. My name is Burt Zaretsky. I'm the Marketing Director for Fairfield County Bariatrics and the Marketing Consultant for the Connecticut Chapter of the American Society for Metabolic and Bariatric Surgery. The views I'm expressing today are solely my own. In fulfilling my responsibilities, I am constantly presented with the opportunity of needing current, as well as, perspective bariatric patients. I have been, and continue to witness, to seeing those who have

suffered and those currently suffering from obesity, and the life-threatening diseases which are a result of it. These diseases are known as comorbidities. They include type 2 diabetes, hypertension, cardiovascular disease, stroke, sleep apnea, gallbladder disease, osteoarthritis, and even certain cancers. New research is indicating that even some dementia is a result of obesity.

One of the charges I have been given is to keep abreast of the latest developments in the bariatric world. Research after research after research have documented that bariatric surgery can reverse the life-threatening downward spiral of those suffering with obesity. Bariatric surgery, excuse me, presents the seal -- the severely obese with the opportunity to regain their health and recapture their lives and as a result of it, they do. Bariatric surgery has and continues to save lives. When I meet the prospective patients in bariatric seminars and hear their pleas for help, I know that they can be helped. However, under the current climate so many of them are unable to get the help that bariatric surgery can provide them with, and they so desperately need. Unfortunately, so many insurance plans here in Connecticut have exclusions preventing them from achieving the necessary surgery to help save their lives. Now, you have the opportunity to reverse the discriminatory practice that permits insurance companies to practice against the severely obese. Their lives are now in your hands. I want to thank you for affording me the opportunity of presenting my plea and my evidence to help save the lives of your fellow Connecticut residents. I urge you to pass S.B. No. 204; you can save their lives. I think you.

SENATOR LESSER (9TH): Thank you so much. I really appreciate your testimony. Are there comments or questions from members of the committee? Yes, Dr. Anwar.

SENATOR ANWAR (3RD): Thank you so much for your testimony. I know about the conversation and we've had this discussion before. I'm sorry this bill did not pass in the past. This is actually truly is going to prolong lives for people and reduce the cost of health care in a lot of people. So, I'm hoping this bill will move forward and in the right direction because there is so much data to support this, and it's unfortunate that sometimes people are caught into a vicious cycle that cannot be fixed without an intervention and I am hoping that we can do better than we did last time.

BURT ZARETSKY: Well, on behalf of my colleagues, I thank you for realizing that.

SENATOR ANWAR (3RD): Thank you.

SENATOR LESSER (9TH): Thank you, Senator Anwar. Other comments or questions from the committee? If not, thank you very much. Next up with have Richard Roberts followed by John Magna Morton. Good afternoon.

RICHARD ROBERTS: Hello. Thank you for listening to me. It's a pleasure to be. I am bariatric patient. I had bariatric surgery in May of last year.

SENATOR LESSER (9TH): I'm sorry, I think I know you name, but could you just state it for the record?

RICHARD ROBERTS: I'm sorry. I'm Richard Roberts. I live in Chester.

SENATOR LESSER (9TH): Thank you very much.

RICHARD ROBERTS: I had bariatric surgery in May of last year and I'll tell you the story about how that happened. First of all, I am small business owner. My wife and I own our own photography business for about 15 years, so as a result, we have to supply our own insurance. We -- before the Affordable Care Act came up, obviously insurance was a big problem for us, and so the ACA actually helped us to finally get insurance that we needed desperately. Both my wife and I have a lot of issues. What I was -- unfortunately found out very quickly after we joined the ACA health care plan was that I was diagnosed with advanced prostate cancer and it had been undiagnosed obviously because I had not been going to the doctor. I was able to get treatment for that, radiation, and followed by hormone therapy for about two and a half years. That was about eight to nine years ago, so I'm cancer free and I'm very happy to do that. The problem with the therapy, though, however, is that over the course of that hormone therapy, there was an enormous amount of weight gain, and I gained over 100 pounds as a result of that. So, by the highest weight gain I was able to get to, I weighed over 370 pounds. So, I was at a point where I needed bariatric surgery but the ACA doesn't cover that in Connecticut, and somebody said it already, but I was surprised when I first started researching it, that 23 states do support this mandate by the Federal Government, yet Connecticut doesn't. And it turned out that it was some study that was done by this legislature, I'm sure it wasn't you guys because you're too young, [laughing] but somebody decided that it just wasn't worth it. So, as a result, Connecticut is the only state around here that doesn't do that. I seriously considered moving the Massachusetts, Rhode Island,

or New York and establishing a residency to just have the surgery because I was getting desperate.

The problem with me was that I didn't have just that problem, I started having hip problems and I was told I needed a new hip, but I couldn't get a new hip, which was covered by my insurance company because I weighed too much. So, I ended up having to figure out how to pay for this because nobody would pay for it. I ended up getting a small business loan, putting my business at risk to get this done, but I was able to do it. And so now, I've got a new hip as well, and the reality is that my hip surgery cost three times as much as my bariatric surgery and that was fully covered. I paid $500 dollars for that, yet I had to pay $25,000 thousand dollars in cash before the hospital would even let me in the door. I took -- I went to every hospital in this area, nobody wanted to talk to me if I didn't have insurance. Middlesex Hospital is the only one that had a self-pay program that allowed me to do what I needed to do and thank God for them. I urge you to, you know, fix what's right -- do what's right and make this plausible for everybody else. It isn't going to help me any, but if you can please help it so that nobody else has to go through this. You don't want to have to go through what I went through the last three years. Thank you.

SENATOR LESSER (9TH): Thank you. And thank you for sharing your story and advocating for others. You know, there are a lot of good things that came from the Affordable Care Act and there were some tough things as well, and one of the obstacles that we're experiencing as we work to address this issue is the way the Affordable Care Act handles new requirements

on insurance plans. It grandfathered in existing requirements but made new obstacles for states when we do try to say, hey look, our coverage should cover new interventions that weren't previously required, at least in this state. So, that's something that we're struggling with and if it weren't for that, then it probably would have passed some time ago, but that's something that has affected the advocates for this bill and for other bills because of the requirements that the Affordable Care Act has imposed. That being said, I'm glad you got the surgery, and I'm glad you're doing well. I'm glad you're still in Connecticut. It is so important that we do everything we can to address the issues that you brought up -- the bigger issue which is the affordability and availability of quality insurance for small businesses because that is a huge issue I've heard from my district, I'm sure from folks in Chester and from around the state.

RICHARD ROBERTS: It's a shame that you have to go through a choice of either life or bankruptcy and you face that every day.

SENATOR LESSER (9TH): Well, we may have some additional legislation beyond today that may try to address some of those issues and hope you can [Crosstalk]

RICHARD ROBERTS: I hope so. I was taken back by the fact that you didn't seem to know that there were 23 states that had that mandate. So, I'm hopeful that you now know and can help advocate for that.

SENATOR LESSER (9TH): I knew that there were a lot of states, I didn't know the exact number, but thank you. I appreciate that. Representative Dathan.

REP DATHAN (142ND): Thank you so much. I really appreciate your testimony. As a small business owner, one of the things that I've heard from the small business community is that they are concerned about how having this mandate to the state would affect small business insurance premiums. Now that you're through this, how is your small business being affected? I mean, do you have lower premiums now that you are in a better weight range? And, I'm assuming, you know, you resolved some of your other health issues and your overall cost of your claims. How are they, now that you're through your surgery?

RICHARD ROBERTS: Well, the thing is that we are not just a small business, we were kind of a like a microbusiness. We are the true mom and pop shop. We had to fire all of our employees because we couldn't afford anything for them. I'm $25,000 above in debt as a result of this and still paying over $700 a month in paying back that loan. So, for us, we can't make a lot of money because then we lose everything. And insurance for us, we have no choice but the Affordable Health Care Act, and as you know, the more money you make, the less your subsidy is, and then it because pretty astronomical. So, we just struggle every day. We're surviving, but it's a struggle and it shouldn't have to be that way.

REP DATHAN (142ND): Just checking, though, but your overall out-of-pocket costs now, outside of the loan and what you've had to pay to finance your surgery, your health care costs now overall, in terms of your

well visits and other visits that you have with your conditions, are they cheaper now than they were?

RICHARD ROBERTS: I've actually been able to get rid of almost all of my medications. I was borderline diabetic. My sugars are fantastic now. I had high blood pressure, I'm pretty much off all of that. I'm off all of my other drugs that I was doing. I had depression pills that I was taking because of all this. None of that exists anymore, so I feel terrific. I have a new hip, I actually walked all the way from the Supreme Court Building because I couldn't find parking anywhere here and hopefully my car isn't being towed because it was expired about an hour ago, but I'll blame you guys. [laughing] I do see a difference and you know, the quality of life that this brings you, it is unspeakable. It's -- and so I would advocate for anyone here to, you know, just understand what -- this isn't about obesity being because I had too many French fries and Big Macs, you know. I didn't ask for this. I was always a big guy, but I was never 370 pounds, and at that stage, you can't walk, and I'm a wedding photographer, think about being on your feet for 12-14 hours a day. Last year, before the surgery, I basically couldn't walk anymore. So, I would have not only been out of business, I probably wouldn't be alive. So, yes, the surgery saved my life. The doctors saved my life. I love my new hip as well. I couldn't believe it, but I couldn't get my new hip without having the surgery.

REP DATHAN (142ND): That's wonderful news. Congratulations and thank you, Mr. Chairman.

SENATOR LESSER (9TH): Thank you, Representative Dathan. Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much, Mr. Chair. Thank you so much for coming and testifying and I cannot thank you enough because I think your story needs to be heard more and more from people. The fact that we have data now that hypertension, diabetes, obstructive sleep apnea, cholesterol, depression, all of those things actually improve in people and then the cost of the medications, and then the longevity of a person changes with this intervention is important.

ROBERT ROBERTS: Absolutely. And I did have sleep apnea and I no longer have to use that stupid CPAP machine. I feel great.

SENATOR ANWAR (3RD): So -- and then the other thing I think that is worth looking at is that the -- the surgeons have mastered the technique now. It's less invasive. The complication risks are much, much less and it is time we actually have an opportunity to have the people be not restricted because of the financial constraints to change their life and then get back into -- you need a drastic change at a drastic time.

RICHARD ROBERTS: You're absolutely right. My wife actually had bariatric surgery 15 years ago and she had a totally different experience. It was awful. In fact, today, she still has problems because of it. The surgery, I've had no ill-effects. I have not thrown up once. And you know you hear the stories about how you basically have any kind sweets or anything like that you do what's called dumping. I didn't have any of that. And I eat very well, and I used to not eat that well, but I gave up fried foods a long time ago. Now I eat protein and I've got my diet really good, and I can't imagine life

anymore, and I love it. It -- you know, I'm Cuban, so I love food. But at the same time, I eat good stuff now, and I've learned how to -- I love cauliflower and all sorts of stuff that allows me to get away from carbs. And I've never felt better in my life.

SENATOR ANWAR (3RD): And I think your testimony would help many of us who may have questions about this to move forward out of the committee and then hopefully the rest of the people in our Connecticut General Assembly.

RICARD ROBERTS: This will save money as well as save lives. It's just got to be done.

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

SENATOR LESSER (9TH): Thank you Dr. -- or Senator Anwar, or Senator Dr. Anwar, however you want to be addressed. Are there questions or comments? Representative Delnicki.

REP DELNICKI (14TH): Just a quick comment. I have a number of friends who have gone through the bariatric surgery and the difference in the quality of life that I have seen with each and every one of them has been truly amazing. To see a person shed 100 pounds of weight literally. And then start jogging which is something they never could do prior to that point, has just been amazing and I've gotta believe it's going to save a substantial amount of money when it comes to whatever care a person that does not have that kind of surgery would need in the future. And of course, we've talked a lot about -- you may have mentioned this when I was out of the room, we talked a lot about diabetes and that issue,

and I have to believe that there will be a substantial reduction in folks that become diabetic.

RICHARD ROBERTS: I am actually chemist by training, and I think you know the studies that stay that obesity is trend forerunner to diabetes as well. So, anybody who is obese the chances are, five years later, they're going to have diabetes. So, the discussion that you guys had about all of the issues are just going to increase ten-time fold and all of the obesity in this country, which you can see anywhere you go is prevalent everywhere. It's going to impact us in a major way. This is curable, and it's curable now with all these great things that these guys can do. We just have to make it something that can be affordable, because not everybody can do it. And I'm fortunate. I'm paying, yeah, and you know, I lose sleep at night about whether my bills are going to be pain, but I know that I'm going to live to be 90 or more and I couldn't say that a year ago.

REP DELNICKI (14TH): And you're going to have much lower use of the health care system going forward.

RICHARD ROBERTS: Absolutely.

REP DELNICKI (14TH): And that will more than make up for the cost of the surgery.

RICHARD ROBERTS: I think people are going to save a lot of money.

REP DELNICKI (14TH): Thank you for coming forward and testifying. Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you. Other comments or questions from the committee? If not, thank you for

your testimony. All right, next up John Morton followed by Amy Dumont.

JOHN MORTON: Good afternoon Senator Lessor, Representative Scanlon and members of the Committee. I'm Dr. John Morton, I'm Vice-Chair of Surgery out of Yale and I'm the Chief of Bariatric Surgery out of Yale. I'm speaking on my own behalf and I'm speaking about coverage for Bill S.B. No. 204. I'm a recent transplant to Connecticut, but I am not new to treating patients with obesity. I'm the past President of American Society for Metabolic and Bariatric Surgery, four thousand members in 40 countries, and I Chair MBSAQIP which is a Quality Accreditation Program in the United States. I've also had the privilege of treating 3,500 patients surgically for obesity. This is my life's work and I appreciate the opportunity to chat with you today. I think people have already outlined the burden of disease that obesity has. It truly involves the entire house of medicine and it is literally from head to toe, diabetes, high blood pressure, sleep apnea, joint disease, fertility and even cancer as you heard so eloquently expressed. There is also disproportionate influence of obesity on ethnicity. If you are a Latino child born in this country, your risk of becoming obese is 50 percent. If your African American, it's 33 percent. There is also cost involved. $0.20 cents on the health care dollar is consumed by obesity. You heard a little bit earlier today about the ability to get a transplant. If your BMI is over 35, and most of the time, in this country, you can't get an organ transplant, or you get care-deferred when it came to hip replacement. There is a fast-forward and that is bariatric surgery. It is safe and effective. We

have 20-year data demonstrating a 40 percent reduction in mortality, and 92 percent reduction when it comes to diabetic related deaths. And there is some data regarding cost effectiveness. The Cochrane Collaborative has demonstrated that per each bariatric surgery, the quality adjusted life here is about $10,000 dollars. The standard is usually $50,000 which is what we get with dialysis. I personally published a paper two years ago looking at the impact of bariatric surgery on health care costs, namely medications, and in the case of diabetes, medications went down by 75 percent.

One of the initiatives I had is when I was President of Society, it was called Leave No State Behind, and I don't want to see Connecticut be left behind. Twenty-three states do cover it. I think there are two great escalators of social mobility in this country, one is education and the other one is health care. I would hope and pray that people have the ability to get the health care that they need and deserve in this country. We don't want to see two Americas. We don't want to see two states neighboring each other with disparities in coverage, particularly when you can see improvements in health. This affects all walks of life, fireman, CEOs, and certainly even legislative members. And so, I would urge you to improve the health and welfare of the State of Connecticut with the passage of this bill and I truly appreciate the opportunity to speak to you today. Thank you.

REP SCANLON (98TH): Thank you doctor and thank you for being here and sharing your life's work with us because I think it's very important. What was the number 1000?

JOHN MORTON: Three thousand five hundred.

REP SCANLON (98TH): Wow, thank you. Any questions from the committee? Rep Pavalock-D'Amato.

REP PAVALOCK-D'AMOTO (77TH): I was just wondering, can you send us your paper? Would you be able to do that? Send us the paper.

JOHN MORTON: Absolutely, yep. I would be happy to.

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

REP SCANLON (98TH): Just get with the clerk with that, who will get that to members.

JOHN MORTON: Thank you all very much. I appreciate it.

REP SCANLON (98TH): Thank you. Next is Amy Dumont. Amy still here? All right. How about Dr. Neil Floch? Yep.

DR. NEIL FLOCH: I want to thank the committee for this opportunity to speak on behalf of S.B. No. 204. It is truly an honor to sit here and speak with you all today. I am Neil Floch, MD. I'm a bariatric surgeon here in Connecticut. And I was the former President of the more local Chapter of the ASMBS of which Dr. Morton was President of national. I work now at Fairfield County Bariatrics, which is private practice, but I will be full time Director at Norwalk Hospital in Nuvance Health System. I have been a general surgeon since 1998 and it was in 2002 that my life changed. Because I operated on my first bariatric surgery patient. Margaret came into my office in a wheelchair, she could barely walk. She had a pacemaker. She had osteoarthritis, and she was a type 2 diabetic and she was on 300 units of insulin a day. Three hundred units. That's not

to mention the dozens of other medications that she took. Well, after undergoing bariatric surgery and many years later, of which, Margaret lived 17 years longer than anybody thought she would, she was taking barely any insulin at all. So, there is a way to resolve or put into remission diabetes.

So, until 2006, bariatric surgery was a covered benefit on most plans in Connecticut and that decreased significantly over the years. When the ACA Plan was established, the essential health benefit was based on a ConnectiCare HMO guidelines which did not cover the benefit. What we noticed in private practice when patients came and they wanted surgery and came to our free seminars to learn about it, is that only one-third of the insured patients actually had coverage or had the benefit. It was quite unfortunate. Many Connecticut citizens are self-employed as you just heard. They're business owners and they have no option, no potential to have any insurance coverage, and they get caught in the gap. Unfortunately, the greatest obstacle to all of this, and to all of the coverage is that we look at bariatric surgery or have looked at in the past very differently. There's a stigma to both obesity and the treatment for obesity, and in fact, when we look at this disease, it in fact is not -- it's not obesity at all, it's actually metabolic dysfunction that we're treating. And the result in what we see is obesity. The AMA has recognized obesity as a disease. There are 200 medical conditions, there are multiple cancers, 13 of them, and we can go on and on discussing this. But what we talked about today a lot was that the high expense of insulin and the growing type 2 diabetes epidemic, bariatric surgery actually is the best long-term treatment to

resolve type 2 diabetes. Nothing else does it like bariatric surgery. Patients, 88 percent, who have had the surgery after one year are off all medication and have near normal blood sugars. How long does that hold up? Well, at 10 years it about 50 percent. So, if you're going to consider this ruling Bill S.B. No. 204, pleased consider it for the treatment of diabetes as well. I thank you for listening and I'd be happy to answer any questions.

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

REP DATHAN (142ND): Thank you very much, Dr. Floch. Just out of curiosity, within your practice, what percent of your patients are covered under HUSKY and what percent is covered, you said about a third that come in to the seminar, but what percent -- I'm just kind of curious on those two levels.

NEIL FLOCH: Well, things have changed over the years. It used to be that we didn't take HUSKY and would operate on patients without charging them because we weren't in HUSKY. Now, that has increased 60 percent of the patients that come into our seminars because we're in private practice and not associated with a health system directly and currently. Sixty percent are on Medicaid at this point. But we have many patients who come in who are on the Affordable Care Act insurances and we have to turn them away. But I think that's disproportionate compared to some of the other programs represented in the room.

REP DATHAN (142ND): So, if you had an insurance that would cover bariatric surgery under your current, about how much of the sort of -- what would

you guestimate are these high deductible plans? Or what kind of plans would be -- would cover this or are they just sort of the platinum plans currently?

NEIL FLOCH: Well, it all depends, because, employees, self-insurance plans, some of them don't cover and it's quite variable. It's hard to answer that question statistically because we see everything. We see all types of situations from insurance coverage, high deductibles, employee benefit plans, etc. And like that many of them just don't cover.

REP DATHAN (142ND): So, in other states where the ACA does cover bariatric surgery, what percentage of patients go into practices like yours that would be covered? I'm just curious as what the -- is it going to be a large uptake of -- all of a sudden, the gates are flooded with bariatric surgeries.

NEIL FLOCH: I don't -- I don't know exactly how many. If I had to give a rough estimate, it's probably only about five percent if this ruling did pass.

REP DATHAN (142ND): That's super helpful. Thank you so much for your testimony. Thank you, Mr. Chairman.

REP SCANLON (98TH): Representative Hughes.

REP HUGHES (135TH): Thank you, Chairman. Two questions to go off of what Representative Dathan was saying. One is, and forgive my ignorance, but you mentioned the type 2 diabetes comorbidity with the obesity. Does that ever change after the primary treatment here of bariatric surgery? The type 2 diabetes?

NEIL FLOCH: Is your question does the type 2 diabetes resolve?

REP HUGHES (135TH): Yes.

NEIL FLOCH: Yes. It -- there are only two ways to make type 2 diabetes resolve. If you go on probably a low-carbohydrate diet and stay on it and eat low calories, which is very difficult to do; and only about five percent of people can do that. Or, bariatric surgery, which in 88 percent of patients after a year, will be off medication, have normal blood sugar and if you look at that at ten years, as I said, there's a paper out there that will say 50 percent are very well controlled at 10 years. A dramatic change.

REP HUGHES (135TH): That's incredible. So, would you say that this bariatric surgery is a case of the insurance industry catching up to the primary way of treatment versus an elective surgery, which has been previously classified as?

NEIL FLOCH: I would say that the biggest obstacle at this point is a lack of knowledge and a lack of wanting to hear the facts. Because there is a tremendous discrimination and bias against both the problem, which is obesity, and the treatment. And people have been set in their mind that diet and exercise is the way to go, when in fact, there is no evidence to show that you're going to lose more than 10 pounds if you exercise every day for a year. And it's very hard to stick to the correct diet because your body and your metabolism will fight you. It will decrease your metabolism as time goes on, the longer you remain on a diet. So, with these facts, the only tool that we have to help people with this

severe disease long-term is metabolic surgery, which is commonly known at weight loss sugary.

REP HUGHES (135TH): Great. I think that answered a lot of that sort of modernizing it with the science and the information that we know now, what is much more efficient, cost-effective, and -- and you know, much higher rate of managing the chronic disease with this type of surgery. I mean it's not just cost-effective, but it's medically more appropriate now than it was maybe 15 years ago.

NEIL FLOCH: If I can comment, as physicians and bariatric surgeons we're a little bit defensive and everybody comes out us with this disease with cost effectiveness. Well, we didn't talk about cost effectiveness with other issues discussed today but, this really is the treatment. Unfortunately, eventually we have to try to prevent the problem and that's the main goal that we all should have, but right now, we have to take care of folks. People are sick, people are dying, and they need help and it's not -- a lot of them it's not their fault. This is a genetic disease. People are genetically susceptible, and they are influenced by our current environment. Food environment and surrounding environment.

REP HUGHES (135TH): Thank you, doctor. That's all.

SENATOR LESSER (9TH): Thank you, Representative. Other questions? Yes, Representative Vail.

REP VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. Are there any insurance companies now that pay for this?

