

CHAIRPERSON: Senator Matt Lesser, Rep.
Sean Scanlon

SENATORS: Anwar, Bizzaro, Cassano,
Hartley, Kelly

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

REP. SCANLON (98TH): It is 11:02 which means that we are going to get started on our public hearing today. As a reminder to everyone, the exits are on both sides. In the event of an emergency please proceed very calmly to one of those exits and I will make this announcement. I did not make it the other day and it came back to haunt me which is not - there's a lot of things that are going to be said in this room that many of us would like to applaud and sometimes there are things that are said that we want to boo, but we do prohibit all expressions of either support or disapproval in this room just so everyone feels comfortable saying what they're saying. So please hold your applause for later and hold your boo's for when I leave the room. Otherwise, you can do whatever you want. All right, with that said, our first witness is Representative Buckbee. You guys can pull some chairs up. I was gonna start singing here comes Santa Clause but I figured you get that very often.

REP. BUCKBEE (67TH): Start singing the song. Good morning. It's very rare I get to sit in front of

Insurance. This is a different group but thank you so much for giving us the time. We are here to speak on several different bills, House Bill 5256, 5248, and 5254.

As we just left the press conference we'll probably, what I'd like to do is allow some time for Tony and Tracy Morrissey who is with me to speak briefly on these topics. In doing a little bit of reading and research, I know these bills aren't finalized and there's a lot of language waiting. In 5256, I'd really like to see line four or number four on there changed which is not fewer than 30 days. That certainly needs to be expanded a bit more. As we've seen in the past, the 30 days isn't necessarily enough so I'd like to see that expanded and maybe allow that 90-day term to go a little more in the lifetime of the piece but certainly some tweaking to be done, but overall I think all three bills are solid. 5248 task force should be included on the establishment of the three-step program with detox and treatment and followup too. So I've submitted my testimony. I'd like to yield my time to the Morrissey's to speak a little bit more from our district. Thank you.

ANTHONY MORRISSEY: Thank you, Mr. Buckbee. Thank you, Mr. Scanlon, Mr. Lesser, and all the folks on the Committee for inviting us to participate in this very important session this morning. We are also here to support 5248, 5254, and 5256. We're in support of these bills because they're in the spirit of the organization that we represent, Brian Cody's Law.

REP. SCANLON (98TH): And just if you can, state your name for the record, both of you.

ANTHONY MORRISSEY: Sorry.

TRACY MORRISSEY: I'm Tracy Morrissey.

ANTHONY MORRISSEY: And I'm Anthony Morrissey. We're of New Milford. Again, we're here to support these three particular bills but actually a collection of bills that you will be seeing across multiple committees in the coming days. We represent a large coalition, a growing coalition of constituents in this state and also beyond. We are basically in favor of anything that focuses on the new battle that we have to participate in and that's the battle to remove any impediment that those seeking services in their recovery journey are after.

Our son, Brian Cody, is just one of a very sad number of people who have passed away due to the opioid epidemic. Our son was a beautiful boy. He had a beautiful little girl and another on the way. He was proactively seeking treatment in his struggle with opioid addiction for several years. Two weeks before his passing, he called us crying explaining to us that he requested an extension to his stay in the program that he was in. He was crying because he was rejected and the insurance company apparently had enough of him. And ultimately what happened is our son died as a result of that. This has happened not only to my son. What I'm showing you right here are just some of the stories of those folks that I've been directly connected with in the last six months since our son died. Each one of these papers represents an individual story from people that we know that have gone through the same struggle. It's a tragedy. It's unacceptable and we can do better. We're the great State of Connecticut and we have a

power team behind us across both sides of the aisle and you know I just want you to know that we're very, very thankful for the work you're doing, for the compassion that you're giving to folks my family and others that are behind me and others that could not make it today.