NEIL FLOCH: Yes. I would say it's not the insurance company, it's the specific plan of the

insurance company. For instance, you could have ConnectiCare, ConnectiCare ACA plan does not cover; ConnectiCare that is self-insured by a company they may decide to cover, they may decide not to cover. If you're in a business -- business -- private business, and you're ConnectiCare, I don't think you can get coverage; you don't have the opportunity. And if you have a nice beautiful silver or premium plan with ConnectiCare, then you have all the bells and whistles and you will be covered.

REP VAIL (52ND): Just a quick follow-up to that. Do you have a rough idea like what is the percentage of the people that come in for that surgery that have the coverage as opposed to those that don't?

NEIL FLOCH: Well, I think most people are educated at this point, but I can tell you that we ran a lot of what we call free seminars, educational seminars, and statistically for years, about one-third of people who would come and want the surgery could get it, and I can't tell you if that's changed now, I believe that we are doing a good job with Medicaid patients but I still think there are a lot of people out there that come to use that pay out of pocket because they're just desperate.

REP VAIL (52ND): Thank you.

SENATOR LESSER (9TH): Thank you Representative Vail. Other questions or comments from members of the committee? Dr. Floch, I've got to say, I've gotten to know you over the last year. I know you are passionate about this issue because you're passionate about your patients and this is something that has come across in the many conversations that we've had and I don't know whether we're going to get this over the hump this year, it's very possible

we will. Maybe it will take more time, it's unclear yet, but I know that this is an important issue and one that you've been really a stellar advocate on and I appreciate it, and I've learned an awful lot listening to you and from your colleagues in the medical community, so, thank you.

NEIL FLOCH: I thank you very much. I hope it does pass. Thank you.

SENATOR LESSER (9TH): Thank you very much. Are there, okay. Next up we have Makram Gedeon, followed by Linda Halpin.

MAKRAM GEDEON: Good afternoon. Dear Chairman Lessor, Chairman Scanlon, and ranking member Kelley, Ranking Member Pavalock-D'Amato, and esteemed members of the Insurance and Real Estate Committee. My name is Makram Gedeon and I'm a bariatric surgeon testifying today in support of S.B. No. 204. I would like to first thank Senator Eric Berthel. His steadfast advocacy for bariatric surgery coverage as well as his courage in publicly discussing this -- his own experiencing in being a bariatric surgery patient are much appreciated. Obesity is recognized as an epidemic as well as a serious disease rather than a consequence of poor lifestyle choices. It carries with it the considerable personal and societal stigma. Beyond a certain weight to height ratio or otherwise known as BMI, diet, exercise and medications are not effective anymore and surgery becomes necessary as a cost-effective as well as a life-saving treatment and with a safety profile that is comparable to laparoscopic gallbladder removal.

The difference that weight loss surgery makes in the lives of our patients is undeniable. This includes an improved overall life expectancy, quality of

life, as well as a dramatic improvement or resolution of many of the associated medical problems. For the past decade, I have been privileged with the opportunity to care for patients affected by obesity and this has been a very rewarding and fulfilling experience.

Some less fortunate patients are denied this critical treatment when they need it the most and because of lack of coverage. This is of great concern considering especially that recent evidence that it is not published, but points towards the fact that when followed for more than 10 years, four out of ten patients who are denied surgery would succumb to the disease or its complications.

Distinguished Representatives, I'm kindly asking for your help and support in passing S.B. No. 204, and I thank you for this opportunity to testify today. I would be happy to answer any questions you might have. Thank you.

SENATOR LESSER (9TH): Thank your Doctor. Senator -- Representative Scanlon. [background talking] Are there questions from? Yes, Representative Pavalock-D'Amato.

REP PAVALOCK-D'AMOTO (77TH): I want to thank you doctor for coming to testify. I know you're from Bristol Hospital, so, I appreciate that. I was wondering how many patients have your treated at the hospital, overall, and I guess you personally.

MAKRAM GEDEON: Personally around 1000.

REP PAVALOCK-D'AMOTO (77TH): And then -- but there are other doctors, so I assume there's more -- are there more patients who have gone through the program at your practice?

MAKRAM GEDEON: Yes, around, probably 1500 in Bristol.

REP PAVALOCK-D'AMOTO (77TH): Okay. And I know -- I'm not sure if other hospitals do it, but I know they have an overall program that is well publicized to I guess inform people about the program and the surgery and I know actually a gentleman who helps promote it. And, have you found that to be successful with helping people and making people aware of the surgery?

MAKRAM GEDEON: I'm sorry, the program to educate people you mean?

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

MAKRAM GEDEON: Yes.

REP PAVALOCK-D'AMOTO (77TH): Pardon me, Mr. Hartley, I know.

MAKRAM GEDEON: Yes, so, we -- yes, so, thank you very much. Those are patient advocates we have that actually come to our seminars. The biggest problem we have nationally is that only one percent of patients who actually qualify for the treatment that they need. But this is not what we're asking for today. It's not the 99 percent of patients who qualify for surgery, we're asking about coverage for patients who actually desire to have surgery and they are denied surgery.

REP PAVALOCK-D'AMOTO (77TH): So, how many -- are there different types of surgery that you perform? That's leading to my next question. Has it changed or is there the same one you do for everybody?

MAKRAM GEDEON: No, we -- the most current operation performed in the United States is the sleeve

gastrectomy. The two, you know, commonly performed operations are the sleeve gastrectomy and the Roux-en-Y gastric bypass. So, -- but in the United States, the sleeve gastrectomy is the most common operation performed.

REP PAVALOCK-D'AMOTO (77TH): I think we were talking earlier, and this is kind of a question for my colleagues as well. I know last years' bill had a, I think, around a $4 million dollar fiscal note, and I'm confused as to where they get that number and how that -- and I don't know if maybe people who testify going forward if they could help us with that number.

MAKRAM GEDEON: So, my understanding is that if this bill passes, around 1000 patients will receive treatment, and that I think is, unless I'm wrong, this is the number that is attached to that on the short-term. Now, mind you, Representative, we have a lot of evidence that shows that two to five years out, this initial investment will be more than paid for, and moving on from that point, it would be really cost saving on medications. This is only about -- this is only speaking about the medication costs. If you factor in the fact that four out of ten patients may not be here 10 years down the line, if you factor in the increase in the workforce, you know, a lot of those parameters are not measured with the immediate cost of the -- of the procedure.

REP PAVALOCK-D'AMOTO (77TH): But knowing there are different types, is there -- I mean is that number just a guess? I guess that's what I'm confused about. If we don't know what type of surgery that they're actually getting.

MAKRAM GEDEON: So, the breakdown for more -- I mean it depends on the program really, but the majority of the programs have a majority of sleeve gastrostomies. I can tell you what we do in Bristol. We have around 60 percent of Sleeve gastrectomy, around 20 percent to 25 percent gastric bypass, and then there is revision operations also done for variety of reasons. This is kind of like the breakdown for the operation. But that is not the cost of the operations themselves. They're very comparable. The sleeve gastrectomy and the gastric bypass, they are a little bit different. The gastric bypass costs a little bit more money but they're very comparable in terms of costs.

REP PAVALOCK-D'AMOTO (77TH): So, what are the different costs between those two types that you mentioned?

MAKRAM GEDEON: I don't know if I can --

REP PAVALOCK-D'AMOTO (77TH): Or would it be -- okay -- I mean it might vary hospital by hospital.

MAKRAM GEDEON: Am I allowed -- you know, we do have a self-paying rate. But I don't know if I'm -- okay.

REP PAVALOCK-D'AMOTO (77TH): That's all right, I understand. Okay. Thank you very much.

MAKRAM GEDEON: You're welcome.

SENATOR LESSER (9TH): Any further questions? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you so much for your testimony. And I think the challenge we have whenever we are looking at the cost, and this was the challenge we actually had

come across last year as well. We're looking at an immediate cost, but we are sort of short-changing the policy. The reason being that the cost of the medicine is well studied on the patient's life if -- there's a longevity benefit, but there's also a cost of health care benefit that comes, and that's -- we start to see those benefits in a matter of about six to ten months' time -- you start to have enough weight loss that the patient's medication requirements and overall health care usage decreases. That is never factored into this cost and then that's the part of the challenge in many of our policies that the office of Fiscal Analysis has a short-term calculation of the immediate cost, not the long-term benefits of the savings at this time. And I think that's where we sometimes have to struggle and when are bombarded with 5000 or 2000 bills, we are looking at the dollar amount and we suddenly panic, and I think that's where -- I'm glad we're having this conversation because this is -- we have seen from the patients but also from the data that is a financial benefit not only to the individual costs, but the collective state cost. And it's almost, we can get a dollar amount that for a dollar spent into this, we will be saving a certain amount of dollars, which is much more than what we are investing into this. So that's, I think, going to be something that we should specifically ask going forward of the Office of Fiscal Analysis because now we have the data, and the calculations can be done. This is not a new procedure; this has been going on for many years. And now the data is getting so much more robust, that we can predict the benefits to the state going forward. Am I accurate?

MAKRAM GEDEON: Absolutely. I think -- and I want to add to your point, Senator, is that besides the cost savings if you really look at obesity being a disease, then you got to treat it as such. You can't say oh, the patient is diabetic but I'm not going to give them medication because it's costly. You know, this is the way surgeons look at it. We look at it as why do we have patients who actually get coverage and some other patients that don't.

SENATOR ANWAR (3RD): I think I -- as I listen to the people who are supportive of it, I'm actually also reading for some of the organizations are against it. So I read from the CBIA rules against us moving forward with this and I think the challenge in our society right now is when they see somebody who is overweight or obese, they actually tend to believe that it is their -- they have made a choice to be that way, and it is so far from accuracy because there are genetic issues, there are metabolic issues, there are personal respiratory illnesses that they may have that they cannot do things, there could be arthritis related challenges that they cannot function, and we know that some of `it is determinant by socioeconomic determinants as well. So, it's a -- it's a web of causation that leads to a person having no control over their weight. And that's why it's important to look at it from a broader perspective, rather than from a judgmental perspective and when people look at it from a judgmental perspective, they say, hey, don't pay for this. It is their cause and they caused it and that is far from accurate and that is -- I think something that we have to have a shift in our vision so we can actually address this and if we don't want to have a shift in the vision, then do it from a

dollar amount that you save respective, so the answer is going to be the same either way. Thank you, Mr. Chair.

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

MAKRAM GEDEON: Thank you very much.

REP SCANLON (98TH): Next up is Linda Halpin followed by Violet Wolf.

LINDA HALPIN: Hi, my name is Linda Halpin. I had revision surgery from band to the sleeve in December 2016. I began my journey originally in 2008. I was at my heaviest weight of 217.8 pounds. I couldn't walk up the stairs without getting out of breath or bend over and tie my shoes or even fit a towel around me. The reason I had the sleeve was to improve my health because I couldn't breathe good and couldn't do a lot of things good, and now I can do a lot of things good, and I want to thank everybody.

REP SCANLON (98TH): I want to thank you, Linda, for coming here to tell us your story today. We really, really appreciate that. Anybody have any questions? Seeing none, thank you, Linda. Next up is Violet Wolf, followed by Dana Contiello. All right.

VIOLET WOLF: So, as you can see, it's worked for me. In 2008 I started my journey. I had the band put in and, oh geeze, now I'm losing my testimony. [laughing] And at that time I weighed 321 pounds. As you can see now, I'm at 167-168 roughly. Dr. Neil Floch has been my doctor through the past 18 years, 12 years, more than that -- [laughing] But he has been my best buddy. So, I've lost 152 pounds

and I've been given a new life. Throughout my childhood and teenage years, I was constantly bullied. I was called names, made fun of, and pushed off the school bus. All because I was obese. It was not the best time of my life, so I had to take control of my life and personally, I wanted to be and needed to be what I wanted to be. Sorry, I'm nervous.

REP SCANLON (98TH): You're doing great. So, none of us can tell, don't worry about it. [laughing]

VIOLET WOLF: So, I had to chance and in 2008 I had the lap band surgery. In starting my bariatric journey my weight loss was at 321 pounds and today I'm down 152, and I weight about 160 some. Having bariatric surgery was the best decision I made in my life other than marrying Andrew, who was a 6-foot 2-inch, tall thin, skinny guy. But he didn't look at the 300 pounds that I weighed on our wedding day, he looked at what was inside my heart. I'm still married to him, so I'm lucky. It will be 14 years in May. So, I started having problems in 2011 with my band. I had to have my band removed and in 2012, I went back under the knife again and I had gastric bypass. So far, I have been successful. In the summertime I walk anywhere from eight to nine miles a day. During the school year, I work with children with disabilities. I know how hard and what a struggle they go through each and every day because I've been down that road before and I put up the fight for them and that's why I'm here today. To put of the fight for people aren't here who can't get out the door.

REP SCANLON (98TH): Thank you, Violet. Now, I want you to know, that I remember vividly last year. You bought your wedding dress.

VIOLET WOLF: I do have it with me.

REP SCANLON (98TH): And I never forgot about that. And I think a lot of members of this committee never forgot about it, and I just can't thank you enough for coming to tell your story because your story and all the other stories and just listening to impact that this can have on somebody's life is very powerful.

VIOLET WOLF: It's the best thing I've done.

REP SCANLON (98TH): Yeah. And I just want to thank you again because when you held up that wedding dress. It showed up, at least me, it showed me everything I needed to know, so I want to thank you for that. Anybody else have any questions? Seeing none. Violet, thanks again for coming again this year. Hopefully this will be the year we get it done so you don't have to come back next year.

VIOLET WOLF: That's all right, I took my last personal day. [laughing]

REP SCANLON (98TH): All right, Dana Contiello. You've got to correct me when you get up there. [laughing] Followed by Jane Sweeney.

DANA CANTIELLO: It's Cantiello, it's nothing fancy. So, thank you. I'm Dana Cantiello and I'm the nurse practitioner in Middlesex Health Medical Weight Loss and Bariatric Surgery program. As a medical professional, I have met many patients affected by obesity. In the State of Connecticut, 26.9 percent of its residents are affected by this

diagnosis and the complications associated with it. When I was an emergency department Registered Nurse, I cared for patients whose health problems were common in this state, high blood pressure, diabetes, sleep apnea, acid reflux, asthma and arthritis. Those conditions were only compounded by obesity making it even more different for the patient to improve their health. It was truly a double-edged sword for them. They were truly struggling to stay alive. Familiar faces with all too familiar chronic conditions, never getting better unless they could get to a healthier weight. According to the Obesity Action Coalition, $1.72 trillion dollars is being spent each year to provide care in this country towards obesity related health care. Health care costs for an individual affected by obesity are 42 percent higher than other individuals. There is a surprising fact that I want to bring to your attention. There are several insurance companies in Connecticut choosing not to cover its insured population with a bariatric diagnosis, and they will not approve life-saving procedures.

Let me repeat that again, there are several insurance companies in Connecticut choosing not to cover its insured population with a bariatric diagnosis and will not approve life-saving procedures.

Now being a nurse practitioner on the front lines of obesity medicine and bariatric surgery, my professional opinion is that this should not be tolerated. This is not inclusive of coverage for all diagnoses. This is a prejudice diagnosis. This is discrimination and exclusion of a person's weight and appearance. The State of Connecticut can become a proactive problem solver for its residents by

mandating insurance companies to suspend any practices of discrimination or exclusion based on size, weight, or appearance related to bariatric diagnosis.

Flanagan and Associates found a three-fold increase in mortality in individuals who cannot obtain surgical access. That's six percent versus 1.9 percent mortality. So, why are insurance companies still denying access to treatment or surgery? I am now in a position where I can provide effective care for obesity with lasting results. But my patients are having to decide between saving for their retirement and saving money to pay for bariatric surgery. They're having to sell or downsize their homes, or they are unable to provide a better life for their children, or they're having to max out credit cards at high interest rates in order to make sure they can live another day. The people who are dying from obesity and its associated comorbidities are young mothers and fathers, grandparents, the person you sit next to at church, your coworker and it may even affect you in the future. This is a population that is already being stigmatized and now they're being denied life-saving care. So, I urge you to support S.B. No. 204, enabling this segment of our population to be fully covered by their insurance in order to obtain surgery to treat obesity, reduce or eliminate comorbidities and to have a better quality of life. Thank you for your time. Thank you for consideration. I'm a little nervous, so, I apologize for the shaky voice. [laughing]

REP SCANLON (98TH): You did great. Thank you. Any questions from the committee? Seeing none, thank you for being here tonight, we really appreciate it.

DANA CANTIELLO: Thank you, and I appreciate it on behalf of my patients.

REP SCANLON (98TH): All right, Jane Sweeney. Followed by Brendaliz Marino.

JANE SWEENEY: Good afternoon. My name is Jane Sweeney, and I'm from Farmington. I wanted to thank you for the opportunity to testify here today. I am here in support of S.B. No. 204. I am here as a nurse, as an advocate, and a voice for the patients of mine that are suffering from the chronic disease of obesity. I knew because I was here last year and testified as well. So, I didn't prepare all the numbers because I knew all the wonderful surgeons that I work with and in our community will have provided that. So, I thought that it would be best for me to come and provide what I've seen and what I've experienced as a nurse taking care of these patients. I've seen firsthand on a day-to-day basis, working on a Med-Surg floor in a hospital, at least either three out of five or four out of my five patients were there because of the disease of obesity. I saw suffering, all the diseases and comorbidities we talked about and they were there on a regular basis. I held their hands and watched some of them die. And so, I carry that, and I carry it into my new role. I now work at a bariatric program because, you know, part of as you care for these patients, you wonder how is this happening. How is there not a solution and of course, through my career as a nurse, I saw that there were solutions and you know, I come to my job with a lot of passion because I've seen where they could be, where these patients are health-wise and I really, you know, wanted to help make a change and do something about it. And was so happy to see that

there is a fantastic solution. I see many patients like, I believe it was Richard, because we do all of our support groups. So, I hear stories like his all the time, and certainly, my goal is that this solution be available to everyone. And I'm sure most people don't necessarily disagree with me. I, you know, just wanted to share like, you know, what I've seen. I really hope that, you know, we were able to -- we had some discussion about the discrimination, and it was just done so eloquently. [laughing] We have like the same format of what we were going to say. But it's so heartbreaking to know that honestly, there's so much stigma associated with this disease that, you know, is this the reason that some of these absolutely fantastic people, you know, are suffering and can't get the help that they need. And I don't think that should be happening, and I really hope you agree with me. I'll continue to come year after year. I hope this is the last year, because I really hope we're able to pass this and do the right thing. Thank you.

REP SCANLON (98TH): Thank you, so much. Any questions. Representative Hughes.

REP HUGHES (135TH): Thank you, Mr. Chair. And I just wanted to thank you for being a nurse and really attending to the ark of -- of care that is needed in our society and to really address the underlying systemic barriers and the discrimination that patients face just to try to get access to manage this disease. Thanks.

REP SCANLON (98TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much, Mr. Chair. Thank you so much for your testimony. Could you share, because you're helping in the support group

part as well. Have you seen the changes in emotions and perspectives of people? Could you just elaborate on that and then share with everybody?

JANE SWEENEY: Absolutely. So, I've seen the journey. I've now been there almost two years. So some of my patients have now cycled through, they're a year out -- the people that I met them in the beginning and I've now seen their, you know, we're a year out from surgery, they've lost 100 pounds. They have energy, they have excitement for life. They have gotten their life back. I've heard patients talk about not being able to walk from a second parking lot into work so they went home to where they have now come to support group a year later after surgery and they're planning a trip to Machu Picchu, Peru to hike the Andes Mountains. So, it sort of the gambit, you know, what people gain from it. But the, you know -- most common they say, I wish I hadn't waited so long. So, I mean, I have seen so many success stories.

SENATOR ANWAR (3RD): I think personal abilities and self-perception have a very significant impact on our wellbeing. And we sometimes take it for granted and individuals who are suffering from a disease which has all those doors closed, they're perceptions and their abilities are impacted to the point that sometimes they may even try to hurt themselves, and we have an opportunity to open those doors and then change the entire trajectory of their lives.

JANE SWEENEY: Yes, absolutely.

SENATOR ANWAR (3RD): And I see that as well, and I think that's why I'm a proponent of this too. But

thank you, and your testimony helps quite a bit. Thank you.

REP SCANLON (98TH): Any further questions? Seeing none, thank you so much. Brendaliz Marino followed by Susan Millrick and then we have finished with this bill and we'll move on to the next one.

BRENDALIZ MARINO: Hello, my name is Brendaliz Marino, I am a medical assistant and I am in support of S.B. No. 204. So, I come here to advocate for the individuals that I meet on a daily basis. In our office, every day I meet someone new and each one has a different story. However, they all have similar outcomes or expect a similar outcome and that is to regain control of their life and improve their quality of care. You know these patients come in they're -- this is not their first option; this is their last resort. They have tried everything to lose the weight whether its exercise, eating healthier, trying dietary supplemental pills, and nothing has worked. And I'm sure these individuals are told regularly by other health care providers about their weight and how that would improve their quality of life. So, they come to us and they're feeling helpless, they're feeling hopeless and they're discouraged and they're looking for help and they're asking for help. They're actually pleading for help from us. So, when they come into our office, they tell us their situation, they tell us their stories and when they speak with us and their surgeons, and they discuss the different options and they review their medical history and then they're told that they would be a great candidate for surgery and the reasons why it would be good for them. They start to get that hope back and feel good. But then it's shattered when they're told

that they don't qualify because of the insurance. So, because of insurance, they can't move forward and improve their life and get rid of the comorbidities that they go through, whether it's high blood pressure, diabetes, cholesterol, some of these patients have gained so much weight that they're maybe in their 30s but they're in wheelchairs because they can't walk anymore. So, to be told that they can't have this done because of insurance, something that they probably pay hundreds of dollars for every single month, but because of that, they can't go and move forward with this, it just is shattering.

And when they're told about self-paying, but when they're told the amount of how much it would cost for the surgery, they just realize that there's no hope for them, and it can put into a state of depression and their mental well-being is broken down. So, having this coverage with insurance would be a big thing for these patients because they need it. Not everyone can afford this out-of-pocket and with the surgery, you know, they have these issues that they're already probably paying hundreds of dollars for, whether it's for medication purposes for their comorbidity and to have this done would help that. To think about it, they would be in further debt to take out a personal loan to get this surgery is outrageous. Why would they need to add to everything else that they're going through?

REP SCANLON (98TH): Thank you very much. Any questions from the committee? Seeing none, thank you so much. And Susan Millrick. Is Susan here? Going once. All right. We will now move on to S. B. No. 209 unless anyone has walked in that would like to testify on S.B. No. 206, 207 or 208?

Seeing none, we will go to S.B. No. 209 with Art Calef.

ART CALEF: Good afternoon members of the Committee. My name is Art Calef, and I'm from Lebanon, Connecticut. I'm not getting paid at all for speaking to you today. I simply come as a very satisfied member of one of the more better-known health care sharing ministries. I appreciate the opportunity to address this assembly today regarding S.B. No. 209, AN ACT REQUIRING HEALTH CARE SHARING MINISTRIES TO COMPLY WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, which I will call the ACA throughout my testimony here.

I'm going to break away from my script just a little bit and I assume the next speaker is going to talk about more in specifics of the bill perhaps and the implications. I'd like to tell you about how my family had about $150,000 dollars in medical expenses shared successfully. Actually, it's quite exciting and paid completely through one of these ministries. I know some, probably most of you have children and find it kind of expensive. I've had six. We submitted each one of them, one at a time obviously, to the ministry and every single dollar was cheerfully reimbursed by other members. I'm part of Samaritan Industries, the main three ministries operate a little bit differently. They all have a little different operating model. Ours, we're considered self-pay to any kind of a provider. We would negotiate the bill with the provider, so we negotiate our own discounts. Typically, what an insurance company would do for us, but we do that ourselves and then we collect up our bills. We would submit them to the agency or the organization and they will submit them out -- or publish them is

what they call it -- out to the various members who have agreed to send their share, to a preset amount, and they send it with a note of encouragement and a promise to pray for us. We're a Christian organization. There're certain restrictions. Not everyone can be a part of it, which helps with the cost of it. But you can only imagine getting, you know, 90 or 100 notes of encourages and promises to pray and $500 dollar checks in the mail. You sure do get looked at weird when you to the bank with 90 $500 dollar checks. But it works really, really well. I enjoy talking about it so much I -- we had the -- two weeks in the hospital with one of my children at a children's medical center and I very much enjoyed talking to the administrators there, the financial aid offices and rejecting the Cobra Advocate applications for the health insurance I really didn't want that. I have something that works. The Samaritan health sharing ministry works so well. I don’t think it’s broken, I think it works really well. So, I see this bill S.B. No. 209 come across the desk here. It's very vague language and it concerns me. It looks like a place holder bill to me. And I urge you -- I don't know where the intent of it is, which way you intend to go with it, but if intends to restrict these ministries that work so well, I urge it to be dropped in committee here. I do appreciate your time.

REP SCANLON (98TH): Thank you, for coming here today to testify and I’m glad you did because I think it’s important that we do have a conversation about this. Are you familiar with the Commissioner -- the Commissioner of Insurance's decision to band two of these companies from practicing here in Connecticut?

ART CALEF: I've heard a little bit about that. I had a little bit in my prepared speech on that. So, the big three companies, the big three being Samaritan, MediShare, and being CHM Christian Health Care Sharing Ministries or something like that. They -- I know that those three-value compliances very careful compliance to the federal law, to state laws, because it’s their reputation at stake. They very much operate on Christian principals and comply. There are another three or four smaller ones within the largest six, I guess, six or seven. And then there's another hundred, roughly 100 newer ones beyond that. It was the original six and I believe that the ones that you're talking about are -- it's really Altrua I believe is the name of it, and their parent company or something like that. And yes, I'm familiar with those. So, there's laws in the books already to protect against the claims that, you know, that these -- or the violations of these companies. There's really no need to add to the mix of laws.

REP SCANLON (98TH): And do you find that, you know, I'm glad that you feel that this is working for her. Obviously, there are some people that complained that those other plans were not working and obviously, the devil is always in the details of all these things, right. But when you were signing up for your sharing ministry, were you under the impression that you were signing up for what you knew you were signing up for. I mean was there any possibility that you thought that you could be signing up for a traditional insurance plan? That's what these people are claiming about.

ART CALEF: Absolutely not. No.

REP SCANLON (98TH): You did not? And why is that?

ART CALFE: So, the guidelines -- the guidelines for Samaritan in general are available online. You could look them up, you don't even have to be a member. I know that also MediShare are listed online and I'm pretty sure CHM is also listed. They're clearly written. I know exactly -- I've read every word of the guidelines for our program. I know exactly what's covered, what's not, what's shareable -- we use a little bit different terminology because it's not insurance. We are well aware of that. They're very clear in all their literature, not insurance. It's a ministry, it's a share. It's a sharing opportunity. So, yes, we are very clear what is covered and what is not.

REP SCANLON (98TH): Got it. And then to my last question and I'll open it up to other folks. Do you feel like there needs to be any additional regulation to this industry? I know you said sort of the big three exist and they're the most popular and then there's a couple other ones. And then there's a lot of other ones below that which includes some of the companies that were recently band here. Do you feel like, perhaps the big three could be doing this well, but then there are some bad actors that are maybe violating the public trust and therefore making a bad name for the rest of your industry that you support or what?

ART CALFE: So, I'm not perfectly familiar with the legislation that's been passed in some of the surrounding states. But I know 30 other states have passed a little bit -- or some legislation regarding this. Essentially what they've done is to, and I covered that too, there's a push to essentially make

it crystal clear, legislatively that these are not insurance companies. It essentially takes it out of the jurisdiction of the Insurance Commissions and the responsibility of them too, and it places it squarely on the IRS, on the -- on consumer protections and then the Attorney Generals then, as opposed to the, you know, the Insurance Commissions having to deal with them. That, I would suggest. I know New Hampshire, Maine, Pennsylvania as some of the closets states that have done that. I haven't read their laws, so I don't know exactly what's involved. But that's consideration.

REP SCANLON (98TH): Okay. Got it. Okay, thank you. I don't see your testimony online. Did you submit?

ART CALEF: I have not, but I will.

REP SCANLON (98TH): If you would, that would be great so we can all have that on there. Okay. Any other questions from the committee? Seeing none, thank you so much.

ART CALFE: Thank you.

REP SCANLON (98TH): Shannee Tracey?

SHANNEE TRACEY: Hello, thank you all for having me here today. My name is Shannee Tracey, I'm the Director of Government Affairs of Christian Care Ministries, which operates the health care sharing program MediShare. I’m here on behalf of the Alliance of Health Care Sharing Ministries which helps coordinate the policy activities, government affairs and communications among some of the health care sharing ministries. Thank you for allowing me to comment on this bill today.

Sharing ministries have been around since the late 1980s. That's 40 years of supporting people with religiously held beliefs to share in each other's medical needs. Today, there are more than a million health care sharing members across the country that are part of a various health care sharing ministries, including just about 5000 members here in Connecticut. Health care sharing ministries are faith-based communities that facilitate a voluntary sharing of medical costs between its members. Each month, a member's monthly share is matched with another's eligible medical bill. Members of sharing communities have agreed to live in a way that allows them to hold true to their religious beliefs, which extends into health care. Members not only share in each other's eligible medical bills, but they also most importantly encourage and lift one another up in prayer.

Health care sharing ministries are not insurance. The policy makers of the ACA believe that these health care sharing communities are an important expression and exercise of religious beliefs for people needing to practice their faith in the health care space. Therefore, the authors of the ACA deliberately exempted from the original mandate U.S. residents who are members of health care sharing ministries that were in existence prior to the ACA. Some of these health care sharing ministries operate nationally and their members make up just about 85% of the health care sharing community.

MediShare is one of seven national ministries. We have over 400,000 members throughout the United States and about 1500 here in Connecticut. At MediShare we have created a system of support based on our religious beliefs that personalizes health

care by putting God first, empowering our membership community and providing accountability and transparency to each dollar shared. We recognize that health care sharing ministries are not well understood by some. Accordingly, insurance commissioners in several states, including here in Connecticut have made findings that one newly formed organization, which is not covered by the ACA exemption has engaged in unauthorized practices under the banner of health care sharing. We fully support efforts to disseminate information about sharing ministries and to prohibit any unauthorized or deceptive practices either under current laws, and/or if necessary, through new laws. We look forward to hearing from you and offering any assistance that we can provide. Thank you and I look forward to your comments.

REP SCANLON (98TH): Thank you very much for being here today. And not to put you completely on the spot, but I'm going to. Are you familiar with the New York Time's article that was on the sharing ministries January of this year?

SHANNEE TRACEY: Yes.

REP SCANLON (98TH): You're familiar with that article? One of the things that it says here and I'm referring to January 2nd article in the *New York Times* and it is describing a gentleman apparently in North Carolina who they say they're paying $530 dollars a month but the group capped the payments for its member at $250,000 annually. Is that a common practice within your consortium of sharing ministries, that there's a cap? Or, no?

SHANNEE TRACEY: It really all depends on the sharing ministry. With MediShare, we don't have

caps, but other ministries might. So, again, I can't really speak to all of their operations, but it is something that, you know, maybe one or two of the ministries do utilize.

REP SCANLON (98TH): Got it. And I am a religious person, so this is in no meaning to be demeaning whatsoever. But the quote from the Samaritan Ministries, are you familiar with them?

SHANNEE TRACEY: Oh yes.

REP SCANLON (98TH): And so, the -- they put out a statement in reference to this article saying, "Just trust God, there is no coverage, no guarantee of payment." Can you explain that a little bit for folks?

SHANNEE TRACEY: I can't because --

REP SCANLON (98TH): Not that specific, but is that the notion behind a lot of these that there's no guarantee that they will cover the full expenses that somebody has incurred?

SHANNEE TRACEY: Right, there are -- right, there are no guarantees and that's what, I guess when you -- that's what separates us from insurance. The fact that there is no transfer risk, and there are no guarantees of payment. But a lot of the health care sharing programs have implemented like Extra Blessing Programs. Or programs that can assist members who maybe have bills that are outside of the guidelines that -- or may have a pre-X condition and then we would then share in that through our Extra Blessings Program.

REP SCANLON (98TH): And how often does somebody have to require the Extra Blessings Program. Do you have any data to show across the --

SHANNEE TRACEY: Yeah, not across the whole industry as of yet. We're currently trying to work with everyone to start gathering that data. But I know for MediShare, it's -- it's not a common practice because everyone reads their guidelines, they understand what is and isn't eligible for sharing. So, once they get into the Extra Blessings process, we kind of know it's coming and you know, we get that out to our members as soon as possible.

REP SCANLON (98TH): Okay. I'll pause my questions there and see if anybody else has any questions for you. Seeing none. We'll leave it there, but, if you could also submit your testimony, we would appreciate having your contact information and thank you for being here today.

SHANNEE TRACEY: Thank you.

REP SCANLON (98TH): Moving on to our next bill. I don't see anybody signed up for S.B. No. 210. Any takers for S.B. No. 210? All right. We will go on to H.B. No. 5176, which I think a lot of people are here for and we will start with Joy Avallone from the Insurance Association.

JOY AVALLONE: Chairman Scanlon, Senator Hartley, Representative Dathan, Representative Pavalock-D'Amato, and members of the Committee, I'm Joy Avallone and Council for the Insurance Association of Connecticut. I want to thank you for the opportunity to provide comments in strong opposition to H.B. No. 5176, but also in the interest of time, our strong support for H. B. No. 5252, AN ACT

PROHIBITING CERTAIN VEHICLE STORAGE AGREEMENTS OF THE PRECONDITIONED TOWING. With regarding to H. B. No. 5176, the concern with this issue is that it would cause the use of original equipment manufactured parts OEM parts, to replacement in crash parts to become standard practice essentially regardless of whether non-OEM parts are of betty quality, more widely available or less costly. Now this practice would allow repair shops to increase their billing based on unnecessary repair services and cause consumers to pay more for insurance premiums which would increase as a result of this practice.

By way of background, the OEM is the original producer of a vehicle's components. OEM's issue of collision repair guidelines, procedures, recommendations and service manuals. OEMs typically recommend the exclusive use of all OEM parts including crash parts, typically exterior parts, cosmetic parts in all repairs. Now insurers typically assess OEM recommendations on a case-by-case basis due to the fact that most manufacturers have a plethora of recommendations that are not necessary for a proper repair to be completed on vehicle.

Crash parts typically fall into two categories, OEM parts, and non-OEM parts. Non-OEM are also known as after-market crash parts which are basically generic parts produced by independent manufacturers who sell them cheaper than the original equipment manufacturer. Crash parts of typically sheet metal or plastic parts that are installed on the exterior of a motor vehicle most commonly cited examples are fenders, hoods, doors, and parts of bumpers. It excludes mechanical parts such as batteries,

filters, mufflers and engine parts. Because non-OEM crash parts are merely cosmetic, they have no impact on the safety of the vehicle and have been found by the Insurance Institute for Highway Safety to have no impact on crash results either.

Non-OEM crash parts may be of better quality and more widely available and less costly than OEM parts. When repairing vehicles damaged in accidents, the use of lookalike aftermarket non-OEM parts, these generic parts significantly contribute to keep the price down for the repairs, which in turn, helps keep auto insurance premiums low for consumers.

Per the top 100 collision repair parts used by consumers from 2009 to 2014, Americans saved $363 million dollars using aftermarket parts as opposed to their OEM counterparts. According to a 1999 study, which I realize is [laughing] an older study that was commissioned by the Alliance of American Insurers, if you were to build a $25,000 dollar vehicle using only OEM parts, it would cost you over $100,00 dollars to do so. So, obviously, if you look at that in terms of today's prices, it's going to be a much more expensive repair. So, requiring the use of OEM parts will give OEM basically a monopoly in the market, drive prices up and result in needless determinations of total losses by insurers. So, basically requiring insurers to cover the cost of OEM parts when comparable or even superior. Non-OEM parts are available and less expensive serves over the drive profits for OEMs at the detriment to consumers.

I realize my time is up, but very briefly with regard to H.B. No. 5252, we're simply seeking to for

Subsection 14.16 -- 14.66 the general statutes prohibits owners of -- tow vendors really from requiring the owner of a vehicle to sign a contract for the repair of their vehicle as a precondition to the towing service. We're -- H.B. No. 5252 is simply seeking to also prohibit towing vendors from requiring owners of vehicles to authorize more than 24 hours of vehicle storage as a precondition to towing. In many cases 24 hours of storage is unnecessary, so it really just serves again, to drive costs and billing for these tows vendors which also results in higher insurance premiums for consumers, so, thank you. And I welcome any questions you have on either.

REP SCANLON (98TH): Thank you. Anybody have any questions before? Representative Delnicki.

REP DELNICKI (14TH): Yeah, thank you, Chairman. Just so I'm clear because you were using terminology back and forth about OEM, non-OEM etc., is your position such that if there are reputable auto recyclers and they have appropriate parts available that came off of a vehicle that they would be acceptable?

JOY AVALLONE: Yes, as long as they are certified parts. So, I think most -- I can't speak for all, but I think most insurers will use these CAPA Certified Parts. CAPA is the Certified Automotive Parts Association, independent nonprofit organization so they rate the safety on these parts. So, yes, that would be acceptable.

REP DELNICKI (14TH): So, are you saying that they would have to be certified by CAPA, although there are many reputable recyclers that actually offer appropriate parts that meet any standard that you'd

want because they came off -- literally came off the vehicle at a fraction of the cost of what it would cost to purchase it elsewhere?

JOY AVALLONE: No, I'm not saying that they have to be, I'm saying that many insurers do go by that.

REP DELNICKI (14TH): Okay. All right. Thank you for the clarification there. Thank you, Mr. Chair.

REP SCANLON (98TH): Thank you. I think that one of the things that we -- well we heard this bill last year and I think we're going to have a substantial conversation with it this evening about this bill now. One of the things that strikes me now is that when most people get into a car accident, unless they're a car guy or a car gal, and they take their car to get fixed, most of them have no idea what's going on and they're relying someone to try and tell them what to do. And the argument that is in contrast to your position on this is that, the insurers are forcing people who do know a lot about cars to tell the insured what part they can and cannot use even if that's against the recommendation of a car guy or a car gal who is fixing your car. And I think once that is understood by people, they have a hard time with that. And so, I do think that you were citing some studies saying that these aftermarket parts are safe, but is there really concrete studies to show that, that you can share with us that are not part of your testimony?

JOY AVALLONE: I am happy to get them for you. I know that they have been included in other -- in other testimony that has been submitted that I'm somewhat familiar with, [laughing] but more comfortable submitting national studies separately

once I've had a chance to actually review them in detail.

REP SCANLON (98TH): Sure. And I know you don't speak for all your clients or necessarily know each ins and outs of all these different policies but do you think that there would be some support from the industry to potentially narrow this to just a certain age of a car? So, if a car is a certain amount of years old, to require that they only use a certain part?

JOY AVALLONE: I am -- I'm going to say that without speaking for members, that I would be reluctant to agree to anything like that. I think the age of the vehicle really irrelevant if we're talking about the safety of the parts that are being used. And obviously, it's still going to have the same implications regarding the cost of the repairs and also the cost of premiums, which directly affect our consumers and members.

REP SCANLON (98TH): Understood.

JOY AVALLONE: I also just would like to point out that there are endorsements available for policies so if someone would like to be able to have the use of purely OEM parts, they're able to purchase that. Again, the use of these non-OEM parts really is just to serve our consumers as best as we can.

REP SCANLON (98TH): Got it. And then my last question is, it is my understanding that a law similar to this exits in Rhode Island. Are you familiar with that law at all?

JOY AVALLONE: I'm not familiar with the details of that law.

REP SCANLON (98TH): Okay. Any other questions? If not, oh, Representative Hughes.

REP HUGHES (135TH): Thank you, Chairman. I was just wondering in terms of the safety, are we also taking into account, and I think we are but I just want to clarify, like the lifecycle costs like of reusing, recycling, already existing parts from, you know, junked cars, or whatever, verses, you know, the life cycle costs of manufacturing to replace the costs. Like, is that part of the balance intent in this?

JOY AVALLONE: Well, if I understand you correctly, so most -- the majority of these parts, these are exterior parts, so they really have no impact on the safety. So, the studies that have been done, the crash studies show that these specific parts don't have an impact on the result of these accidents.

REP HUGHES (135TH): Great. So, is it possible that we are attempting to incentivize reusing already using unused parts out there?

JOY AVALLONE: I think the purpose of this bill really is just to keep costs as reasonable as possible for the consumers; from our standpoint anyway, that's really our main concern here, as long is the safety of the consumer obviously -- obviously comes first, but you know, we're trying to serve our consumers as best as we can.

REP HUGHES (135TH): Okay. Thank you.

JOY AVALLONE: Thank you.

REP SCANLON (98TH): Thank you. William DeBacco followed by Rich Montesi.

WILLIAM DEBACCO: Good evening guys. My name is Bill DeBacco, I'd like to thank you, Chairman Lessor, Chairman Scanlon, Ranking Members Kelley, Pavalock-D'Amato, and other committee members here. I'm the President of the Connecticut Auto Recycler's Association. I'm here representing my association on the concern of this H.B. No 5176 what it would do to our industry. My association fully opposes this bill because this would, by law, not allow us to sell recycled original equipment to a repair facility. Upon inspection on any new acquired salvaged vehicle at any of our facilities, we inspect unharmed recyclable parts which would be able to sell and put to any kind of any auto repair facility. Obviously, this is a green method because we're not producing more parts, it's just reusing what's already been out there. The only thing that would have to be done is light repair work to it and pain if needed.

If this bill were to be passed, our industry's 60 or so license recyclers would be gratefully hindered or employees of all ages, races, and legal backgrounds would be drastically altered if this were to be opposed since the profits of our facilities would not be able to exist. If our industry were to be hindered, the automakers will have full control of price points of any new part. So, these if these parts were to continue to rise in cost with no competition or price comparison options like us or even possibly after market. It allows automakers to have a monopoly of the market and full control of new parts and the prices they choose to sell them for. If a new OEM part steadily increases over time, which obviously with inflation it would, insurance companies would total out more hard-earned Connecticut resident's vehicles which in total --

which in fact will force insurance companies to increase rates just as the previous lady mentioned. If these rates were to increase it would have a ripple effect on any Connecticut resident, especially young professionals who we obviously want to maintain in our state and retired residents will see the most financial burdens with obviously increased rates of their insurance.

One of our main reasons we believe this bill is being proposed is for the profitability of the automakers mainly and the auto repair facilities. With a higher repair cost as in any service industry, it is essential for any company to mark up a part for service to make a profit. The problem is not having a price comparison option for insurance adjustors making the insurance company to have no choice except to purchase and expensive new part. With auto repair facilities wanting for the new expensive part, their mark up on it, whatever it may be, would be a higher reward verses a used part. Just a quick example, an Audi hood new is like $1625 dollars, a used one would be about $500 to $700 dollars. So, as for the auto -- excuse me -- so, as for the auto recyclers, it is important to sustain part prices within the state and many of our association members would be financially burden if this were to go through. So, again, Connecticut Auto Recyclers oppose H.B. 5176. I'd gladly take on any questions. I appreciate it.

REP SCANLON (98TH): Thanks, Bill. And good to see you again this year. Again, I just want to refresh my memory and do a crash course with you on this. So, it's a little different than last year.

WILLIAM DEBACCO: I know. I know, but I'm saying on the recycler's themselves.

REP SCANLON (98TH): So where do you guys get your parts from.

WILLIAM DEBACCO: From Auto Salvage. So, on a vehicle that was deemed salvaged or too much, too expensive to repair, goes to an auto salvage pool, or even people, if they don't have full coverage, which is happening, more and more, surprisingly, they just have liability on like a 2015/2018 car. If they were to damage their car, it would just be at the residence with [inaudible -06:05:21] them or mainly, most of the time, it would be auto salvage facilities.

REP SCANLON (98TH): Got it. So, then, you buy them from the salvage [Crosstalk]

WILLIAM DEBACCO: I'm sorry, auction -- auction facilities.

REP SCANLON (98TH): You buy them from there. Take them to your spot, and then take off all the parts that you believe that you can salvage.

WILLIAM DEBACCO: Correct. Some do a full breakdown; some leave the car complete until a part is sold in terms of a door. It could be weeks, months, or a year for the door to be sold. Some smaller operations who are on limited property space do a full breakdown, all components are going to come off, the shell gets discarded and they have inventory accordingly because of just space. So, it just comes down to per operation how they run.

REP SCANLON (98TH): I drive a Ford Edge, so let's say you have a Ford Edge on your lot. At what point

does somebody, and how does somebody find out that the part that I need for a Ford Edge in Alabama or Kan -- is it -- I'm assuming you sell the parts nationwide, right?

WILLIAM DEBACCO: Mostly, yes. Depending. For some shops, yes, they do ship them. A lot of smaller shops like myself, we don't go through the point of shipping doors, fenders, it just never gets to the final consumer as it normally leaves my facility, so we stay away from it, but every, obviously, operation has their own approach.

REP SCANLON (98TH): Okay, somebody calls you or online, somehow it happens.

WILLIAM DEBACCO: Let's do it simple, a 2000 whatever 14, Mercedes E350 with blind spot monitoring, so, when we normally bring this vehicle, because most of the time, as long as we're able to get power to the vehicle when we do an inventory, we'll have a member of my staff go along the side to make sure the blind spot is picked up for an accurate light. There's always a chance that things fail later on in life, but it gets guaranteed nonetheless for certain specific time right from the get-go to make sure it's fully safe and equipped.

REP SCANLON (98TH): Okay, so where does the body shop come into this equation?

WILLIAM DEBACCO: What they're doing is they're trying to eliminate the recycled auto parts for the first, I think 100 some days. So, it's almost five years. So, any vehicle that we purchase, a 2000 whatever, 15, 16, 17, we wouldn't be able to sell those parts until it reaches a five-year point. For us, that can be detrimental. A lot of these yards

do pure high-end stuff. I'm a middle age yard, so I'll be affected a little bit but any of the bigger yards in our association that do purchase many parts from like all these auto salvage facilities, or auctions, if they can't sell their part, then they're sitting on a product that is not making them money. So, they're getting taxed on their land for no point on a piece of equipment or retail merchandise that we can't do anything with until the five-year mark.