Please do carefully deliberate what is being proposed here and please look at the other proposals that are coming your way. These are proposals, not from people who haven't been down this journey. These are direct reflections and ideas for fresh proposals to battling this epidemic and I believe we can win. We've already started to do that. So again, we want to thank you. I want to thank the members of our organization, Brian Cody's Law dot org. I want to thank Mr. Buckbee and Mr. Scanlon and all the folks as well as the folks who you know put on the Keith Urban concert last year, Connecticut Realtors, WTNH and everybody that was part of that. They actually continue to do good service. They delivered 100 Narcan kits to our local community. I have seven in my car right now because of their gracious acts. We need more of that and again, I thank you very much for allowing us.

TRACY MORRISSEY: I just want to add one thing. The insurance recommended that my son go to outpatient. They had no right to determine what my child needed and with outpatient the day before and within hours he was deceased. That was not enough for my child.

ANTHONY MORRISSEY: If I can, we need to put doctors in the position of decision making, not insurance companies that are going by a budget line item or what you paid in. That is not the way that we

should be measuring the, you know the recovery path for folks. So we want to make sure everybody understands the importance of the decisions that are being made by people who are not connected to the people that we're losing. So thank you again.

REP. SCANLON (98TH): Mr. and Mrs. Morrissey, I want to thank you very much for being here today with us with the folks who are standing behind you. It takes a lot of courage to do what you're doing and you guys are doing it every day and you're online and I'm following you and the work you're doing is helping to end the stigma because one day at a time we teach one more person about why this is important, it's one less person that says that's never gonna happen to my son, that's never gonna happen to my daughter or my wife and I want to thank you for being here today. Just a few questions for me and then we'll open it up to the Committee. You just sort of touched on something that's very important to the work that we're talking about today which is this notion that insurance companies are not always doing what's in the best interest of the patient that's in front of them and I'm wondering if you could elaborate a little bit more about what your son was going through and what you guys were going through to try to ensure that he was getting the help that he deserved from the treatment facility that he was in.

ANTHONY MORRISSEY: Yes, thank you for the question Mr. Scanlon. I am very, very sad to report that our son didn't go to just one treatment center. Multiple treatment centers basically failed him because he wasn't given enough time even though he was requesting it. I want to also add sir that in spite of our pleas to the insurance providers to

extend our son's services, they rejected him. The day that we had to go and identify our son's body at a trap house nonetheless, we came home to a letter from the insurance company, a two-page letter. Page one reads you owe us \$30,000. Page two reads your request for additional services has been declined. Can you imagine what we were going through in that moment? Literally minutes after my son's body was identified on a gurney in a trap house. There are many failures. We'll talk more about them in the other sessions. I just want to make sure that the start of this is to make sure these folks are getting what they need, that the right people are making decisions.

We're also talking today about MAT. You're going to hear a story from my daughter who is also on the recovery journey and she's gonna talk to you about the merits of MAT. And also this notion of peer support. There are studies that we did in our local township where we surveyed the high school students. It was unanimous. Students talk to their friends more than they talk to their parents. It's alarming but it's true. So if that's the case, why would we not support peer services for those that are struggling with this epidemic?

REP. SCANLON (98TH): And I would hate to say that I believe that your story is unique because I know it's not and I know you know it's not and so I'm wondering if you could also talk a little bit about the fact that since you guys have started this campaign for change, you have touched and been involved with many other lives who have had a similar story so can you speak to that? Cause I don't want anyone to leave this room with the impression that your story's unique cause it's not.

ANTHONY MORRISSEY: Thank you. Thank you for allowing us to talk about the folks in our organization who are every day waking up with the pain that we are waking up with. Again, what I show you right now is just a small output of a large group of people who have submitted stories online. You of all in this Committee received just a couple because I'm trying not to flood your email boxes, but it's coming. You're going to see every one of these stories and there's more. You know I can go name by name but you'll see them. We have a little girl in our organization who lost both her parents. She has in the time since her childhood had to figure that out. The family has had to figure it out with her. This young lady is a phenomenal story because today she's in the recovery coach and treatment domain. We have another person that lost their fiancée and their brother who were both seeking services. We have another person that is currently on the recovery journey and he actually had to leave the state because he wasn't getting the services that he needed. We have another person who lost their boyfriend after they spent \$25,000 dollars on treatment. We have another person, should I continue cause I know we only have so much time but I implore you to please, please read these stories and you will then get a sense of the fact that Mr. Scanlon is presenting, that we are not the only ones and this is just the people we're directly connected to.