REP SCANLON (98TH): Got it. And then, two more questions. Who are you mostly selling to?

WILLIAM DEBACCO: I'd probably say -- every -- like I said, every company is different but 50 percent I'd probably say almost 100 percent is to mostly auto repair facilities. So, it could be anything from hard parts to suspension because obviously rust and rot issue with anything -- the chemicals that are put on the ground, to just body parts in general for repair. Someone whacks a door, he has a pretty big dent in it, we'll sell him a door. They obviously sand it down, spray it the color and specs and on it goes.

REP SCANLON (98TH): But very little is direct to consumer, right?

WILLIAMD DEBACCO: Every company is different. A lot of cities have way more walk in than I do. I'm out in the country, so, it's a way different story for me, but like I said, I'm probably -- I'd say I'm in the 80-90 percent of auto to license repair facilities in the state. While there are other ones closer to 50 percent because they get way more walk in traffic. Especially like cities that have

poverty they sell these parts way more frequently then.

REP SCANLON (98TH): Got it. Then, the last question is. For the parts that you sell, are you liable for their applying the safety of those parts?

WILLIAM DEBACCO: Technically, it's a tough one to kind of put at us, because we're selling an OEM -- a ROE which is a recycled original equipment part which came on an OEM vehicle. So, their safety and crash tests and all that, that was done to that vehicle four years ago has no effect to the point of the part four years later. Unless, obviously, it was involved in another wreck at some point or for some reason mother nature has deemed it not worthy of a safe part on our end. But there is no true, true way to safely say, a used part is safe, but it's just the fact that it is an OEM part. That's what we're referring to.

REP SCANLON (98TH): Got it. Okay. So, there's no way to say if it's safe.

WILLIAM DEBACCO: Yeah. But, at least -- I'd have to get back to you on that one.

REP SCANLON (98TH): But your business, and the business of your guys that you represent gotta be on reputation, right? Because if there's no real guarantee it's all about your reputation for selling quality parts, right?

WILLIAM DEBACCO: Correct.

REP SCANLON (98TH): That's your only guarantee there is?

WILLIAM DEBACCO: Well, the fact that it's from an OEM car. So, if they're going to release it five

years ago, and they're going to put their name badge on it, any of that part should be fully safe for the life span of that vehicle.

REP SCANLON (98TH): Got, okay. Representative Delnicki.

REP DELNICKI (14TH): Thank you, Mr. Chair. And thank you for coming forward and addressing this issue here. Can you tell us how many people are employed by your association members?

WILLIAM DEBACCO: I don't have that true number. A lot of our guys -- I mean our field has a --

REP DELNICKI (14TH): Just a rough estimate.

WILLIAM DEBACCO: Probably a little over 1000.

REP DELNICKI (14TH): You made comments about the work force, about people having opportunities to actually get a job?

WILLIAM DEBACCO: Correct. Yep. We do have a couple facilities that do -- are obviously city-based yards so they're going to hire more ethic based -- ethnic based personnel as well as we do a couple facilities that do, as well as myself, have a lot of criminal background individuals who obviously would have a much harder time getting a job then.

REP DELNICKI (14TH): So, you're actually providing jobs to folks that are looking for a second chance.

WILLIAM DEBACCO: Correct, we do have that -- we do have a couple facilities that do that -- 100 percent do that. Yes.

REP DELNICKI (14TH): And just to reiterate what I think was already said, the quality of the material

that your members are selling is equal to what was on that vehicle originally?

WILLIAM DEBACCO: Correct, because it would be an OEM part.

REP DELNICKI (14TH): At a fraction of what the cost would be if they were to buy say a brand-new fender for my Chevy Equinox from say Gengras who would be a heck of a lot higher.

WILLIAM DEBACCO: Potentially, yes. And then a lot of the times, we also, depending on what kind of part, will also include like an inner fender liner on that fender which that from OEM would be another purchase that you would have to make. So, all these costs continue to add up. So, insurance rates, it's inevitable it will pretty much skyrocket.

REP DELNICKI (14TH): And likewise, aftermarket parts, what your folks would sell would be far better than any aftermarket part that was say made in China and shipped over?

WILLIAM DEBACCO: It's a touch call there as well because there are -- some of these OEM manufacturers do -- some of these same facilities do produce an aftermarket cover or what not, so I can't really speak for that, there are a couple individuals who will be presenting on that behalf. They obviously have way more knowledge in that regard since most of the stuff that if we do have anything aftermarket it would be all small stuff and in terms of like rear taillights, and mirrors. So, we don't get to the point we're all out of body panels which some of these aftermarket companies actually specify, because --

REP DELNICKI (14TH): I've heard some real horror stories about some of the aftermarket stuff just not fitting properly and it was obvious when the person had cut corners and saved a few bucks. They thought they were getting a great deal at an aftermarket part and they found out it just didn't work.

WILLIAM DEBACCO: Right, but the holes don't line or anything. Yeah, I don't want to speak on behalf of that because I do have a couple people who are on our side who are on both sides. So, I'll let them breech that fine little line there.

REP DELNICKI (14TH): Okay, that's fair. I would hope that everybody was listening to the line of questioning both of the chair and myself and will address the issues as they come up. Recycling. Representative Hughes brought that up a moment ago. So, this is basically -- I'm going to refer to it as a Green business.

WILLIAM DEBACCO: It's as green as it gets.

REP DELNICKI (14TH): Because you're actually taking products that don't have to be smelted down and turn into a raw material and then re-done.

WILLIAM DEBACCO: Correct. Zero pollution involved.

REP DELNICKI (14TH): Literally, you're saving energy costs, etc.

WILLIAM DEBACCO: Every aspect, yes.

REP DELNICKI (14TH): And quality? The quality?

WILLIAM DEBACCO: It's the same standards that was released from the showroom floor. So, other than if there was any small repetition in terms of a ding to the sheet metal or something like that, it's all --

it's OEM specks. So, all five-star safety crafts rated.

REP DELNICKI (14TH): Well, again, I thank you for coming forward. I think you made a good case in my opinion. I was listening to what you had to say here.

WILLIAM DEBACCO: I appreciate that.

REP DELNICKI (14TH): And I don't think much has changed from last year to this year.

WILLIAM DEBACCO: We're kind like all we can do is battle.

REP DELNICKI (14TH): And if you really want to keep Connecticut open for business and you really want to have opportunities for people to have jobs, I'm certainly in support of your industry, especially, with the Green aspect and the aspect of the recycling and minimal energy usage, etc. Thank you, Mr. Chair.

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

WILLIAM DEBACCO: All right, thank you, guys.

REP SCANLON (98TH): Rich Montesi, followed by Paul Folino.

RICHARD MONTESI: Chairman Scanlon, my name is Richard Montesi. I'd like to thank the rest of the committee members. I'm going to keep it short and sweet as I testified to this last year. Pretty much the same issue here. H.B. No. 5176, it's a job killer. It would put most of us and our industry in this state out of business. We all pay taxes, we employee people. It creates a monopoly. Basically,

it's the auto manufacturer selling their parts to insurance repaired cars for five years. Again, that would put most of us out of business. It would increase all the insurance costs for everyone in Connecticut, because everybody's insurance policies would be higher because they would have no choice. It restricts trade. Basically, you know, there would be, you know, it's one-stop shop. You know, if your car gets wrecked within five years, you gotta go get the part from the auto manufacturer, put it on the vehicle and that's it. There is no other option. And, you know, we believe this unfair. You know, we do believe in free trade here.

An also, you know, many of our members as it was stated do employ a lot of ex-cons, people who have trouble getting jobs other places and they fit well at our facilities and they do well, and you know, they work for us for a long time. So, I believe that's very important as well. I don't have much else to say, but I will take anyone's questions if anybody has any questions here.

REP SCANLON (98TH): Representative Hughes.

REP HUGHES (135TH): Thank you, Mr. Chair. Can you just give us an idea of what the prevailing wage is in one of your facilities that you're employing folks?

RICHARD MONTESI: Well, it all depends on experience, you know. Somebody comes through the door, you know, an auto dismantler, you know, they might be making, you know, around $15 dollars an hour to start if they're, you know, with no experience. You know, somebody with more experience, this one might be making around $20 dollars and hour. Somebody who's, you know, could

be yard manager or something might be making $25 dollars an hour, you know, in that range, you know. But, you know, again, these are jobs that many people who have, you know, found themselves in bad situations earlier in their life, have tried to change their lives around and they fit in well at our facilities, you know. They really do, you know. I've seen it. A lot of people get good help that way and it's a good thing for a lot of people.

REP HUGHES (135TH): Yeah, I appreciate that. And it sounds like your turnover rate is relatively low once people get the skills, and get a little faster, get a little bit more savvy about the different, you know, models they're working on, or whatever, right?

RICHARD MONTESI: Yeah, with experience, you know, like anything else, any job, with experience, you get better, you know, so.

REP HUGHES (135TH): Great. And can you give us an example again how many -- I think somebody said it before in their testimony, but how many facilities are represented in that association?

RICHARD MONTESI: Well, there's probably around currently active, you know, -- It's 30-something of us. Thirty something yards in the state that are active. And, you know, there's probably a dozen of us that are more prevalent than the rest. Some of them, you know, are very small and this and that, but you know. And some of the yards are, you know, we have yards that employ 50 people, you know what mean. And the largest yard employs around 50 people, I think well over 40 people that work for them are ex-cons, so.

REP HUGHES (135TH): Wow. So, the workforce we're talking about is at least in hundreds if not thousands, right?

RICHARD MONTESI: I would say -- yes, I would say hundreds, you know, but across the board, you know, you may be closing on a thousand between, you know. But it's definitely in the hundreds for sure.

REP HUGHES (135TH): Great. Thank you very much.

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

REP PAVALOCK-D'AMOTO (77TH): Thank you, Mr. Chair. As far as the parts, how many parts would you say in a year go through the yards? Is it, just because I have no idea, is it hundred, thousands, millions?

RICHARD MONTESI: Oh, thousands, thousands of yards -- thousands of parts. You know, just in the state, you know, it's -- having the option of a recycled OEM part keeps many, many cars on the road. You know, if it was just an option of paying for a brand new part from the manufacturer, so many cars would be totaled out and a lot of these cars would be off the road and it would make a lot of, you know, the used car market in this state would also be affected, because there would be less used cars at lower prices for people who really need, you know, lower priced cars. They would be taken off the road, even though, you know, it's just -- as when the whole tax for clunkers program was put in, it destroyed the used car market. That was not a good program. It did -- it drove used car costs up for everybody and made used cars so much more expensive. It helped the auto manufacturers out, they sold more cars, so, you know, it bailed out the auto

manufacturers, but locally, people who couldn't afford to buy, you know, they're looking for a $5000 dollar car, they couldn't find a $5000 dollar car, they had to buy a $10,000 dollar car, you know, and they were lucky if they could find one of those when that program went through. So, it did have, you know, consequences that weren't intended, you know. So, that's what we're afraid of here is, unintended consequences with this law.

REP PAVALOCK-D'AMOTO (77TH): So, in a year if we're -- if they're holding onto parts now, -- well we're talking about five years, they would be holding onto thousands of parts and those parts are subject to an inventory tax, correct?

RICHARD MONTESI: Well, yes, I mean -- not even that -- you'd be taxed on your inventory, you're taxed on, you know, your property, your insurance cost, your insurance bills come in every week. You know, being in business in this state, like everything you're holding on to, if you don't roll your inventory over, you don't stay in business. You have to sell them as fast as possible in order to be able to stay in business.

REP PAVALOCK-D'AMOTO (77TH): So, I can imagine, I'm sure maybe some can calculate it, one of the owners, the financial impact of just taxes alone, how much that would cost a business in a year.

RICHARD MONTESI: If we were restricted on what we can sell, we wouldn't be in business because you need to be able to sell everything off the vehicle. If you can't -- you can't stay in our business, it's just -- it's impossible, you know. We'd be shutting down plain and simple. I mean it's just -- it's not possible. You need to be able to sell body parts to

body shops, to the insurance companies, you need to be able to do that. This would also restrict -- if it were, you know, if we couldn't use a mechanical part, I have new car dealers who actually buy parts off of me. They're one of my biggest customers for mechanical parts. A lot of times they have parts that are back ordered, they can't get them. They call me up and I, you know, I come -- I deliver them parts, and you know, that's the largest part of my mechanical parts business as well. So, I need to sell mechanical parts, body parts in order to stay in business. If I don't, we gotta close the doors basically.

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

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

RICHARD MONTESI: Thank you, very much.

REP SCANLON (98TH): Paul Folino followed by Michael Angelinas.

PAUL FOLINO: Good afternoon Representatives, Senators, Committee Chair. My name is Paul Folino. I live in Terryville, Connecticut and I work for LKQ Corporation which is one of the largest alternative parts distributors in the nation. We have four locations throughout the State of Connecticut. We employ well over 117 peoples and we pay approximately $3.6 million in Connecticut taxes annually. I'm speaking here in opposition of H.B. No. 5176, the alternative parts restriction. Now I'm a parts guy. I've been in the parts business going on 22 plus years. I've had the opportunity to go overseas and visit with our manufacturers, as well as parts that are -- alternative parts that are

manufactured right here in the United States. Many of these manufacturers make the OEM equivalent parts that we're talking about that the car companies distribute, the dealerships. I've had the opportunity to go to CAPA. We've heard CAPA mentioned before. CAPA is the Certified Automotive Parts Associations, non-for-profit organization. They use Intertek, which is a world-renowned lab to test aftermarket collision replacement parts. So, I can tell you that the parts that we sell are safe. And my brothers have talked a lot about the recycled parts, the ones that we dismantle off the end-of-life vehicles and in the essence of time, I'll talk to you a little bit more about the aftermarket parts that we distribute. We sell millions of dollars' worth of parts in Connecticut annually. And I will tell you that these parts are crash tested every single day. How many have driven down 84 through the tunnel and seen three cars pulled off to the right-hand side, right? Chances are some of those may be a second time around, a third time around, and they do have aftermarket parts on them.

If aftermarket parts were a detriment to safety, do you think that the insurance industry who is responsible for paying for any related liability would recommend them? I could tell you as a husband and a father, and a brother and a son, I couldn't sit up here and sell them. I know the parts are safe that we distribute. Our parts have a lifetime warranty on them. If you get a chance, ask the OEM manufacturers what their warranties are. Most of them are inside of a year. As a company, we offer our promise of protection to our repair customers for any alternative parts that they purchase. And what is that? That is our commitment that as long

as a license installer installs one of our parts properly and if that part fails, we offer them complete indemnification from any damages whether financial, God-forbid personal death, injury, we will represent them in a court of law to the assets of the company. Now, we can't sit here -- we can sit here and say knock on wood, we haven't had a claim, but that's what guides our principles and making sure that we buy the highest quality parts that are out there.

My brother ended up taking some time to talk about the impact of what it would do to auto insurance policies, about people that are upside when they purchase a car going 60 to 72 months, they still have a loan but a vehicle that can't be repaired because it doesn't meet an insurance companies threshold that is out there. I would tell you that in the bill, you talk about if an OEM part is available. Well, an OEM part is always available. If you pass that bill, basically you're going to legislate a whole other part of the industry out of business. You also asked for a consent for aftermarket parts. So, somebody is getting their car repaired, if they have to sign off, that really puts an additional stigma, an unfair stigma on all of parts, recycle, aftermarket, reconditioned.

REP SCANLON (98TH): Paul, if you could just summarize the rest of your testimony that would be great.

PAUL FOLINO: Yep. Even some of the car company parts that we carry. So, in conclusion, again, we are against H.B. No. 5176. I appreciate your time. I'd be happy to answer any questions that you may have.

REP SCANLON (98TH): Thank you very much. Anybody have any questions? Seeing none, thank you very much for coming tonight to testify.

PAUL FOLINO: Thank you.

REP SCANLON (98TH): Michael Archangels, followed by Chris Demarzino, and Bob Amendola.

MICHAEL ARCHANGELO: Chairman Scanlon and members of the Committee, thank you for the time today. I come to you today as the operator of four auto recycling facilities and --

REP SCANLON (98TH): I'm sorry, if you could just state your name for the record.

MICHAEL ARCHANGELO: Oh, It's Michael Archangelo and I'm from Chuck and Eddie's Used Auto Parts. I'm the operator of four auto recycling facilities and employer of nearly 200 people engaged in auto recycling here in our state. I ask you to oppose H.B. No. 5176. This bill would cause an immediate negative impact on our industry and the consumers in our state. H.B. No. 5176 looks to create an address a problem that does not currently exist in the market with an outcome that benefits the few that are pushing its passage. The current insurance marketplace has many options available for consumers and responds to the commands of the consumers with products accordingly. The insurance marketplace operates more efficiently with more options for consumers are available. This bill would restrict options for the consumer and in turn increase costs. If the marketplace needs an insurance product to address this problem, then it would respond accordingly. This does not need to be done through burdensome legislation. H.B. No. 5176 would limit

the replacement part options available to repair collision vehicles causing insurance repairs to increase, which would cause insurance premiums for consumers to increase as well. Passage of this bill would cause more vehicles to be totaled which would cause an undue burden on consumers by forcing them into vehicles with new loans as well as increased tax bills that go with them.

The repair facilities that currently complete insurance work already have the means in place to refuse a part that they believe is unsafe. There is no need for legislation to further state what the marketplace has already taken care of.

I would ask any member of the Autobody Association if they have ever completed a repair with an unsafe part or put a vehicle back on the road that was not properly repaired. The answer would be a resounding No.

Again, I would hope you would oppose the passage of H.B. No. 5176. I'd be happy to answer any questions you have.

REP SCANLON (98TH): Thank you very much. Does anybody have any questions? Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much. Thank you, Mr. Chair. Thank you for your testimony. I think there are some other aspects that you have to explore in this situation as well. One of them is, if we are not, for lack of a better word, recycling the existing old motor vehicle parts, we are actually going to create a very significant amount of metals that we will be actually -- we right now are having a disaster if you will with respect to our current garbage that is being created. But

another outcome of the current bill in its current form would be that we will have so much metal that we won't know what to do with it and we will be actually having another group meeting in the Environmental Committee trying to figure out what to do with that. So, we will be increasing the costs of repair, we will actually -- and in most of the parts of the world, people are actually smartly using or reusing the parts that can be reused. And that's where the brain and the technical expertise come. So, I recognize where you're coming from and I can see some of the intended, but also unintended consequences of this bill which is going to be harmful for our small businesses and harmful for our environment as well.

MICHAEL ARCHANGELO: Yeah, for sure. The highest form of recycling is reusing, so that's what we would be -- what we do every day with regards to selling used parts to put them back out on the road and onto vehicles.

SENATOR ANWAR (3RD): Yes. Thank you so much.

MICHAEL ARCHANGELO: Thank you.

REP SCANLON (98TH): Any further questions? If not, thank you so much. Chris Demarzio followed by Bob Amendola, and Jeff Webster.

CHRIS DEMARZIO: Thank you Committee Chairs and Committee Members for letting me speak to you today. I appear before you in opposition to H.B. No. 5176. Although well intentioned, the proposed amendment as written will have far-reaching, negative impact to consumers, commerce and to the extent -- to some extent our environment. With regard to vehicles being repaired by an insurer as written, a lack

specificity and criteria for the designation of what will constitute an unsafe part by the repairer on its face will allow broad interpretation that will most likely guarantee that only new OEM parts be used on any vehicle of any age and let explain the word or. In language, basically as I interpret it means that any vehicle of any age, they would be able to determine an unsafe part. If it's five years or new, it definitely can't have an OE part. That's how I interpret it. Maybe I'm wrong but you good people can look at it and see how you read it. But that's how I read it and it's scary.

The first and foremost by not allowing the use of quality used OE parts, costs of repairs will skyrocket as well as the number of vehicles that will then be deemed a total loss. In addition, the restriction imposed by this bill would drastically reduce the demand for used parts, which will then drastically reduce the salvage value of the vehicles that do get totaled. Basically stated, as a recycler, if the vehicles that I buy have no residual value because I can't see the parts, then the vehicle then becomes only worth buy for the precious metal and scrapped. And I can tell you right now as an industry standard, any vehicle is probably between $300 and $400 dollars for that purpose. Contrast that to the industry standard for vehicles that we purchase for the repurposing of sale of parts. Those vehicles are realizing about $2600 to $2700 dollars on average we're paying for those cars. That's going to represent a significant drop in value from the insurance companies are going to experience when they go to sell these salvaged vehicles that they're now going to be totally a lot more of and so, the whole thing has a spiraling

effect. Having had a body shop of my own for many years, I know firsthand the struggles faced by the repairers, but I'm also aware that the increased number of cars that will now be deemed a total loss will further exasperate -- exacerbate the already shrinking of volume of work needed by the repairers to stay operational. It is well documented that the collision industry volume of work is down and that's because of good sound policy put in place by government, law enforcement ant the insurance companies to prevent accidents from occurring. That's been happening for years, and now it's further complicated by the accident avoidance systems on the cars now which is further reducing the amount of accidents. That's all a good thing, but it's drastically reduced the volume of work that shops can bring in, and if the -- now going to total most of the cars that are brought in, that's further going to hurt them.

The only stakeholders in the repair process that I see benefit from this is the OEM manufacturers. It creates an unfair monopoly.

Lastly, and I won't take any more of your time. If you have -- there's been multiple studies showing that the use of used OE parts is good for our environment. If you haven't reviewed the WPI study titled *Auto Recyclers Reduce Carbon Footprint*, I urge you to do so. As somebody from the recycling industry, I take great pride in the conclusions from that study. Every repurposed part we provide eliminates the need to have a new part produced. Our industry supports thousands of mechanics, machine operators, salespeople, logistics personnel and support staff. I ask you to also keep them in mind when you vote on this legislation. Thank you.

REP SCANLON (98TH): Thank you very much. Any questions from the committee? If not, thank you very much. Bob Amendola followed by Jeff Webster.

BOB AMENDOLA: Yes, hi, I'm Bob Amendola and I'm the President of the Autobody Association of Connecticut. Thank you, and I appreciate everyone's time. I would like to start, thank you for considering the H.B. No. 5176 and I would like to -- I have a prepared statement I'd like to make. We have repairers that are fixing these cars that are getting increasingly more complex with the whole adage of OEM parts. We never once had the intention of not using used parts. We met with this association and tried to express this to them as well. Used parts are OEM parts, and when OEM parts are required by the manufacturer, we are the ones solely responsible for their safety, not the insurance company, not any other entity other than the person that's putting it into their harm’s way. And that's the sole purpose of what our intention is. It has nothing to do with used parts. Any used part that is OE, we commend it. We have no difference in that. It's -- the thing with H.B. No 5176 which is imperative to promoting safer repairs and consumer protection. I currently serves as I said, as President of the Association and have owned a collision repair shop for almost 35 years. I hold a mechanical engineering degree from the University of New Haven, and I am an ASA certified technician. Throughout my career I have experienced plenty of challenges and changes within our industry. Many of those challenges specifically arising from pressure from insurers to repair vehicles with improper or use incorrect parts in the effort to save money.

In the same respect, insurers prematurely and inappropriately deem vehicles to be a total loss, thus routinely placing Connecticut motoring public in harm for obvious reason that everyone here has testified to. That's not the point of this. Today's vehicles demand the highest level of insight and skills our industry has never seen before. Advanced technology systems like [inaudible - 06:38:26] braking, blind spot monitors, parking assistance and surround view cameras have created demand for substantially increased technical prowess. Equipment and resources because of this, we constantly refer to repair procedures and technical bulletins from manufacturers. One of the things about the volume of repairs are going down because of all these systems, which is absolutely tremendous. Those that are repairing cars correctly, we're in a diminishing field. We are losing repairers on a monthly basis in the State of Connecticut. Mostly because they cannot substantiate the cost for these equipment and these proper repairs to do this. This is a fact. We don't -- if you're current with your repair technology, you have cars waiting to be fixed, it's not the other way around and I can personally attest to this.

Despite this, insurers regularly pressure us to -- us as repairers to use substandard imitation parts as a cost-saving measure. While these parts are typically cheaper, they are not tested or certified to -- by the manufacturers to meet the precise technical specifications needed to insure as they perform the same way as an OEM part does. Due to the complexity of today's vehicle and future vehicles, these technical specifications are

absolutely paramount and simply cannot be ignored. The use of aftermarket imitation parts my compromise the overall safety of the vehicle, compromise the vehicle's safety systems, void a vehicle warranty, violate a lease or financial agreement resulting in premature corrosion, pain issues, poor fit, ultimately causing diminished value and placing Connecticut's motorists in direct harm.

The legislation at hand prohibits insurers from forcing inferior parts on consumers in attempting to dictate repair methodology on licensed and trained repair professionals without licensure or experience too. Likewise, the legislation also provides the much-needed protection for consumers with respect to new cars that are financed or leased.

Our neighbor Rhode Island already has similar legislation in place. In speaking with countless shop owners within their state I am certain that helped Rhode Island consumers immensely.

Throughout my career, I have experienced insurers continuously weaponizing the ability to total vehicles at their discretion. And such occurs when towing a vehicle is in the insurers favor. However, in my instances, totaling a vehicle is not in a consumer's best interest for a host of reasons that many people have before. That's why the 75 percent, it's important, and recycling, all facets, we have nothing against that. There isn't a word in here about anything, and you know, I just want that to be clear. Recycling is one of the best things that we have for all future generations. Thank you.

REP SCANLON (98TH): Thank you, Mr. Amendola. So just a few questions from me. So, what percentage of cars on the road today, I don't know if you know

this or not, but what percentage of cars on the road today are five years or newer?

ROBERT AMDENOLA: I don't know the answer to that. That study, you know, would have to be done. I just don't know.

REP SCANLON (98TH): But would you say it's less than 50 percent, more than 50 percent?

ROBERT AMENDOLA: It's hard to say. It might be, and like I said, you could have a new car and putting a used part on it, that's an OEM part, it can be very substantial. So, it's not.

REP SCANLON (98TH): And what percentage of cars do you fix at your shop?

ROBERT AMENDOLA: Probably seven years, in that range, most of them.

REP SCANLON (98TH): Is the range.

ROBERT AMENDOLA: Correct.

REP SCANLON (98TH): And do you buy parts from the recyclers currently?

ROBERT AMENDOLA: Yeah, yes, we do.

REP SCANLON (98TH): And would you continue to do that under this bill?

ROBERT AMENDOLA: Absolutely.

REP SCANLON (98TH): So, can you help us try to understand the disconnect then between the testimony we heard earlier and the testimony that you're now giving which is that previous witnessed have testified saying that they think that their business would be dramatically impacted by this?

ROBERT AMENDOLA: Well, here's the thing. I understand their concerns totally. Absolutely. It's very hard to do business in any state -- or state, there's challenges that we have for sure. It's not any of our goals. We all need to work together. Everybody on the recycling association, they're all great people. There's absolutely no animosity here whatsoever. The problem that we have is when an insurance company dictates to us how to fix the car, then someone gets injured and they step away. We're finding ourselves, unfortunately, having to go into court for short pays because of all the various reasons. No-one wants higher insurance costs, that’s not what this is about. Accidents are diminishing, so therefore, we're going to be fixing fewer cars in a more complex fashion and everything will find its -- seek its level as for what it is. But there is no way around it, car repairs are going to cost more and the days of -- you ask your average lay person what a repair looks like to you, they have some image of, you know, a guy with a hammer and a dolly with a cigarette in his mouth. These guys are becoming aircraft technicians. I don't how you feel, but if you had to get on a plane, I'd think you'd want the best qualified person working on it because there's no cost that can be associated with someone's life.

REP SCANLON (98TH): Sure. And when it comes to the Rhode Island state law, can you tell us how that's been implemented, if you're aware of that?

ROBERT AMENDOLA: Yes. They have in place their law for OEM parts and that is either -- there's no designation between, you know, recycled or new. It's -- it has allowed them to follow the OEM procedures and get away from having to do a repair

that the OEM manufacturer deems unsafe. Because everything, like I said again, falls under repair. It's our responsibility to keep the motoring public safe. Bar none, not the recycler, not the insurance company, it's us. I use this saying, we're one bad repair away from being homeless.

REP SCANLON (98TH): Hmm. Because the liability squarely falls on you.

ROBERT AMENDOLA: Dead straight.

REP SCANLON (98TH): And how -- last question Mr. Amendola -- how often are you, back to the analogy that I was giving with Mr. Debacco. A guy gets in an accident, comes to our shop, and says, hey I don't know anything about this, but my car looks bad, what do you do? You go through all the process, then you go to his insurance and the insurance says, no we're not paying for that. What percentage of time does that happen on an annual basis?

ROBER AMENDOLA: It happens quite, quite frequently, and we are either forced to charge the consumer the difference, and if you're third-party, meaning you were hit by someone else, and you should be incurring zero cost, that's becoming very, very hard to combat unless they want to take a substandard repair. The insurance company isn't offering aftermarket parts for the reason of your safety. They're offering it for saving money. And how much are they passing onto consumers? That I don't know. I would imagine it's --

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

ROBERT AMENDOLA: Thank you.

REP SCANLON (98TH): Jeff Webster followed by Anthony Ferraiola.

JEFF WEBSTER: I guess it's good evening by now. So, I'd like to thank the representatives and the council for hearing me again this year. I thought last year I was going to be thrown out. This is a different approach. Green is very popular notion, which has just been brought up. I remember reading years ago that to build a new fender would take a dollar. I'm sorry, to -- excuse to build a used fender -- to take a used fender off a car and deliver would cost about a dollar. To actually go out and mine the oar and process the part and build the fender would cost ten times as much. Wasted materials and things like that. The problem that I run into is greed. Now when we're able to provide, as a broker of right quality and kind of OEM parts which are the standard of living -- or the standard of excellence in this industry at a substantial savings, sometimes over 50 to 75 percent cheaper than list, you have to look at the shops who are using these parts and saying, well, here's a $2000 dollar part, we can make 25 percent on or I could buy a used one, it's in really good shape for $500 dollars and make 25 percent on that. I'm not the sharpest pencil in the pack but it seems to me that greed has something to do with this. The shops are going to go and they're going to steer which is an unpopular term, they're going to steer he customer into buying the more expensive part. All we’re asking for is a potential to have a fair shot at the market. We are only asking as brokers for the original equipment parts to keep on your car, when they were brand new when they came out of the

dealership. I would like to also add that as a gentleman from LKQ eloquently stated that his parts have a lifetime guarantee, which I was not aware of. I think you'll find that the OEM manufacturers guarantee their parts for approximately a year. So, it's not really a valid point. These are parts that are not structurally critical in any collisions and they should be readily available at large savings to anyone who is trying to save money. For example, if you have a policy where you say, all right, I'm going to pay $300 dollars a month for this policy, I only want OEM parts. Then you say, well, you know, I'll take a chance for maybe $200 bucks a month, I'm going to save $1200 dollars a year, I will accept aftermarket, or I will accept used parts. That is up to the individual and there are savings available to them if they choose that insurance policy. So once the accident occurs, whatever you pay for is what you should get.

I'll answer any questions about OEM or aftermarket, or used, happy to do it.

REP SCANLON (98TH): Just a quick question from me, which is that, the previous witness testified that he felt like the motivation -- or he said the motivation for this is because he feels like he's the one who has the liability for the safety of the motoring public. You're, I think, suggesting that that's not entirely true, and that the original liability is with the manufacturer of the part. Is that what you're trying to say?

JEFF WEBSTER: That's absolutely incorrect. They're both exactly the same part. They're both the exactly the same. Original equipment manufacturer part, one is used, one is new. The new one you're

going to pay $2000 dollars for, the used one you're going to pay $500 dollars for. In many cases, if you have a 2015 vehicle, you may be receiving a part off a 2017 vehicle which is even newer than your car. So, the spread is, where's the money?

REP SCANLON (98TH): No, I get that's what you're saying. But I guess I'm asking you a different question, which is, who has the liability regardless of whether it's the same part, you're saying one is $2000, one if $500, it's the same part, it's just a different classification of the part, right? But who's got the liability?

JEFF WEBSTER: I don't know if the body shop actually has the liability on it. I can't swear to that. The manufacturer should have I would assume, they built it.

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

JEFF WEBSER: Thanks. Hopefully I will not see you next year.

REP SCANLON (98TH): [laughing] Anthony Ferrailo followed by John Buckley.

ANTHONY FERRAILO: Good evening Committee Members and thank you for taking the time. This is a very important issue. I have written testimony, but I am going to go rogue here and kind of clarify some stuff that some people have already said. My name is Anthony Ferrailo, I'm the owner of A&R Body Specialty Collision Works in Wallingford. I'm a 30-year family owned and operated business. I am an authority on repairing vehicles. I am professional. I am an expert in repair. We're certified. My technicians have trained at the highest level. We

know this business very well. We've tried aftermarket parts. In most cases, they do not work, and all the data that these people have determined of crash test parts from a CAPA Certified company is an entity that supposedly tests these parts and certifies them, but there's a lot of questions going on whether or not these parts are actually crash tested on vehicles. In fact, to the contrary. Some of the manufacturers, such as Ford, Volkswagen, and Honda have crash tested cars with parts -- aftermarket parts put on these vehicles and they have failed significantly. When the lady from the Insurance Association of Connecticut. That testimony, you should disregard at all because most of it is kind of inaccurate. In her -- in her testimony it says OEM recommends -- insurers typically accept OEM recommendations on a case-by-case basis, due to the fact that most manufacturers have a plethora of recommendations that are not necessary for proper repair to complete -- on a completed vehicle. I don't know where they have the authority on figuring that they know more about the repairing of a car than the manufacturer of the vehicle, but they seem to, you know, want to tell you that. She said something about crash test studies being done, I don't know by whom they're done. And this is the big part that I really have a problem with, merely cosmetic. They have no impact on safety and can be found by the Insurance and State of Highway to be safe, no impacts or crash results. These parts are hoods, fenders, core supports, bumper reinforcements. They absolutely have an impact on safety of these vehicles on how the systems deploy, air bag systems, supplemental restraint systems, seatbelts, are all dependent on

how those systems crumple and, you know, how they react in an accident.

This bill is not about the recyclers, it's not about the repairs, this is a consumer -- pro-consumer bill. This is to help them not diminish the value on their cars and also put their families not in harm's way and put other families and other people's vehicles that they hit not in harm's way. This fight is really should be delivered by the aftermarket parts industry, it has nothing to do with the recyclers, their parts have a viable place in the market. We use them, they are OEM recycled parts. This is not about them. But the aftermarket companies seem to be pushing them to spearhead the battle on this thing.

I believe that those shops are still going to, in five years of these vehicles, still use recycled, quality OEM parts. The consumer still has the choice. If they want a car repaired with aftermarket parts, the consumer still has the choice here. They have the choice of whether to use recycled parts. They have the choice whether they use OEM parts based on the expertise of the repair.

SENATOR LESSER (9TH): Can you please summarize.

ANTHONY FERRAILO: I'm sorry to keep babbling on. But, there's so much testimony that is inaccurate here, it's hard to combat it in three minutes. I hope you can ask some questions that I can elaborate more on this.

SENATOR LESSER (9TH): Thank you, Mr. Ferrailo. Are there questions from members of the committee? Yes, Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much, Mr. Chair. There are consequences from the bill. You're a proponent of this bill?

ANTHONY FERRAILO: Yes, we are in favor of it, yes.

SENATOR ANWAR (3RD): And I think there are going to be consequences from this bill going forward that is going to, in my mind, result in a number of small businesses that are probably as old as your family business who are going to lose those businesses and be harmed significantly. That's how I'm seeing this.

ANTHONY FERRAILO: Well, I don't think so because the larger corporations like LPQ are the ones that are targeted here. The recyclers are really not targeted here. They still should be able to do business on a regular basis. They don't -- well some of them may sell aftermarket parts, I don't know, but if they are marketing their parts as recycled original equipment parts, they should be able to continue to sell their parts.

SENATOR ANWAR (3RD): I'm not convinced of that frankly, to be honest with you. I think your intention may be there, but I think the unintended consequences are that there will be hundreds of businesses that are going to lose those businesses if we move forward with this. That's how I'm reading this. That may not be the intentions, but these are the unintended consequences of the bill as I see it moving forward.

ANTHONY FERRAILO: Well, if you look at the State of Rhode Island that's had this bill for a few years now and actually they upped it from three to four years of OEM parts, I have talked to a lot of shops

in that state and they have said that recyclers have not diminished. So, I have to disagree that that's going to happen.

SENATOR ANWAR (3RD): I don't have that information. From the safety data, do you have any data to support the safety concerns?

ANTHONY FERRAILO: Yes. I mean we have tests from Ford, from Honda, from Volkswagen, they're out there that these parts have failed. There's been cars that were repaired that were in accidents, the people have gotten injured. There's been huge lawsuits on the fact of cars being repaired improperly with the wrong parts and wrong proper techniques. And again, this is all about the consumer safety. This has nothing to do with us or profiting more on OEM parts. I can make more of a markup on aftermarket parts. There's a bigger markup on aftermarket parts. I will not use them because they are proven that they are not like kind in quality. The consumer should have like kind in quality parts back on their car.

SENATOR ANWAR (3RD): Can you speak to about -- in your testimony, I have not -- I will have to look at the references to what you're talking about. Data, not anecdotes, data.

ANTHONY FERRAILO: There's data. I mean I'm sure we can provide data from the manufacturers. In my testimony I included an article on Ford crash tests, confirmed aftermarket, imitation parts are unsafe. I put that in there. There's more data out there, we certainly could put it together and get it to Representatives Scanlon whoever wants to be interested in it.

SENATOR ANWAR (3RD): And tell me about the other unintended consequences of increased totally of cars and then having the climate change be negatively impacted.

ANTHONY FERRAILO: No-one seems to be addressing the second part of this bill that -- that addresses the 75 percent -- the consumer can sign off up to 75 percent to get their cars repaired. So, we're trying to keep more of these cars in the repair process by upping the limit. Right now, there's 20 states in the country that have 75 percent or better of what the amount that the repair can go up to, to repair the car. So, the insurer can't total loss that car at 50 percent which sometimes they do if there's a high salvage value on it. So, we're saying the State of Connecticut under this bill, you would have the right as a consumer to fix your car up to 75 percent of the total-- of the value of the car. So, it would actually increase the amount of cars that are being repaired, not decrease it.

SENATOR ANWAR (3RD): Okay, thank you. I'll look at it from that perspective. Thank you so much for your testimony. Thank you, Mr. Chair.

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

ANTHONY FERRAILO: Thank you for your time.

SENATOR LESSER (9TH): Next up we have John Buckley followed by Ashley Burzenski.

JOHN BUCKLEY: Good evening, Mr. Chairman. Thank you for your time. My name is John Buckley and I'm from the law firm of Buckley, Wynne & Parese. My partner, John Parese has been legal counsel to the

Autobody Association of Connecticut for the last 13 years, and I am here in support of H.B. Bill 5176. Attorney Parese has submitted a letter to you which was dated February 24, 2020 in support of the bill. And in the course of that letter, he goes through the rationale as to why this particular legislation is so important and so important to consumers in the State of Connecticut, particularly in the year 2020 as we go forward towards, and I think we all know it's inevitable, self-driving vehicles. And as we move in that direction, the importance of OEM parts becomes even greater. This bill in an attempt to put the decision as to who is making the decision regarding parts back to where it should be. It should be in the hands of the consumer and it should be in the hands of the licensed repairer, not the insurance company. I say that again, give it back to the consumer and the licensed repairer and take it away from the insurance company. That is what we're here about today. I've looked at the bill. We do not, during the course of this bill, or it is not part of this bill to in any way do anything to the recyclers, the recyclers are not part of the contemplation of this bill. It is not in the language as I understand this bill. What we're talking about here is original equipment manufacturers, and the safest and the only true way to repair a vehicle. The fit, the function and the design are all best served by the use of OEM parts and recycled OEM parts. So, to the extent that we utilize recycled OEM parts, we keep the recyclers in play, we keep the salvage people in play. I understand that there may be an argument from the aftermarket people, I understand that. But as to the salvage, as to the people who are doing the

recycling, recycling works, we use those parts and we want that to continue.

The importance of this right now is, and I think the last speaker, Mr. Ferraiola who does more of this than anybody I know, really deals with what's happening with these vehicles right now. These are not cosmetic parts. Bumpers and other parts of this sort are not cosmetic. The types of metals, the types of parts and the types of materials that are being used are critical to how these systems work and the fact of the matter is, crash worthiness and how the vehicle responds. Whether your airbag deploys, or your airbag does not deploy, whether seat belts engage, or the seat belts don't engage is critical to everybody --

SENATOR LESSER (9TH): Can you please summarize.

JOHN BUCKLEY: That is in a vehicle. So, I urge you to look at this very carefully. Understand that the recyclers are not involved, understand that the cars have to be understood as a whole and lastly, if I could, totaling cars has been a default position for the insurance industry over the last 10 years. If somebody wants to do the right thing by them, if they want to make sure that the right kind of parts are being used, if they want to do the right job on this car to put it back on the road safely, they'll always use that as a threat, we're just going to total the car. Let's put a metric in place that 22 other states have that makes sense. Let's take as much discretion away from them and let's put --

SENATOR LESSER (9TH): Please summarize.

JOHN BUCKLEY: it back into the hands of the consumer as well as the licensed repairer. Thank you very much.

SENATOR LESSER (9TH): Thank you. Are there questions from members of the committee? Thank you very much for your testimony. I assume Ashley Burzynski is not here? Okay. Joe Genovese followed by Chris DiMarzio.

JOE GENOVESE: Good afternoon, Chairman Lessor and the members of the Committee. My name is Joe Genovese. I represent Arite Used Auto Parts in New Britain, and I am also the Vice President of the Connecticut Auto Recycle Association. I strongly urge that the committee oppose H.B. No. 5176. I believe that it is detrimental to not only the company that I work for, the employees that I employ, but also the consumers here in the State of Connecticut. I was not spearheaded by the aftermarket companies to come here today. It is mainly the language that is in the bill. And the H.B. No. 5176 as proposed is anti-safety, anti-repair and anti-consumer. The H.B. No. 5176 as proposed is anti-safety. The language in the bill gives leeway for the repair facility to decide if a part is safe or not. The bill does not determine what makes a part safe. This in turn will allow the repair facility to refuse any part that he or she does not want to use and call it a safety risk. A new OEM part, which costs significantly more than a used part, it worth more money to a repair facility. For example, if a door costs $2000 dollars verses a used one that costs $400 dollars, the repair facility will make 25 percent above list price. Therefore, the body shop will make $500 dollars off that one part verses $100 dollars from what I am

selling. The repair facilities would like you to believe that it is a safety matter and that they wish to not allow used parts for the first five years of a vehicle life. What happens after five years? My parts are now safe?

H.B. No. 5176 is also anti-repair. When the new OEM part sale is otherwise known as the car manufacturers have no other competition, the price for the parts will go up. Right now, having an alternative, the car manufacturers are forced to keep their prices down in order to compete. The car manufacturers will have a monopoly over the industry. Every day I talk to local body shops about keeping the parts low in order to save the car. When they passed the threshold, the vehicle that was in a car accident is now what the state considers salvaged. What would happen then if the price of the parts increase, more cars would be salvaged, therefore, the body shops will have less work because more cars will be going to the salvage pool, which we won't purchase because we can't sell our parts because they want the five years for not to be able to use my parts.

H.B. No. Bill 5176 is anti-consumer. Costs of the repairs will go up due to the fact that the price of parts will rise because of the monopoly that car manufacturers will now have. The insurance companies will have to pay more money for each repair here in the State of Connecticut. In order for the insurance companies to cover these costs, they will have to increase the cost of insurance. The increase will not only affect the parties that got into a motor vehicle accident, but in a whole, will raise rates on every insured driver in Connecticut. This would be a domino effect on every

consumer in the state. The body shop association would like you to believe that this is pro-consumer. But how is this pro-consumer when the cost of every insured driving will increase?

I also wanted to say that we did try to talk to the Body Shop Association about adding language into the bill that would include recycled OEM parts. We tried to talk them to about it, and it was not included in here. The reason why the recyclers are here today is because that it was not included into the bill. If it is stated into the bill that recycled OEM parts were the same as new OEM parts, then the Connecticut Auto Recycler Association wouldn't have an issue as we have today. Any questions?

SENATOR LESSER (9TH): Thank you for your testimony? Are there? Yes, Senator Bizzarro.

SENATOR BIZZARRO (6TH): Thank you, Mr. Chairman. Mr. Genovese, thank you very much for being here today as a constituent, and I also want to thank you for operating a business in my hometown, New Britain. So, I've been listening to the testimony today and I remember a lot of the testimony from last year too. I'm trying to understand it. It's -- it seems very simple on its face, but I don't know if it's because we seem to have some conflicting testimony or what, but the nature of this topic doesn't seem too complicated. But I am grappling with the issues. Can you -- walk me through a scenario. So, if I hit a snowbank with my Infinity SUV, and I bust the side mirror and I need a new housing assembly for that mirror, and it's got the blind spot and all the new-fangled gadgets here. So, Infinity tells me that that part is going to be,

I don't know, $1000 dollars just for that side mirror.

JOE GENOVESE: If you're lucky.

SENATOR BIZZARRO (6TH): Yeah. So, can you just give me a hypothetical because you talked about the markup that the body shops will typically use when it comes to one type of part as opposed to another. So, walk me through what would happen if I go and I need to get that mirror repaired if the shop does not have access to certain of the parts that people have been testifying to today.

JOE GENOVESE: Okay, so you would walk into your local body shop, let's say New Britain Autobody, and you would go in there and they would call your insurance company up, they would write the estimate up for your part. Depending on the cost of the part and the cost of the repair, the insurance company will choose a part for the body shop. Now, as it stands now, I believe that it's either going to be a new OEM part, a used recycled part, or it's going to be an aftermarket part, and depending on the cost, that's what the insurance company is going to decide which part that the body shop will have to install to that part, and also paint and prep.

SENATOR BIZZARRO (6TH): Okay. And so, there would be -- so what you said earlier in your prepared remarks is that there would be an incentive for the shop to use a part that is intrinsically more expensive because then the markup is higher, right?