TRACY MORRISSEY: I'd to add also that our 12-year-old who's in 7th grade also came home to tell us that her friend lost a brother and that was after her brother, Brian Cody, had passed. Another friend

lost her mother. My 12-year-old wanted to go to that funeral. It's too soon.

ANTHONY MORRISSEY: It's very sad. All right. We will hear more testimony from folks behind us. This is just a few folks who could make it up here today. In the followup sessions you'll see more of us but p

REP. SCANLON (98TH): Representative Buckbee, yes.

REP. BUCKBEE (67TH): Scooch up close enough cause I'm not loud enough as it is. I think the important thing to say here too is each of us has heard a story here and there in our districts and somebody has approached you and talked to you about something that's an issue I think it's just time for the insurance companies to be held a little more accountable for what they're doing and what they need to be doing by our hand and the Morrissey's, as brave as it was to step forward, have taken such a step beyond that in organizing this group of people and each one of these lives meet, who cares what district somebody's in? Each one of these stories touches your heart. And this is something we're here for. Every one of us should be stepping forward for this. I this accountability piece for the insurance companies is critical to everything that we're doing across the board in every other committee and that'll be six different committees involved with pieces of what we put together coming in here and I know short session's not for that. I get that. This doesn't wait for short session so thank you for getting all this forward. I truly appreciate that.

REP. SCANLON (98TH): You're welcome Representative, and thank you for all the work that you're doing with the Morrissey's and many other people in your

district to shed some light on this and try to make some change because we know that change is needed. Any further questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you for your testimony. We're not going to solve all of the issues in this state this year but by having the courage to tell your story my hope is we can move the ball a little bit forward this year to make sure that fewer people have to go through what you've gone through so I'm just grateful for your courage in being here. I'm hoping we can work together to make a little bit of a difference in this state. So thank you.

ANTHONY MORRISSEY: We will. Thank you, sir.

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

REP. DELNICKI (14TH): Thank you, Mr. Chairman and I only wish I could say I've not heard this story before because there's one thing I've learned is that this addiction is scourged. It doesn't care where you come from, what race you are, what creed. It doesn't care if you're from a good family or what others would say isn't a good family. Once it gets ahold of you you're in trouble and you just don't know it and I wholeheartedly agree and I want to thank you, Representative Buckbee for coming forward today and I want to thank you two for sharing your story here and I would dare say the vast majority of us have heard from constituents, from folks, from friends have gone through this tragedy and I agree more has to be done. This cannot be ignored by the insurance companies, it can't be marginalized by them and it needs to be addressed so again, thank

you for having the courage to come forward and talk about this because this has to be a very difficult situation to talk about and I applaud your courage.

ANTHONY MORRISSEY: Thank you, sir. Thank you so much.

REP. SCANLON (98TH): Any further questions? If not, thank you again Mr. and Mrs. Morrissey and Representative Buckbee for being there this morning.

ANTHONY MORRISSEY: Thank you so much.

REP. SCANLON (98TH): And we look forward to hearing the rest of the testimony from your organization. Next up is Senator Formica. Representative Gilchrest?

SENATOR FORMICA (20TH): Good morning, Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato and absentee. We're here today to talk about Senate Bill 205 and we thought that as we're number two and three on the agenda today we would hopefully expedite things with your permission and kind of all go at the same time cause we're both here supporting Robin and Jackie so you want to make a comment?

REP. GILCHREST (18TH): Thank you for the opportunity. Not only is Robin a constituent, she is a friend and I thank you for being brave and using your experience to shed light on an important issue.