JOE GENOVESE: The markup is higher for any -- the markup is going to be higher. The body shops will make more money from using a more expensive part.

SENATOR BIZZARRO (6TH): Which will then be passed along to the consumer either through the insurance, the increase in the insurance premiums, or through direct pay from a consumer that does not have insurance coverage, is that right?

JOE GENOVESE: Correct.

SENATOR BIZZARRO (6TH): Okay. All right, so, and in the current model, the way -- in the perfect world the way it would work is that the repair facilities and the shops would all be incentivized to find the last expensive -- least expensive but, you know, sufficient part to replace whatever is damaged, is that right?

JOE GENOVESE: Used auto parts, yes.

SENATOR BIZZARRO (6TH): Yeah, a used auto part, okay. And so there is -- they are incentivized to be as efficient as possible and so the -- my colleague, the Senator from the 3rd District's point, we're using -- we're recycling material too so we're not buying new material from the manufacturer, is that right?

JOE GENOVESE: Correct.

SENATOR BIZZARRO (6TH): Okay. All right, so, I guess, you know, I appreciate your testimony. I thank you for answering my questions. I have listened to everybody. I mean I remember the testimony from last year. It dawned on me when I started listening today that last year when I heard this, I remember saying to myself, I don't know that there's a problem with the way things are done right now, and I think one of the previous speakers may have made that point, actually, so. Anyway, but thank you very much for answering my questions.

JOE GENOVESE: Thank you.

REP DATHAN (142ND): Is there any other questions? Okay. So, thank you so much for your testimony and waiting this evening. I appreciate it. Next, we have Chris Demunzo, Demirzo, apologies if I got your name wrong. Thank you, Chris.

CHRIS DIMARZIO: Yes, first of all, let me state that I have already spoke, so I don't know if there was a communication thing there, so I would yield to the next speaker, but before I do. [Crosstalk]

REP DATHAN (142ND): Okay. I was going to say, you looked awfully familiar. [laughing]

CHRIS DIMARZIO: Before I do, I would just say, while I have the microphone that I think it's well intentioned what they're trying -- the body shops are stating, but I don't think that what is written here actually says what they're reporting as far as the allowance of used auto parts. It certainly opens the door. If you read it correctly, a specific part can be deemed unsafe and as long as OE manufacturers have repair guidelines that specifically state, they don't believe the use of used parts is recommended, a body shop could fall back on that repair -- on that recommendation and say, OE doesn't want used parts, so that part is unsafe and I want a new one. And that's, I think, where the disconnect is with our industry and the body shop industry.

REP DATHAN (142ND): If you'd like to resubmit your testimony to the website and indicate that in your amendment you could do that if you'd like to.

CHRIS DIMARZIO: Yes, I will add that to my written statement that I forwarded this morning.

REP DATHAN (142ND): Great. Thank you very much. Tom Tucker. All right, thank you very much. Is there anybody else here to speak on H.B. No. 5176, that either didn't sign up or maybe missed their name called earlier? Going once, going twice. Okay. Next, we're going to move on to the H.B. No. 5251, AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH CARE INSURANCE COVERAGE FOR UNDOCUMENTED IMIGRANTS IN THIS STATE. The first speaker we have for this is Tom Swan. I think he did speak on this earlier today. Okay. Next, Rosana G. Feraro.

ROSANA FERARO: Hello Committee Members. Thank you for the opportunity to speak today. I am Rosana Garcia Feraro, Policy and Program Officer at Universal Healthcare Foundation of Connecticut, here in support of H.B. No. 5251. We support H.B. No. 5251 because we believe that health care is a human right and that everyone should have access to quality affordable, equitable health care. There's a persistently high uninsured rate for immigrants in our state. According to the Migration Policy Institute, 30.1 percent of foreign born, noncitizens are uninsured. In the undocumented communities, the uninsured rate is 52 percent. While Connecticut has a relatively low uninsured rate of 5.3 percent, we will never truly achieve 100 percent universal coverage in the state without addressing the needs of our immigrant communities including the undocumented. Currently undocumented immigrants are shut out of public and private health insurance. Medicaid HUSKY covers qualified immigrants, but this does not include the undocumented community nor some other groups of immigrants. In the private market if families want to purchase their own coverage, private health insurance companies require either a

social security card or some other proof of legal status limiting access to the undocumented immigrant community yet again. Undocumented immigrants are also unable to access financial help or purchase plans on the State Exchange.

We support a task force that conducts thoughtful study on these and other issues of immigrants including the undocumented facing receiving health insurance coverage and care and offer some recommendations to ensure the task force is equipped to address the issue.

We'd like to expand the scope of the task force study to include all immigrants who are ineligible for health insurance due to their immigration status and the scope of the task force should be broad enough to include exploring options for covering undocumented immigrants and other immigrants who are currently ineligible for private and public programs in the state by covering them through private and public insurance programs such as HUSKY A, B, C, and D. Those most impacted by this issue, the undocumented and other immigrant communities should be included in the composition of this task force. We recommend that a representative from an Immigrant Rights Advocacy organization and a representative from a health care advocacy organization sit on the task force. And that's my testimony today.

REP DATHAN (142ND): Great. Thank you so much. Is there any questions on this? I just have one question for you. I think one thing that we need to ensure is addressing affordability of insurance and what kind of plan. In your experience in with working with people in this community, what do you -- what do you think -- I mean, the costs are really

high, you know, are people going to be able to afford to buy health care coverage?

ROSANA FERRARO: That is part of the reason why we hope that there will be an exploration of expanding Medicaid programs because there's somebody who's coming after me who has a better idea of sort of the income breakdown of the undocumented community in the state. But, I think expanding -- affordability is a concern and that's why looking at expanding Medicaid programs is one thing I think the task force should do, as well as considering there may be families that would be able to afford health insurance on the private market. Maybe the task force should also consider subsidies for the private market as well for immigrant communities. That might be another area they could explore.

REP DATHAN (142ND): Okay, great thank you. Oh, wait, we have one question here from Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much. Thank you, Madame Chair. Thank you for your testimony. We are living in interesting times and right now, well we're living in interesting times. Having said that, I'm looking at this bill and this bill has pretty standard process of who are the different people who are going to appointment people on this taskforce. And this depends sometimes on who knows who and they get into the task force and you're looking at a very critical moral and as well as scientific and a strategic, and financial and health care-based decision. And I'm just worried about how this bill reads at this point, which basically is saying that such and such leadership is going to appoint whoever they will choose, and it's almost a weak list about a task force without the depth of

knowledge that is needed to address this very real issue which has a moral part to it as well as a financial part to it. So, have you looked at it from that perspective and how it's?

ROSANA FERRARO: Yes. That is part of the reason why we think somebody from an immigrant's rights organization should be at the table and a health care advocacy organization should be at the table. I don't know really how quite to rework the language, but potentially to make sure that the expertise that is on the task force is what's necessary to really and truly explore this critical issue. So, I'm not sure how you would rewrite the bill or change the language, but perhaps, somebody with expertise in health insurance coverage and with expertise on Medicaid programs, those sorts of people I think would be a really added value to this taskforce.

SENATOR ANWAR (3RD): Yeah, again, I've not been at the ground floor of this vision that's trying to be implemented here, but I am having concerned feelings about this bill in the current form. While we need taskforce, your task force is only as good as the people on the task force and the way this is made is based on five or six people for a very important issue who are not being -- it's almost like you're saying I'm going to appoint somebody who's going to make a car, and a policy around a care. It's like, no, you need an expert on hat area to be able to do this and there's nothing in this bill that says that there are going to be people who are going to have a specific capacity to be able to make those decisions. And, I'm worried about how this is going to be made up and I'm worried about what they're going to tell us, and then we will be using the

information of the task force to be misinformed and misguided and then God forbid, come up with bills which would not necessarily address the problem. I'm chairing the Federally Qualified Health Care Centers, there are many across the State of Connecticut. They're the ones who are first-line in providing some of this. You actually sit down with 15 or 16 CEOs of those companies and then the health care center and in about two hours you will know what to do. And I'm not sure if we -- because across the entire state, they're the ones providing the care right now and we would not necessarily need a bill and then have these appointments to create a report.

But I just wanted to put my thoughts out there [laughing] as my concern about this, but at the same time, I can understand where it may be coming from, but I'm not sure it's in its full form yet.

ROSANA FERRARO: I share your concerns about making sure that there's expertise on the task force to really inform this issue. I agree, like the Federally Qualified Health Centers are absolutely on the front lines of this issue and should probably also have representation on the taskforce. I think the task force gives people, the public at least, an opportunity to participate in the process, which I think is valuable. And I think, for example, the high deductible health plan task force that was meeting this past year, at the foundation we certainly submitted testimony and observed the taskforce, and you know, gave public comment and I think a taskforce, that's one of the bonuses of having a task force is the ability to really bring in the public and hear stories and all of that. So,

that's why I would lean towards a taskforce, but I share your concerns about expertise.

REP DATHAN (142ND): Thank you very much. Senator Anwar and I know that's one of the things that we are addressing in the bill and one of the reasons it's so great to have your voice heard here in public hearing. So, thank you so much for your input. Hopefully we will get this over the finish line, and we'll be able to see -- to see it come to fruition. Thank you very much for your testimony.

ROSANO FERRARO: Thank you very much for your time.

REP DATHAN (142ND): Sure. Next, we have Jonathan Gonzalez Cruz.

JONATHAN GONZALEZ CRUZ: Good afternoon, oh, it's 7 o'clock, sorry, [laughing] Good afternoon, my name is Jonathan Gonzalez Cruz, I am the Policy Coordinator at Connecticut Students for Dream, a statewide organization that fights for the rights of immigrants and today we are here in support of H.B. No. 5251, AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR UNDOCUMENTED IMMIGRANTS IN THE STATE. In Connecticut, there are approximately 187,000 uninsured individuals, roughly 5.3 percent of the state. Although that percentage is low compared to other states, they are reported by the Migrant Policy Institute so it's a dramatically higher uninsured rate among immigrant communities in Connecticut. Noncitizen immigrants such at Green Card holders have a 30 percent uninsured rate or about one in three people. That percentage jumps to 52 percent uninsured rate in the undocumented community, meaning that one in two undocumented immigrants are uninsured in this state.

Consequently, immigrants compose about a third of the uninsured rate in this state. As such, establishing a task force to study health insurance for immigrants is imperative as the states seeks to help reduce the coverage gap. In order for the task force to be effective, we recommend there be two areas of study. The first one is opening HUSKY coverage for immigrants regardless of status and increasing access to private health insurance.

According to the Migrant Policy Institute, approximately 32,000 undocumented immigrants in Connecticut earn less than 150 percent below the federal poverty level and should quality for HUSKY coverage based on income guidelines. However, because they are not qualifying immigrants, they cannot receive -- they are unable to.

Considering undocumented immigrants contribute $145 million in state and local taxes each year, according to a New American Economy report, the task force should study how to expand HUSKY for immigrants too. However, another area of study should also be in the private insurance market. Siting the data from the MPI again, "Approximately 55,000 undocumented immigrants earn 200 percent above the federal poverty level. In turn, these undocumented immigrants would earn a bit too much should HUSKY be expanded. As such, they would need to purchase private insurance, however, some insurers, such as ConnectiCare require either a social security number or proof of status. Consequently, this creates a barrier since currently those individuals couldn't simply go to Access CT and buy a qualified health care plan. Once again, due to their status.

To summarize, the immigrant communities in Connecticut have a dramatically high uninsured rate and as such, the task force should study both public and private sector means to increase coverage for immigrants in the state. In terms of the composition of the task force itself, we strongly do recommend that there is a representative from the Immigrant Rights Community either from Connecticut Student's For a Dream, Make the Road or Connecticut Immigrants Rights Alliance, and as well as a representative from the Health Care Advocacy community either from Planned Parenthood, Universal Health Care Foundation or Health Equity Solutions.

Thank you for your time and we strongly hope that you approve this taskforce.

REP DATHAN (142ND): Thank you very much, Jonathan for your testimony. Representative Hughes.

REP HUGHES (135TH): Thank you, Madam Chair. Yeah, I remember last year you testifying as well. Did we have numbers, and I might have missed it in last year we actually were looking at including in HUSKY, maybe in front of Human Services, right? And I remember 76,000, is that right? In terms of numbers of what we were looking at, do you remember?

REP DATHAN (142ND): I don't remember numbers.

REP HUGHES (135TH): Yeah, but do you know how many we're looking at that are -- that would be included in HUSKY the numbers wise for Connecticut? I don't remember.

JONATHAN GONZALEZ CRUZ: In terms of HUSKY, that would be simply for children, I believe the number is around 11,000, which is based off the Connecticut Children's Center for Advocacy reports that they did

when they had a bill to extend HUSKY before undocumented children.

REP HUGHES (135TH): Okay, so 11,000 children.

JONATHAN GONZALEZ CRUZ: Around that.

REP HUGHES (135TH): Yeah, so, I think the whole community we were looking at may be 70,000 and you said something about how much were contributing to state and local taxes. And then we were trying to cost out how much [laughing] that would be. But that's something I think that this task force is trying to grapple with is like look at solutions and numbers and costs, and savings. Especially from emergency room visits.

JONATHAN GONZALEZ CRUZ: In terms of the income guidelines for HUSKY, about -- between 32,000 and 46,000 individuals fall under the 200% poverty level, but because they're not exactly matched up with HUSKY guidelines, we could only estimate that range. But definitively, there are about 32,000 undocumented immigrants who make below $150,000 and all of them should qualify for HUSKY.

REP HUGHES (135TH): Got it, okay. Thank you, that helps clarify. And also, the language seems to be vague enough that we could still make recommendations about including some of the stakeholders that you -- that you mentioned with firsthand impact, you know, experience about what -- what the -- the fallout of not having health insurance coverage, and that's why not just the federal documented health centers, but also what happens when people don't go to those centers and go underground with their health needs, especially with communicable disease.

JONATHAN GONZALEZ CRUZ: Exactly. And in terms of a composition of the taskforce, all of the different organizations that we are recommended were all part of a coalition that is fighting to expand health insurance for immigrants in the state and we have been starting to work a health economist to help us to figure out the cost analysis of expanding HUSKY.

REP HUGHES (135TH): Wonderful.

JONATHAN GONZALEZ CRUZ: So, that's why we recommend that somebody be represented in the taskforce.

REP HUGHES (135TH): Thank you.

REP DATHAN (142ND): All right, thank you representative. Any other questions? Jonathan, I had one question for you -- or two actually. Do you have any data on how much undocumented people are using emergency room services and other health care services in the state that insurance would typically cover that either they are paying out of pocket for or too, that the hospitals are having to cover?

JONATHAN GONZALEZ CRUZ: In truth, I don't have that specific data, but I could try to find it and follow back with you.

REP DATHAN (142ND): Okay, that's great. Secondly, do you -- are you aware of any other states in the country that offer insurance -- the ability to purchase insurance if you're undocumented? And which states are they?

JONATHAN GONZALEZ CRUZ: Yes. The most prime example is California. They initially expanded their version of HUSKY, which is call MediCal for undocumented children first, and I think that they have since increased it to anyone under 25 and they

are currently trying to also include senior citizens in that. So that's the one that I can think of right now.

REP DATHAN (142ND): Great, thank you very much. Any other questions? All right, thank you.

JONATHAN GONZALEZ CRUZ: Thank you.

REP DATHAN (142ND): Next on the list we have Alisen Martinez.

ALISEN MARTINEZ: Hi, good evening members of the Committee, Madam Co-Chair, I'm Alisen and I'm here in support of H.B. No. 5251, AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR UNDOCUMENTED IMMIGRANTS. I, in April of this year, will have been 22 years in this country and I am undocumented. I do have a work permit I renew every two years under the Deferred Action for Childhood Arrivals Program. I currently work as a clinic assistance at Planned Parenthood and I'm a student at UCONN. Our immigration status and I'm here also to represent my family. I came to this country with my mom and dad, and I want to talk to you about our immigration status and how that affected being uninsured. So, we don't quality for health care and it's normalized neglecting our overall health and I see the impact that has made most recently on my mom.

Whew, okay, she's a woman who has always been the rock for our family and one of those people that could never stay still especially when it comes to helping people and dogs. She has a very soft spot for dogs [laughing]. Since August, my mom has been in and out of the emergency room and doctor's offices. Recently she was diagnosed with different

things. During the testimony, I don't feel comfortable saying it in front of everyone, but next week she has an appointment where she will be tested for lymphoma, by an oncologist, which is a doctor for stomach cancer. At her revisit, her doctors are hoping we answer yes to having health insurance to cover all her visits and every time we say no, my heart breaks because I am afraid that because we are unable to pay for her procedures, it will lead to her death. I don't have any siblings which adds to the pressure of making sure she can afford her health care costs. Being my mom's caregiver while she is sick is a no brainer and I enjoy helping her, but I know that things would be a lot easier if our family could quality for health care insurance.

Passing H.B. No. 5251 would allow more immigrant families to feel encouraged to partake in preventative care visits and would decrease the chances of chronic illnesses in the future.

I have seen it firsthand at my job when patients come in for their annual women's health visits that are little to no cost to them. This is thanks to State funding that Connecticut received after the Federal Government cut Title X money from Planned Parenthood. Similarly, at my job I'm always so glad when patients qualify for the 45-day insurance coverage under HUSKY. I love seeing how comfortable -- how much more comfortable they feel when they can come in for visits, especially after -- because they won't then have to worry about costs.

Connecticut has a chance of doing the right thing in giving immigrant families the same satisfaction by expanding health care to us. The creation of a task force made up of immigrants ready to improve our

state's public health speaks to wanting Connecticut that is a welcoming and inclusive -- and inclusive of everyone regardless of their immigration status. Personally, it will help me believe that immigrants are not just valued for their labor but that we also matter because we're people. I support this bill, H.B. No. 5251 and I hope the committee will vote favorably. Thank you.

REP DATHAN (142ND): Thank you very much for your testimony. Does anybody have any questions? I mean, one question I had, is being a student at UCONN, I know a lot of university students are able to get insurance through the university. Assuming that would be the case if you would go for that in the future? Would that be something that you would like to partake in? Because generally, those sorts of university insurance plans tend to be a bit more cost effective for a young student.

ALISEN MARTINEZ: I think earlier data was mentioned about living under the poverty line when you're undocumented and the insurance is very expensive and you have to be a full-time student, so you have to pay tuition has a full-time student to qualify for that insurance.

REP DATHAN (142ND): Got it. Okay. Thank you so much for your testimony. Have a good evening.

ALISEN MARTINEZ: Thank you. You too.

REP DATHAN (142ND): Next, we have Katherine Villeda.

KATHERINE VILLEDA: Dear Senator Lessor, Representative Scallion and Honorable Members of the Insurance and Real Estate Committee. My name is Katherine Villeda and I am a community organizer of

Planned Parenthood of Southern New England testifying in support of raised bill H.B. No. 5251, AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR UNDOCUMENTED IMMIGRANTS IN THE state. Planned Parenthood of Southern New England serves over 68,000 patients yearly for reproductive and sexual health services in 16 health services across the state. At Planned Parenthood, we believe everyone in Connecticut deserves access to quality health care as a basic human right regardless of income, insurance or immigration status.

With roughly 120,000 estimated undocumented immigrants residing in our state and approximately 52 percent being uninsured, this is a public health concern. H.B. No. 5251 seeks to better understand the necessary steps needed to promote and increase health care coverage for undocumented immigrants. Access to preventative care will lead to better health outcomes for people, communities and our overall state. Preventative health care coverage not only keeps people healthier, contributes to public health outcomes we all want but it also saves public and personal dollars at the same time.

However, we urge the committee to ensure that this task force not only study health insurance coverage for undocumented immigrants but to also study other immigrant populations that are also vulnerable to high uninsured rates because of their immigration status such as legal permanent residents who have lived here for less than five years. And as a daughter of formerly undocumented parents, this is also a personal issue to me as access to health care has always been difficult for them.

People who are denied health care coverage because of their immigration status depend on health care providers like Planned Parenthood who will provide them affordable basic, primary, and preventative health care. Yet, threats to accessing reproductive health care at community health centers at Planned Parenthood because of policies like the Title X gag rule make it more difficult for immigrants to access health care. Undocumented immigrants in our stay pay roughly $145 million dollars into state and local taxes every year. Undocumented taxpayers or funding health -- health care programs our residents use but due to their status, are unable to access any health programs. They deserve an equal and fair opportunity to access the very safety nets that they help fund.

No-one's health should be compromised should be compromised because of their immigration status. We strongly support H.B. No. 5251 and hope the committee and Connecticut law makers will vote favorably to ensure that all people will have access to health care, a fundamental human right that should be guaranteed for all people in our state. Thank you.

REP DATHAN (142ND): Thank you very much for your testimony. Does anybody have any questions? Nope, good job. Thank you. Next, we have Mary Elizabeth Smith. Okay. Is Maureen Welsh available? Maureen Welsh? No, okay. Mackenzie Baysinger? Mackenzie Baysinger? Okay. Camila Bortolleto? I saw her a second ago. There she is.

CAMILA BORTOLLETO: Hello Committee Members, and good evening. I know it's been a long day. My name is Camila Bortolleto, I live in Brookfield,

Connecticut and I'm a founder and leader of Connecticut Students for a Dream, which is an organization that fights for rights for undocumented youth and families. Today, I am here to stand in support of H.B. No. 5251, AN ACTIVE ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR UNDOCUMENTED IMMIGRANTS IN THIS STATE. This issue is very personally important to me. Like several of the speakers that have gone, I'm an immigrant myself, I'm undocumented. I came here from Brazil with my parents when I was nine years old. But I grew up here and I consider it my home. Access to health care as a child and teenager growing up was always a haphazard affair. My parents didn't have health insurance, I didn't have health insurance. So, getting care was the mix of getting to school nurses, long lines at the community health clinic, and emergency rooms more often than not.

Now, I'm privileged enough to have good health insurance. I have DACA, Deferred Action for Childhood Arrivals, and through that I'm able to get employment and I'm able to get a job and get health coverage through my employers. However, most immigrant families are not that lucky. Most people do not have DACA and do not have a work permit, so they cannot get health insurance through their jobs. My parents are undocumented, and you know, my parents are in the same boat.

This presents a lot of undocumented families from being able to get health insurance because they don't qualify for Access Health CT, and we don't qualify for the HUSKY program, and private health insurance is too expensive to be able to buy which is why I support H.B. No. 5251 to create a task force to study health care access as a first step to

address some of the disparity that happens with immigrant communities and undocumented folks.

I'm also speaking on behalf of Connecticut Students for a Dream and asking the committee to consider the task force to study both access to private health insurance but also access to HUSKY and other program in Connecticut so that undocumented people can have a fuller range of health access.

And second, I am also asking that in addition to including, you know, legislatures and experts in the task force, will you also include members of the immigrant community and members of the health care advocacy community as well in order to provide that side of the expertise of to the task force.

Just to end, access to health care should not be a commodity only for the wealthy and privileged, it should be a human right and everyone should be able to access health care and not be denied or face obstacles in trying to get access to the care they need. Thank you, and I urge to support H.B. No. 5251.

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

REP HUGHES (135TH): I'll just ask one. Thank you again for coming before this committee. If you could, you know, recommend from your experience right now, what would that access as a human right look like for everyone including the undocumented community? What would that look like, what would you recommend if you were in that task force right now?

CAMILA BORTOLLETO: That might be beyond the scope of the committee. I would recommend a universal health care or Medicare for all. I know that's not in your scope of power right here. But I think having access to the current HUSKY program of Connecticut, I think that's a realistic thing that can be done.

REP HUGHES (135TH): Great. Thank you very much.

REP DATHAN (142ND): Thank you very much, Representative. Thank you very much Camila. Next, we have Brigith Rivera.

BRIGITH RIVERA: Hello. My name is Brigith Rivera [inaudible - 07:44:16], and I just want to say that. A personal background, I am -- I am undocumented and I am a UCONN student currently, and I support the H.B. No. 5251 bill because it would -- a personal story is that I know that my father works in construction and it's a very labor intensive job so that has led to my mother personally having to maintain the household with her income, and given how many jobs she works now it is only a matter of time before she personally develops some kind of issue health-wise that would then require me, myself, to leave school, so it is important to acknowledge the intertwined issues that having access to health care would provide to undocumented folks. If I do leave school, if health care is being provided to undocumented people, that would provide more opportunities for them to seek a better outcome for their lives. And having the act being past, it would be a steppingstone to having a long-term effect of having undocumented people have health care and the task force of course should study all individuals who are undocumented and

ineligible for HUSKY. And it is important because undocumented people are counted in the population to have representatives in the U.S. households, so if they're being counted in the population, their issues need to be addressed and it's time that their voices need to be heard. Thank you.

REP DATHAN (142ND): Thank you very much for your testimony. Is there any questions? All right, thank you so much. You have a good evening.

BRIGITH RIVERA: Have a good day.

REP DATHAN (142ND): Thanks. Next, we have Alok Bhatt. And apologies if I got your name completely wrong. You can just correct me when you get to the mike, thank you very much.

ALOK BHATT: Good evening members of the Insurance and Real Estate Committee, my name is Alok Bhatt I'm the Community Defense Coordinator for the Connecticut Immigrant Rights Alliance or CIRA. And CIRA is a grass-roots state-wide coalition of different migrant justice organizations around the state, many of whom are included and represented here beside me. And CIRA is here to testify in support of H.B. No. 5251 regarding the task force to study health care coverage for undocumented folks. And really, we just want to emphasize and reinforce a lot of what -- a lot of what our colleagues and comrades have already expressed to the committee. In lieu of a substantive bill that would actually create some sort of channel of access for undocumented folks, we do feel like a task force would help collect some of the necessary data and insights that, together with the community and state law makers and other experts that we hope will populate this task force as Dr. Anwar mentioned. We

really take his point to heart that we really feel like the community and relevant experts are critical to any study and then again, in the following year advancing any sort of proposal to open up health care access, not just for undocumented individuals and families but also all noncitizens of the State of Connecticut, because as has been expressed by some of our colleagues and comrades, all noncitizens face systematic and systemic barriers to health care -- health care access. We really feel like in order to achieve some of the total population health outcomes and to really address some of the health care and health coverage disparities that exist in our state, and that all disproportionally impact people of color and considering that within the immigrant community, these sort of disparities become compounded, we really feel like this is a critical effort to make sure that all residents of our state have an opportunity to be -- to be healthy and happy and that our state is not systematically discriminating against any of our residents, and therefore, compromising the total health of our entire population by allowing barriers to health care access and health care to exist.

So, we look forward to hopefully working with our state lawmakers to find ways to compose a very effective task force and we look forward to continuing to work with you all in upcoming sessions to find substantive ways that we could open up health access and really start to address inequities in our health care system and our population. Thank you.

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

REP HUGHES (135TH): Yes, thank you, Madam Chair. Just the same question. If you were already in the task force, then and bringing all of this experience, what would your recommendations to the legislature be?

ALOK BHATT: I think as far as like in our capacity as a State Government, I think opening up -- taking any steps we can to open up HUSKY but also opening up Access Health to undocumented folks, and also removing the current -- I think there's some -- some residency based time barriers. I think removing some of those -- well removing all the barriers to health access. I mean, I think, everyone, every individual in this state should have health access.

REP HUGHES (135TH): And just one more question. Do you know of any folks that are also suffering with lack of access to insulin who are Type 1 diabetics in your community?

ALOK BHATT: I do. I do, and I know all kinds of folks who are suffering from all sorts of really severe -- of really severe ailments and have not been able to afford the care they need. Many of whom I know personally, and so, this is something that hits really close to home for myself and my community and really for everyone in our state.

REP HUGHES (135TH): Thank you.

REP DATHAN (142ND): Thank you very much, Representative. Thanks so much for your testimony. Thank you very much for your testimony, have a good evening. Next, we have Camille Kritzmen. My apologies if I mispronounced your last name. If you can go ahead and correct me, I'd appreciate it. Can you please turn on your mic? [background laughing]

CAMILLE KRITZMEN: Sorry. [laughing] Good evening Members of the Insurance and Real Estate Committee. My name is Camille Kritzmen, I'm a case manager at IRIS which stands for Integrated Refugee and Immigrant Services in New Haven, Connecticut. Most of the people I work with are undocumented, asylum seekers, and asylees and legal permanent residents.

This testimony is in favor of H.B. No. 5251. For many of my clients, health care is their most important issue and the one that causes the most stress. I urge you to pass this pass this bill to begin doing the work to get health insurance coverage for all Connecticut residents regardless of immigration status.

The majority of the people I work for are uninsured. My clients have thousands of dollars in medical bills or chronic medical needs that they have been putting off because they're unable to pay. This goes for both undocumented clients and legal permanent residents who have not had status for the past five years.

I'm going to share three stories with the permission from my clients of cases that illustrate the danger and stress that comes from being uninsured.

A single mother who has severe vaginal bleeding went to an emergency room where she was told to find a primary care doctor. She then went from clinic to clinic while bleeding seeking someone who could help her. In the free clinic, she was told she had to complete a lengthy application for free care, get approved and then she would have an appointment in a few months.

A family of five, the father has AIDs and as the father's health gets worse, the family relies on independent, non-for-profit to access treatment. Despite the assistance that drops the price for medication, every week the family has to decide between purchasing food for their three children or buying medication for the father.

A single mother of three, the 33-year-old son is deaf, blind and mute. He needs brain surgery. Since coming to the United States 30 years ago, he hasn't been able to get any care. But the surgery is too expensive for the family to afford. His health continues to deteriorate. The mother has to stay home and care for her son while her two teenage daughters work to support the family.

I'm sharing these stories to demonstrate that this is a matter of life or death for so many in this state. It's extremely urgent and it's an issue that, as a case manager, it wasn't originally in my job description, but it's an issue that I deal with every day.

These might be extreme cases, but like I said, all my clients have a story of themselves or somebody in their family who have this situation. Since they are unable to afford primary care doctors, when an urgent health issue arises, most clients go to the emergency room causing them unnecessary use of emergency resources. So, this bill presents a unique opportunity to study and suggest ways that the State of Connecticut can increase access to health care coverage. And the task force, as others have stated today, the task force should include members of the immigrant community and those most impacted -- who would be most impacted by this

policy. This would ensure that the experiences and the voices of those living the reality of being uninsured are included.

I would like to also suggest that the same groups that have been suggested previously, Connecticut Rights Allian -- Immigrants Rights Alliance, Make The Road Connecticut, Connecticut Students for a Dream, and also organizations that have already been providing some of this coverage including Planned Parenthood, Connecticut Voice for Children, Universal Health Care Foundation, and Health Equity Solutions.

REP DATHAN (142ND): Thank you very much for your testimony. Is there any questions? All right, thank you so much for staying. Is there anybody else that would like to speak on H.B. No. 5251? All right, we will move on to the last bill of the evening. Oh wait, the penultimate bill of the evening. Apologies. H.B. No. 5252, AN ACT PROHIBITING CERTAIN VEHICLE STORAGE AGREEMENTS AS A PRECONDITION TO VEHICLE TOWING. First on the list we have, James Modzelewski. And apologies if I mispronounced your name. I lived in Poland for six months, so, I'm usually not too bad at these. So, if you could just correct me for the record. Thank you.

JAMES MODZELEWSKI: Good evening, Members of the Insurance and Real Estate Committee. My name is James Modzelewski, I'm from Modzelewski's Recovery, Repair, Towing body shop. We run about five locations in the Western District of Connecticut. I am not in agreeance with the proposed H.B. No. 5252. First of all, it's a little confusing. To prohibit owners or opera -- or excuse me, to prohibit owners

and operators of a wrecker service to not have a vehicle -- or excuse me have a vehicle contract signed prior to towing -- pre-towing conditions. Our industry standard practice in our industry is nothing is even comprehended or spoke about until the vehicle is deposited into our storage facility. I submitted a written testimony in regards to this bill.

We don't force any vehicle owner to sign any documents until they are fully aware of, obviously, their choices and to explore other options they may. The issue we have and the issue that is continued that we have is the State of Connecticut has us tied down as far as the approved storage rates from the Department of Motor Vehicles. We're regulated every day by the Department of Motor Vehicles for nonconsensual towing and we feel that this -- this bill cannot be passed, and it pretty much indicates that we cannot interact with the vehicle owner and their choice of their vehicle. The steps that take place during a vehicle tow is whether the owner of the vehicle calls us, the police department calls us, law enfor -- any law enforcement calls us, we are required to remove the vehicle from the roadway, the problem again I see this is that the insurance companies are moving forward to try to limit our compensation and obviously our livelihood to benefit them.

It does not drive up profits as they stated in their testimony -- their written testimony. What drives up profits is the insurance companies not coming out to look at the vehicles within 24 hours. I can count on my one hand how many times the insurance companies have come out within 24 hours. Sometimes it's 48, sometimes it's a week, sometimes they don't

come out for two weeks, until they understand the at-fault party. So, the 24-hour is a little excessive in regards to holding our companies, I speak for myself, hostage as far as not paying us for 24 hours. I feel it's inaccurate and it's another way for the insurance companies to take the general public, and the consumer and bring them to their approved facilities for repairs. I have no further. Questions?

REP DATHAN (142ND): Great. So, on average, how many days would you guess that it takes for insurance adjustors to come out and inspect. I tell all of our customers that come through our door anywhere from 48 to 72 hours. That's the standard practice of the insurance companies. Sometimes they don't come out for weeks. I have a vehicle that we -- just a quick scenario, we towed last Tuesday, and the insurance company still has not called. So, they're trying to tell us 24 hours is unnecessary, which, how is that unnecessary, they haven't even called us? So, that's our oppose to this bill, that they want us to filter us into a corner and then, you know and not come out. And then, the biggest problem we're having too is the insurance companies telling the consumer to remove their vehicle from our storage facility at a certain date or they will not pay for storage. And obviously, we have vehicles that have been dumped at our storage facility because the insurance company feels that they're not paying no more. We have, you know, we get in -- excuse me, every day we get letters from the insurance company stating that there is a storage cutoff date, it's a standard practice that they send, after a certain date, we are not paying for the storage and then it goes into the consumer's

lap and then they have to deal with it. So, I feel that it's just another way of the insurance company to limit our ways of making a profit in the state. Obviously, it's -- we all know what time it is, we've been here since noon, so, thank you for your time. Any other questions?

REP DATHAN (142ND): I have -- you go ahead, Representative Hughes.

REP HUGHES (135TH): [laughing] Thank you, Madam Chair. So, what in your experience, would be the solution here? I gather that this act is solving both from the consumer who's stuck, they've just had an accident, like they have no idea the process, and from you the tower, like how could we -- what would the solution look like?

JAMES MODZELEWSKI: That's why it's confusing to us because the -- they put in the language, AN ACT PROHIBITING CERTAIN VEHICLE STORAGE AGREEMENTS AS A PRECONDITION TO VEHICLE TOWING. So, you know, I don't know exactly what direction they're trying to go in, but our, like I said, our general industry practices if a consumer gets into an accident, our main focus is obviously to get them to the next step. Obviously, they have to seek help, they have to get a rental car, they need to get perishable items maybe out of the car. They have to get the essentials out of their car, medication, and obviously, we have to be available 24 hours. So, if you -- if somebody gets into an accident at 7:00 right now at night, and they go to the hospital and then the next day is, in the morning, they come down, they pick up their stuff, and the insurance company is saying that within 24 hours, so 7:30 tomorrow night, they have to make a decision. I

can't make a decision 24 hours after I get into an accident. I'm distraught, I have to figure it out. I'm talking on a consumer standpoint now. Obviously, we all pay vehicle insurance, and again, I just feel it's another lever for the insurance company to predict what they're going to do to the consumer.

REP HUGHES (135TH): So, what would an overnight storage cost look like for --

JAMES MODZELEWSKI: An overnight storage costs, on a nonconsensual tow is $26 dollars a day. I just researched, prior to coming up here, that to park a car in the City of Hartford is $2 an hour. So, 24 hours is $48 bucks to park my car and they -- what's the overhead they have? So, $48 dollars and we're getting $26 dollars a day, so, I wasn't forced to come here today. I have a choice to come here today. So, the point of them forcing or telling the consumer, that us, the towers are forcing them to sign an agreed contract is inaccurate. So the solution to be would obviously be what it is now, the consumer has the right to choose where they want to bring their vehicle, whether they want to leave it at my facility, whether they want to bring it to this guy's facility, or her facility. They have the choice to do it. Who is the insurance company to say to them where they have to bring their car or pick their car or so on and so forth? I don't like someone telling me where I have to bring my personal belongings.

REP HUGHES (135TH): And I guess the only other question I have is, would you require a contract for less than 24 hours storage or does that not make any sense?

JAMES MODZELEWSKI: The law states on DMV is the first eight hours the vehicles is deposited into our storage facility. So, the first eight hours, we're allowed to charge one day of storage. So, you know, 24 hours is not accurate to make a decision. I mean, we have multiple -- there's police holds on vehicles so, you know, we can't touch the vehicle until they tell us it's okay to touch. I mean investigations, there's so many variables that we can't be held accountable for 24 hours. It's just impossible.

REP HUGHES (135TH): And my final question. Do you know how other states have resolved this? I'm just wondering.

JAMES MODZELEWSKI: I don't think I -- to my knowledge, I don't think there is, you know, an act or a bill that proposed in this aspect and how the language is driven to certain vehicle storage agreements. We all have choices. If we bring a vehicle to anybody's property, okay, we can't just leave it there, and obviously, you know, we're entitled to storage money. We pay property taxes, we pay, you know truck taxes. There's so many variables that we pay as -- as, you know, business owners, that it's almost impossible to, you know -- we rely on the storage money because obviously that helps us pay for our property taxes. I mean the mill rates and -- in all different towns. You know you take mil nate -- excuse me a mill rate from Greenwich compared to mill rate in North Canaan, okay, so it's a big gap and we get the same rate. I'm talking about storage, we get the same rate for that storage. If I park my car in downtown Stanford, I can guarantee it's a lot more than obviously in Danbury where I live. No one

prohibits, you know, parking garages, you can only charge X amount per hour, so why is the insurance company telling us what we can and can't do.

REP HUGHES (135TH): Thank you.

JAMES MODZELEWSKI: Thank you.

REP DATHAN (142ND): Representative Pavalock D'Amato.

REP PAVALOCK-D'AMOTO (77TH): Thank you. So, this bill, can you just clarify it for me. The bill is restricting you. Who's asking what to do what? I mean, I'm very confused. [laughing]

JAMES MODZELEWSKI: So, how I understand the bill is the Insurance Association of Connecticut submitted the testimony in regards to prohibiting certain vehicle storage agreements. So, in a nutshell what it comes down to is that they're trying to force towers to not interact with the vehicle owners until after the vehicle is deposited into the storage facility. So, for instance, if somebody gets into an accident, I can't say to that -- him or her -- person, would you like me to bring your car to a repair facility. Would you like me to get you a rent-a-car? They want no interaction and state laws also prohibit us, and we can't just work on someone's car. We have to have written authorization. So, there again, we have to have your consent to your, you know, to your vehicle to work on it or touch it. It just doesn't -- you can't just work on the vehicle.

REP PAVALOCK-D'AMOTO (77TH): And you already testified I believe that there is no contract signed between -- because it seems to be stopping the

vehicle owner from signing a contract with you. There's no contract signed?

JAMES MODZELEWSKI: Well, there's a contract -- if we're repairing the vehicle, we have to have a written contract.

REP PAVALOCK-D'AMOTO (77TH): But without repair, though, just towing.

JAMES MODZELEWSKI: There's no -- what contract is there? I mean, we're towing the vehicle in the same pre-condition, which is -- what is pre-condition? That's what we're confused on. What, you know, is it halfway to our shop and say, hey, Mrs. Smith, would you like us to repair your vehicle? Well, what they're putting in this, is that we can't interact with Mrs. Smith until the tow is completed, pre-conditioned. So that's where this bill can't -- it can't go through. It's going to obviously limit further on with our industry and take the profits that we use every day to survive and just start taking that away. It's impossible, it can't go through.

REP PAVALOCK-D'AMOTO (77TH): The current contract would be between the car owner and the insurance company.

JAMES MODZELEWSKI: No, the contract is between us and the car owner.

REP PAVALOCK-D'AMOTO (77TH): But I mean as far as what's covered. If they're going to cover certain days -- amount of days of it being stored, that's between the car owner because they have the insurance policy with the company.

JAMES MODZELEWSKI: If there's no insurance, the consumer still has to pay for that -- for the storage.

REP PAVALOCK-D'AMOTO (77TH): Right. But I'm saying for the purposes of like the situation that you provided earlier. I'm dealing with this exact situation with a client right now, and the insurance company, you're right, more than a week before they even came out. So -- almost two weeks. So I don't know what good 24 hours I guess in that situation, but also, it was, you know, there's going to be a difference between whether it's the person's own insurance company or let's say if the other person is at fault, their insurance company. So, there's different variables that we're dealing with that aren't contemplated in this, and I don't think this bill covers.

JAMES MODZELEWSKI: It doesn't. There's no concrete foundation in regards to this and it just -- it comes down to, it's very sporadic at how they introduced and presented the evidence with the written testimony they had to you folks. It's very -- it doesn't make sense to me and I'm explained to you on how our practices go forward and, you know, if someone else is at fault, that other person's insurance company is not coming until they understand who's at fault. I've had cars sit for two to three weeks, even further.

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

JAMES MODZELEWSKI: Thank you.

REP DATHAN (142ND): So, just one point of clarification, I know you've been here for a long time, I'm really sorry. If cars are parked

illegally, you are -- there's usually a sign in like a lot, let's say somebody parks illegally. It says, you know, trucks will be towed by the Modzelewski Towing Company and so that is an unwritten contract. As -- if somebody oversteps their -- parks too long, you tow the car and then they have to pay you the $24 bucks or $26 bucks you said for each 24 hours that they're there, and that's mandated by the state, right? Which protects the consumer, right?

JAMES MODZELEWSKI: Right, that's what protects the consumers. So, if you get a vehicle -- if you're parked illegally on the streets of Hartford here and a company comes out and tows your vehicle, the consumer is protected with that storage rate.

REP DATHAN (142ND): So, by the same token, it's -- let's say I'm on Merritt Parkway and I have an accident, God forbid, and I'm unconscious and I get taken away in an ambulance, your towing company comes, picks up the car, I'm not able to give you consent to tow the car, but presumably there's some sort of agreement that, you know, in order for safety of other drives on Merritt Parkway that you are able to tow those cars, and presumably the insurance company would agree with you that rate without my express agreement that you are able to tow the car, is that correct?

JAMES MODZELEWSKI: Yeah, so that scenario you just gave me, we would come out and let's say we'd be dispatched by the police department whether it be state or local police to bring your vehicle to our storage facility. The next day, you’re coming to our storage facility or you're calling the police department and say, hey, I'm looking for my car, you know I went to the hospital last night, and now

obviously you understand that your vehicle is at ABC Towing so you come down and I say how you doing, how you feeling, so and so forth. Do you need anything, do you need a rental car, and we go through the processes for you to understand the process because you have no idea how the insurance companies work? We deal with it every day. So, when you come into our office, I can speak for ourselves, I explain to you in full detail your options. One option is, is obviously we can repair your vehicle. We can work directly with your insurance company and there's other options for you. Or you could choose to take your vehicle or have your insurance company bring you to their approved storage facility, storage-free facility, so there's many options for you. But we have the direct contract after the vehicle is deposited into our storage facility to interact with the owner of the vehicle and it's your right and your choice, you know. Everybody has a choice. No-one is forcing -- and how they -- how they word it in here, that we're forcing -- they're trying to prohibit us from talking about, you know, the next step of obviously motor vehicle accident.

REP DATHAN (142ND): Thank you so much for providing that much needed clarity that we all needed. Is there any further questions from anyone? Thank you so much. I apologize for how long you had to wait, but really appreciate your patience because I think, you know, we needed to hear your views on this bill. So, thank you very much for your testimony. And you did submit it online it looks like.

JAMES MODZELEWSKI: I did. There's a written testimony. Thank you so much. I appreciate it.

REP DATHAN (142ND): Great. Thank you. Next, we have Joe Miano.

JOE MIANO: Good evening -- good evening and first of all I just wanted to say thank you for staying this late with us. I know everyone else probably had to leave for dinner and family obligations so thank you very much for staying.

I am opposing --

REP DATHAN (142ND): Can you please state your name for the record.

JOSEPI MIANO: Josepi Miano. I am a resident of the Town of Wethersfield and I have a business in Hartford here. So, I am opposing H.B. No. 5252 and I'm totally in agreement with Jim Modzelewski who did a phenomenal job going through all that. I just wanted to reiterate that basically the insurance company is further -- I don't know the word I want to use, but they're going through more scaring process, convincing the customer to move the car quicker, to get them to go to their storage-free facilities. To get them to go to their direct repairs, to get them to use their photo apps. The photo apps are saving the insurance companies billions of dollars because they are short-changing the customer in getting their vehicles repaired properly. I think it is something like 50% to 60% of those people that do those photo apps don't even get their cars repaired, so they're getting shortchanged on that. So by doing that, by getting them not to agree with the towing companies or to the repair shops, and getting the cars looked at in the first 24 hours, not doing anything basically for the first 24 hours is contributing to additional scaring tactics by the insurance company.

I myself am a licensed appraiser for the State of Connecticut, so I can write all the appraisals I want all day long, I do that, and I do them very accurately with every detail as much as possible. Insurance companies, they do it as least as possible with the cheapest parts possible to get the car moving again, as you want to say, but it's not safely done that way.

As you know, Senator Blumenthal back in the day he did the campaign with Your Car Your Choose with the Autobody Association. This stems to that where they're taking that option, that choice away from the customer where they want to sit in the customer's seat basically to get that car repaired or moved out of there, which is the reason why I'm opposing H.B. No. 5252.