ROBIN BRENNAN: Good morning, Chairman Scanlon, Chairman Lesser, and the honorable members of the Insurance Committee. Thank you for the opportunity to speak in strong support of Senate Bill 205, or as I like to refer to it, Sean's bill.

My name is Robin Brennan and I'm a lifelong Connecticut resident living in West Hartford with my husband, Jack, and it's where we raised our two children, Sean and Leanne. On July 14, 2019, our family's world came crashing down when our beautiful son, Sean, took his one life in the basement of his apartment. Unless you have lost a child, you have no idea and you cannot imagine the pain and heartache we have been having to deal with since then. I wouldn't wish it on my worst enemy.

Our family loved to travel and we had planned a trip to Europe for September 2019, but after Sean passed we knew we could not go without him because of certain expenses that came up after his funeral. I was confident when I submitted -- I had purchased an insurance policy through AIG's travel guard and so I felt confident that I would at least get a portion of our trip refunded. On August 12, I submitted the claim through AIG's website, as directed, along with a copy of Sean's death certificate. Five weeks later, AIG's insurance adjuster called us and left me a message saying that our claim was denied due to the cause of death. You can imagine my response. I was shocked. I called the adjuster to get an explanation and she said well it is written in your policy, you should have read it before purchasing. She showed no remorse, no offer of condolence, nothing. A week later, I did receive a written copy of the denial with the excerpt highlighted from AIG. Again, no offer of condolence, no sorry, nothing.

I posted my utter disbelief and disgust with AIG on social media. I got an outpouring of response. One in particular was from the West Hartford Town Councilwoman, Beth Kerrigan. She had seen my post and contacted me privately. She arranged for a

meeting between me and Senator Slap and from then on, the ball was rolling. Since then, I have received an abundance of support from both inside this room and outside this room. It has been quite humbling to me. The support of the leadership of this committee, as well as Senator Slap, Senator Formica and Representative Gilchrest has meant the world to me and has given me the courage to be here today.

This exclusion must be removed from all travel policies. Mental illness is a disease like any other. If my son had died from cancer or diabetes, our policy would have been covered but because he was suffering from mental illness without any outward signs of distress, we were denied and caused additional stress during the most horrific time in our lives. We are not seeking any money or retribution towards AIG. We know that this bill will not prevent another suicide, but it will prevent another family like ours from suffering additional pain as we have done. It is the right thing to do. Thank you for your consideration and God Bless.

REP. SCANLON (98TH): Any further members of the Committee which to ask a question? Senator Anwar?

SENATOR ANWAR (Thank you, Robin, for being today and for having the courage to tell your story and Sean's story. It's very hard to hear it because you would assume that that's already the law and I assumed as the Chairman of the Insurance Committee that that was already the law but you can't assume that because we know all too often mental health is absolutely stigmatized and treated very differently than everything else that you just mentioned and as

I said early this morning, Senator Lesser and I and this Committee passed a mental health parity bill last year to make sure that health insurance no longer discriminated differences between diseases of the brain and diseases of the body and today, we have an opportunity with your bill, Sean's bill, to do the same for life insurance because nobody should ever be treated differently, on travel insurance, excuse me, because they should not be treated differently at all ever and so I want thank you today. I want to thank you the folks that are with you and Senator Slap who I know is on his way, who brought this to our attention with you and I'm really honored that we have the opportunity to act on this on your behalf and on Sean's behalf so thank you for being here today.

REP. SCANLON (98TH): Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman, and thank you, Robin, for being here. Thank you as well to Senator Formica, Representative Gilchrest and I know Senator Slap is interested in this bill as well. We do hard things in this building. We have to make hard decisions. When I heard your story, it was not a hard call at all and I thought there must be something about that story that I missed. There must be some reason why we need to do a bill because it seemed so self-evident that there was an injustice done in your case so I sat down with your insurance company. I had a conversation with them and as best as I can understand, their response to this is you should have purchased, you could have gone out and purchased a different travel insurance policy that had a special suicide add-on if you had anticipated that a family member might be in this case and just the idea that anybody would do that or

that's how, like that anybody would imagine that they could be in the heart-wrenching situation that you're in right now, it just defies my understanding and I don't have a lot else to say other than I am appreciative that you had the courage, the strength to be here and to tell your story. I am heartbroken about what you've gone through and that in addition to suffering, this personal tragedy, that you've also had to have this fight with your insurance company.