One of the biggest things I think is that our state agencies don't work together with the Towing Association, with the Autobody Association. You have the Department of Motor Vehicles; you have the Insurance Department and we have the Insurance Association. You know, if we all came together and worked together as a team, we'd be much better off, but the communication, the efforts of doing this on behalf of the consumer, is never thought of. It's always money-wise where everyone wants to save a dollar to get it done as cheaply as possible. And I've heard many testimonies today where they're all saying, you know, it's going to increase your insurance rates, it's going to do this, it's going to do that, we all know that that's not true. You know, they're not going to increase your insurance rates if you put better parts on your cars, it's not going -- none of that is going to happen for -- you know, every year the insurance costs go up

regardless. Someone's gotta pain, no matter what, someone's gotta pay. So, some of those things that you hear today, not -- they're not true. I think that's about it. If anyone has any questions, I'd be more than glad to answer them for you.

That was great timing.

REP DATHAN (142ND): Saved by the bell. [laughing] Is there any questions? Representative Hughes.

REP HUGHES (135TH): Thank you. Thank you for staying for this, you know, the passion you have for your industry can I just pose, what would the ideal solution look like to both -- especially given that most of the towing is occurring after a fairly traumatic incident. Nobody like loves and plans on getting their car towed off of a highway, it's an unexpected event. So, what would the solution look like?

JOSEPI MIANO: Probably for the insurance companies not to lie to the consumer, because basically that's what they're doing. They're telling them that, you know -- they're giving them all these horrible situations, you know. If you bring your car to our shop, you know, our program this and that, you get the free storage, you know, they're going to over-charge you. We'll put you in a rental right away. All those scenarios happen which none of that's, you know, you can do that a regular shop. We're all independent business owners. All paying taxes, and state tax, all paying insurance. You know the same insurance company that will tell you, you know, hurry up and move your cars, probably the same insurance company that we're insured with. So, they're lying to their consumers. So, the best way to do it is for us to all work together via the

State Agencies, the DMV, DOT, the Insurance Department and all the associations together.

REP HUGHES (135TH): So, when you say work together, would you recommend sort of a standard kind of across the board either rate for overnight storage for the first 24-48, whatever, hours?

JOSEPI MIANO: The rates are all there. Those are set by the Department of Motor Vehicles, the Towing Association petitions the Motor Vehicles once every two years to do all that. So, the rates are there. They are reasonable. They're not -- you know, we're not overcharging. We're not -- we're probably under charging depending on the taxes that everyone pays. Because like Mr. Modzelewski had stated, all the towns pay a different mill rate, but yet, the storage rates are all the same. Same thing with, you know, repair rates, most of them are the same throughout, you know, what the insurance companies pay are basically one price throughout the state. Every company has their own rate, but our cost of doing business is much more than that.

REP HUGHES (135TH): Okay. I could have kept going. Thanks.

REP DATHAN (142ND): Any other questions? One quick question. You mentioned something about an app. Are the insurance companies going towards having the tow companies record damage to the car in way of an app? Or submitting photographs or anything like that for the initial part of the claim?

JOSEPI MIANO: Not the tow company, no. But they do ask the consumer to do that, which is a bad idea because you cannot -- you cannot see all the damage

on the pictures. Trust when I tell you. Depending on the [Crosstalk]

REP DATHAN (142ND): No, you're -- yeah, I was actually in an accident. It looked like I had a tiny fender bender in the back, but then when the adjustor came and the repair company looked at it, they said, you have major frame damage, but you couldn't see that on the external part of the car. So, they totaled the car out when I thought I was going to have maybe a $1000 dollar repair job on probably a less than two-year-old car because someone rear-ended me. So, I certainly get that.

JOSEPI MIANO: So that's why it's important to always, you know, speak to your shop first. We are a towing shop, we are a body shop, mechanic shop. It's always important to talk to the shops first and then talk to your insurance company and we all come to an agreement as to what needs to be done. But, the point of, you know, trying to do the free 24 hours, not signing anything. You know, for us to do any work on the vehicle, we need to -- the shop needs to have the owner of the vehicle's permission to do it. They need to sign. We can give them an estimate ahead of time, but that doesn't mean we are going to be fixing their car, and then they need to say yes or no I want to proceed with the work, that's when you get them to sign the paperwork to have the work done. So, nothing happens before then.

REP DATHAN (142ND): Got it. Thank you very much. Any follow up? No. Thank you very much, Mr. Miano.

JOSEPI MIANO: Thank you very much. Have a great evening.

REP DATHAN (142ND): You too. Again, thank you for your patience. Sal Sena.

SAL SENA: Good evening distinguished members of the Insurance and Real Estate Committee. Thank you for letting me take this opportunity to testify in strong opposition in regard to H.B. No. 5252, AN ACT PROHIBITING CERTAIN VEHICLE STORAGE AGREEMENTS AS A PRECONDITION TO VEHICLES BEING TOWED.

The bill appears to be an attempt by the insurance industry to get around the anti-steering law, which permits the consumer to freely choose any repair shop that they like of their own preferences.

My name is Sal Sena, I'm the President of the Connecticut Towing and Recovery Professionals. The TRPC is composed of two hundred companies who all employ multiple employees located throughout the State of Connecticut. Each one of us is hired by state agencies and municipalities to clean up accidents that need taken care of. We're the first people on the scene of an accident besides EMTs, the police department, and so forth.

What the insurance company is trying to do -- I'm going off script a little bit here, so I apologize for it. They're trying to take away your choice. You get in an accident, Joel comes out or Mr. Modzelewski comes out, and we help you out. I'll get you to where you need to be. In many cases, right then and there, you will get a first read on somebody you meet. If you like the people, or you feel they can help you out, they're trying to take that away from us -- or take it away from you.

What they're trying to do -- in Connecticut, the moment your vehicle is towed in, as you said, you

can wait two days for an adjustor to show up, you can wait two weeks depending on the police report. Oh, we got to find out who's responsible. The insurance company, instead of doing what they need to do to help out their consumer which would be hire more adjustors, put more people on their payroll to help out their insured. That's not what they're trying to do. Instead, they're trying to beat up our industry. We're going to take away your storage, we're going to take away what you're entitled to, to make a living and we're going to make it so that we have control. They've passed many bills. *Connecticut General Statute 38a-354* is a Steering Act, which this is totally what it was designed for, to stop them to be able to have control where you bring your vehicles, what's done, your choices.

For that reason, the Towing Industry of Connecticut most respectfully requests that you guys do not pass this bill. Any questions?

REP DATHAN (142ND): Did you submit testimony?

SAL SENA: Yes, Ma'am.

REP DATHAN (142ND): So, you did email it to, it's not on our site yet. Okay, great. Representative Pavalock D'Amato. Oh, good. Excellent. Thank you so much for your patience. I know you've been here for a very long time and you're probably need to get back and service your customers. Thank you very much.

SAL SENA: Thank you for your help.

REP DATHAN (142ND): Next, we have Paul Hilario. Hilaro. If you could just correct me on the pronunciation of your name.

PAUL HILARIO: No, you did good. [laughing] Good House Members, I appreciate your time tonight. I did submit written testimony this afternoon. I'm going to read for the record what I wrote.

Dear Members of the Insurance and Real Estate Committee. My name is Paul Hilario, owner of multiple towing and repair facilities in Western Connecticut, down towards the Danbury, New Town area. I'm not a state-based organization seeking to mitigate my losses. I'm a small business owner -- owner of this proposed house bill affects, H.B. No. 5252, AN ACT PROHIBITING CERTAIN VEHICLE STORAGE AGREEMENTS AS A PRECONDITION TO VEHICLE TOWING.

Insurance carriers are trying to reduce their exposure to claim by shifting the burden to the tow companies. A prime example of this practice is set forth in the attached letter of Allstate Insurance Company unilaterally ceased payments for storage. I submitted that online as well. Leaving the owner primarily responsible but in a practical manner leaves my company responsible. See attached Allstate letter 03/27/2015. Allstate abandoned this worthless vehicle, which is still in my storage facility to this day, five years later. Regardless if there's an abandoned vehicle law in Connecticut, it's safe to say that a million dollar insurance company knows that a small guy like me, the tow guy is going to run out of money and time long before -- or quickly -- way before they will to fight them. But there is a law in place, but that's a flagrant disregard to that.

The insurance company cannot be sued directly for these charges, but you the vehicle owner can. The insurance company may in fact be liable for storage

charges to which the owner agrees. In any event, a consensual storage agreement prevents this type of abuse by the insurance companies. They glazed over that fact. They glazed over many facts. This bill voids consensual agreements between tow operators and the vehicle owner. Moreover, this bill does not differentiate between types of vehicles. We could be talking about a tractor-trailer, we could be talking about Prius, it doesn't differentiate. It is not uncommon to contract for a longer storage for commercial vehicles, usually carrying products. This bill attempts to prevent private parties from entering into consensual contracts. This bill directly circumvents the decision made in Progressive verses Farmington Auto park, Case No. CCC-2014-1032, Administrative Decision by the Department of Motor Vehicles in 2015.

The apparent thrust of this bill is to sanction controlled anticompetitive pricing by insurance companies similar to Allstate, who apparently have access to free storage facilities, in competition with storage facilities such as mine and some of these other members here that came to speak tonight.

REP DATHAN (142ND): If you could please summarize.

PAUL HILARIO: Yep. This may be worth an investigate to appropriate agencies as to anti-competitive trying arrangements between insurance companies and these storage free facilities where repair costs are tied to free storage. This free storage may in reality being tied to the same facilities who have repair arrangements with the insurance company. The vehicle owner is then pressured by the insurance company by threats not to pay storage to have the vehicle taken to an

insurance carrier recommended repair facility for free storage.

One other important fact that I want to bring to your attention, on this house bill, if you read line 32 and 33, No license shall require the owner to sign a contract for the repair, they inserted, or for more than 24 hours of storage. That's open-ended. I'm not 100 percent sure why they include -- why they even developed that. If you read further down, they inserted --

REP DATHAN (142ND): Is this part of your written testimony?

PAUL HILARIO: It is not.

REP DATHAN (142ND): Okay. If you would like to include that, you're welcome to submit your -- you can amend the testimony to include that, so, you could make sure that that is looked at.

PAUL HILARIO: Yep, I will revise that and send it in. Is there any questions? I mean I'd welcome any questions.

REP DATHAN (142ND): Any questions? Representative Pavalock D'Amato.

REP PAVALOCK-D'AMOTO (77TH): Thank you, just a comment. I understand what you're saying. I mean I thought it was oddly written as well. But I think you bring up some good points, and the site for the Court Case, is that in your written testimony, or if you could include that as well, the Farmington Case, 2015.

PAUL HILARIO: I did include that.

REP PAVALOCK-D'AMOTO (77TH): You did, okay.

PAUL HILARIO: Yep. Within that 24 hours, it appears that they don't want us interacting with the consumer. However, they conveniently omitted themselves, so they're the only ones that they want -- they want to be the only ones in your ear.

REP PAVALOCK-D'AMOTO (77TH): Understood. But I appreciate that. I don't have any further questions. I don't know if you guys do? I'm all set but thank you very much for testifying.

REP DATHAN (142ND): Thank you, Representative anything else? Thank you so much. And if you would resubmit that, that's really helpful. Some of the points you brought up were very valid. Thank you very much. Robert Greco.

ROBERT GRECO: Good evening. I didn't have any time to submit any written testimony online on short notice. We came across this bill, it popped up, or was slipped in I guess if you want to call that. I'm an operator out of Harper, Connecticut. My business is Central Auto and Transport. I'm a third-generation owner of this company. You know, I'm against H.B. No. 5252. I think it's just something the insurance company submitted under the wire and were looking to see if they could get something passed. I see it as just another way of, you know, steering business away from our business. And you know, business, as tough as it is, and in Connecticut, you know, we're just not doing the type of business that we've done in the past, you know. Our business service is a lot of fleet customers, that doesn't affect some of these guys, but, you know, the common consumer that you tow in from day-to-day, that back fills some of our work for our

company. We have multiple locations, so, you know, we thrive off of this work.

I don't understand the language that they submitted in; I don't know the game. I wish I knew a little bit more about it, but on short notice, we tried to compile an understanding as to what the -- what the game was, or the goal was for them submitting this language. But, you know, it is steering work away from us, so, I'm against the bill.

REP DATHAN (142ND): Your verbal testimony will be on the record, but if you do want to submit written testimony, please feel free to do so to the email address. Does anybody on my committee? Thank you very much for your time. Is there anybody else that would like to testify on H.B. No. 5252? Oh, we have another one? If you can please come here and state your name for the record, and if you have submitted testimony please let us know.

ADAM PEO: I have not submitted any testimony online. Thank you, ladies, for staying here tonight. Hopefully I'm the last person you'll listen to. I'm sure you guys have families as well as we do.

REP DATHAN (142ND): Would you mind stating your name. I'm sorry.

ADAM PIO: Sure, my name is Adam Pio. I own Farmington Auto Park. I've been in business for 15 years there. I've been in the industry for 25 years. I am opposing this bill. Once again, this is the way insurance companies are putting their nose in our business and trying to dictate to us on how we do business. It's just another permission slip for the insurance companies to drag their feet more than they already do.

Currently, they're in snail speed. I saw you scratching your head before trying to figure out this bill. I get it. We're all scratching our head. It's not -- it's silly.

The State of Connecticut has already regulated our rates. They're approximately half the rate of a parking meter, as Mr. Modzelewski said in Hartford. The different is, is the cars that we're storing are smashed, they're leaking motor oil, antifreeze. Sometimes they're leaking blood, okay.

A 24-hour period is just more time for the insurance companies to scare the victim to another shop where they're ultimately getting shoddy repairs. If an accident happened on a Thursday afternoon, this bill would make it difficult for the person to get anything done by Monday morning.

Furthermore, if they don't have rental coverage, they're going to be incurring more rental fees out of pocket which is going to hurt the consumer. If they do have rental coverage, they only have a 30-day policy. So, they just wasted Thursday, Friday, Saturday, Sunday, Monday, just like that.

Insurance companies are playing with billions of dollars, and we are fighting to feed our families. These CEOs are sitting on yachts drinking Mai Tais at the consumers expense.

Not only do they want us to store vehicles at no charge for 24 hours, there is a cost associated and protecting storing and ensuring the vehicles because they are in our care and custody. That's all I have to say for tonight. Any questions.

REP DATHAN (142ND): Um, great, I'm going to open up for questions, but if you could, when we're

finished, talk to the clerk here and give her your name and spelling that would be great. Representative Hughes.

REP HUGHES (135TH): Yeah, thank you for staying so late. I have a question that I feel like I should have asked the other operators as well. But do you have a person that is just dedicated to going after the insurance companies and dealing with the, you know, the back and forth on trying to resolve what's going to happen next for the customer? Like, do you have an administrative person that really spends all that time?

ADAM PIO: That's myself.

REP HUGHES (135TH): That's what I was wondering. So, that's -- how much say of your time would you say is dominated by this?

ADAM PIO: [laughing] Almost all of my time. That's what I do. I mean, I'm calling insurance companies, I'm calling the claims in as she said, you know, a week goes by, two weeks goes by, so I'm calling the insurance companies every day, emailing them so I have a chain. The insurance companies, what they're doing nowadays, especially if it's a third-party claim, you know, if someone rear-ended you, and we're going through their insurance company, they're going to say, well, we're waiting for the police report to be finished. State police take two weeks. Town police take a week. So, they -- sometimes they're like well our insured is telling us a whole different story so, we're not even coming out there. And I was there cleaning up the scene. I know what happened. I saw them get rear-ended at the -- you know, I didn't see the accident, but I see, I talked

to the police officer, you know. They don't want to hear about it, they drag their feet the whole time.

And then, when they gamble with liability and they finally realize that they gotta accept liability, then they complain about paying storage for seven days at $23 dollars a day, at $26 dollars a day, whatever it is. It's peanuts. It's ridiculous. The fact that we've stayed here all day long, and I appreciate you guys staying here as well, this is how, you know, strong we feel against this bill.

REP HUGHES (135TH): I appreciate that. Thank you.

ADAM PIO: NO problem. Any other questions?

REP HUGHES (135TH): Representative.

REP DATHAN (142ND): Thank you, again. It really is a true testament to how important you feel about this bill to have come here for eight hours or nine hours of your day.

ADAM PIO: Well, I appreciate you ladies staying as well. Thank you. That's all right.

REP DATHAN (142ND): Anybody else that would like to testify on H.B. No. 5252? Okay. For the final bill of the evening. H.B. No. 5255, AN ACT CONCERNING LIVING ORGAN DONOR INSURANCE DISCRIMINATION. Robin Gilimartin? Robin Gilimartin? Diane Mack? Alaicea Hildatch? Ned Brooks? Sheila Sokolski? Jack Delaney? Wow. So, you much be Sara Mussen.

SARA MUSSEN: Hello, I'm closing out the evening here. My name is Sara Mussen. I'm a resident of Colchester and it's my understanding that Robin may have testified earlier in the day.

REP DATHAN (142ND): Quite possibly, there was a few people that did testify on this. Her name wasn't marked off or his name wasn't marked off. My father-in-law is Robin, so it could go either way. The name wasn't marked off.

SARA MUSSEN: Very good. So, I am planning on submitting written testimony. I have not done that yet, but I will summarize.

So, I'm speaking in support of H.B. No. 5255. In 2012, I was honored and grateful to be chosen as a living liver donor for my nephew, Devin. He was born with a medical condition that caused his liver to fail and by the age of four months old, his doctors told us he had two weeks to live unless he received a liver transplant. Even after he was made the number one regional pediatric recipient priority, the odds that he would find a match in time were dismal. His yellow, pain-ridden, infant body hung on just long enough to find out that I was a match. Our brilliant and dedicated teams completed successful surgeries for of us, and I am pleased to say that seven and a half years later, we are both in optimal health and having outstanding prognosis for the future.

I fear though that without the insurance coverage I've had, my story would be a much darker one. I fear that I would have had to weigh my financial future against that struggling little boy's life. In two months, I will be opening my doors as a new small business owner and I will need to find new health insurance. In order to stay healthy, serve my community and be available to offer my generosity and assistance to others in the future, I and other donors like me must be protected from discrimination

by insurers. With your support, a passage of this bill will mean that thousands of would-be donors can stop asking, will saving your life destroy mine?

I think you for all the difficult work you do, to consider the needs of all Connecticut residents and constituents, and it takes fortitude, courage and thorough consideration on your part to consider all the information necessary to make the decisions you make. I hope that my story illustrates how vital it is to give organ donors the ongoing opportunity to say yes to saving a life, without hesitation and without fear.

Thank you, and I'll be happy to answer any questions.

REP DATHAN (142ND): Thank you very much for that wonderful testimony. It must have been a very difficult situation for your family and how overjoyed they are that you stepped up in such a quick period of time. So, thank you for that. Representative Hughes.

REP HUGHES (135TH): As a living donor as well to my cousin's son, also born with a defect that meant his kidneys would fail and he would die without an organ transplant five years post-transplant and healthy. Did you -- I don't know where your transplant was done, but I know I had to sign an agreement that said I knew the risk of possibly being denied insurance in the future as a living donor because of this, what they considered elective surgery?

SARA MUSSEN: That's correct. Yes. That was the case for myself and regardless of what is on the books as far as federal, you know, health insurance coverage is concerned that any one period of time,

you know, unless there's concerted effort to keep that, maintain and be very specific and strategic about offering organ donors that kind of anti-discrimination.

REP HUGHES (135TH): Protection.

SARA MUSSEN: Protection, you just can't be sure, unless that's the case.

REP HUGHES (135TH): Also, I agreed and consented to being part of John Hopkins Living Donor long-term follow research so that they could get more data and evidence that this is a good fit and that living organ donors don't necessarily incur more, you know, health care costs at all.

SARA MUSSEN: Absolutely. I am not part of the administration or any studies like that, but I can speak for myself and from what I've heard from other donors anecdotally, and staff members from the Yale-New Haven team where I was given my surgery, and for myself, as I mentioned, I'm in optimal health and that definitely includes my liver which is the organ that I donated a piece from. Three months after the fact, your liver grows back to its original size.

The liver that my nephew has now is the size that it needs to be for him. All of my tests show that if you didn't know I had this scar on my abdomen, you'd never know there was anything ever a problem with my liver, it's perfectly functional. And that seems to be a very reasonable prognosis not just for myself but for quite a few people, you know. So, for insurance companies -- I don't know if anyone else spoke to the insurance side of it, but to my understanding, trying to make it sound like organ donors are a great bit liability that would

reasonably raise insurance rates just doesn't jive with the reality that I have access to.

REP HUGHES (135TH): And one more comment. When we think about it all being connected, both the -- the acute needs of people with organ failures, but also the longevity -- the proven longevity of living organ donation verses -- I forget the term -- from non-living organ donations is much longer -- much longer. We can expect a kidney to be, you know, 15 or 20 years instead of five to seven years -- from a living organ donation. So, that really is so much more cost-effective. Because those folks will need a transplant, you know, to continue living and go through that all again. But if we can, not incentivize, but protect living organ donors for the whole system, it saves costs. Its whole system saves tremendous costs of the life cycle.

SARA MUSSEN: Absolutely. I think in general, probably not just in this situation, but in general, the idea of doing it right up front [laughing] saves costs in the long run. You can apply that to just about anything.

REP HUGHES (135TH): No further questions.

REP DATHAN (142ND): And what an incredible bond you will have with your nephew forever.

SARA MUSSEN: Indeed, yes.

REP DATHAN (142ND): He will owe you big time. [laughing]

SARA MUSSEN: Well, I hope he stays so healthy that he never thinks about it. [laughing]

REP DATHAN (142ND): I know. Any other questions? Representative?

REP PAVALOCK-D'AMOTO (77TH): I just wanted to thank you for coming and waiting all this time with the last person to testify. I think I saw you walking in this morning. So, we came at the same time. And, I guess I just -- any of that research or those figures. Did anybody submit testimony on either side as to any of that information? Any research or anything like that, I'm not sure that I saw that, though. But I think that would be very helpful. Anything that you referred to would be great to show, because I think it's a great bill that we'd like to push through. It's hard in a short session to get so much done, but I think this is just one of those bills we need to put at the top.

SARA MUSSEN: Absolutely. And just to clarify, I know I haven't submitted my written testimony yet, and I can include that for you. Is there a time limit by which I need to get the testimony to you for it to be included in this decision making?

REP PAVALOCK-D'AMOTO (77TH): And before we vote, I'd say that's the probably the -- which will be in a week or two. But, yeah, definitely, I wouldn't wait that long.

SARA MUSSEN: Okay, so within 24-36 hours should be okay?

REP PAVALOCK-D'AMOTO (77TH): Yes. That should be good.

SARA MUSSEN: Okay, I'll gather that.

REP DATHAN (142ND): Well, it looks like just for -- Ned Brooks did some testimony and I do believe he actually did speak now that I look at his testimony. And he did put some lists of some websites and other statistics and information so you can look at his

testimony which is on the website. Anything else you want to add? Well, thank you so much. I really appreciate you waiting. I mean, I know this is marathon and clearly, you're passionate about what this is all about, so thank you very much.

And I guess this is -- is there anybody else that would like to testify on H.B. No 5255? Is there anybody else that needs to testify on anything else this evening? Great, well this concludes our public hearing for this evening. Have a good evening and a safe drive home.