REP. SCANLON (98TH): Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair, and I want to thank you for having the courage to come forward on this issue. It's almost like we have a common thread right now that we're hearing about and that common thread is the cold, callous nature of the insurance industry itself when it comes to these kind of situations where there isn't even a modicum of compassion and all I can say is, sometimes and industry will bring it upon themselves, but thank you for bringing this to us and making us aware of this and thank you for your courage.

REP. SCANLON (98TH): Any further questions? Seeing none, again, thank you for being here today and we are going to get this done in the name of Sean and in your honor so thank you. Next up I have Representative McCarthy Vahey? I don't see her. How about Representative Perillo? Okay. I don't see Senator Bernstein but I do see Mr. Doolittle, the healthcare advocate.

TED DOOLITTLE: Good morning, Senator Lesser, Representative Scanlon, and other honored members of the Insurance and Real Estate Committee. My name is Ted Doolittle. I'm the head of the State Office of

the Healthcare Advocate and just really briefly for the benefit of those in the room who haven't heard of the Office of the Healthcare Advocate, we have a staff of nurses, attorneys, and paralegals that can represent you if you're having difficulties with your health insurance plan so if you've had a claim denied or if you're having a billing issue of some sort, don't fight that fight alone, don't worry alone. Call up the Office of the Healthcare Advocate and we'll help you.

I'm rising today to very briefly comment on HB 5247. As you know, that is the bill that provides some privacy protections for folks who receive Explanations of Benefits from their health insurance companies. The reason why my office supports that is because of the privacy concerns of young men and women and spouses who are on somebody else's policy. They can have sensitive health treatments such as for sexual transmitted diseases or mental health issues that they don't wish to share even with close family members and therefore, it's appropriate that those explanations of benefits do not go to some other adult who is the policyholder. This is the case whether there's abuse in the situation or not, although those cases are particularly important.

I'll conclude my comments by quickly mentioning another arena. I think our young adults are getting more and more in our society and I'll mention item that I know as the father of two kids who are both over 18. Just as with health insurance, I pay a lot of money for them to go to college. The college won't send me their grades. That's the way it is. That's another reflection of this situation, the recognition that adults over 18 have sensitive information. It doesn't necessarily matter whether

somebody else is paying for their education or for their healthcare. They still should have a privacy interest in that. Those are my comments. I'm happy to take any questions from members of the Committee.

REP. SCANLON (98TH): Thank you very much for your testimony this morning. Any questions for, Senator Lesser?

SENATOR LESSER (9TH): Thank you, Mr. Doolittle, for your testimony. I certainly support the Explanation of Benefits bill. I think it could be a major help for a lot of folks out there trying to get the care they need without having to confront the stigma that is attached to that care. Last year we got it through the Senate. Hopefully this year we get it through the house but I had a question about another issue. You're the Healthcare Advocate and you assist people all across this state with issues with their health insurance companies. We just heard a heartbreaking story about travel insurance and certainly people have issues with other forms of insurance. I know that that's beyond the scope of your office. Are there specific places people can go if they're having an issue with another form of insurance?

TED DOOLITTLE: There is the Consumer Affairs Office at the Insurance Department and that is a good place to start. My office by statute is limited to helping people with manage care plans so we can perhaps direct to another insurance resource, but I would certainly start with the Consumer Affairs Division at the Department of Insurance.

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

REP. SCANLON (98TH): Senator Cassano.

SENATOR CASSANO (4TH): Thank you, Mr. Chairman. Probably not what you're coming here for today but after seeing the announcement yesterday by the Governor and just being around this morning and various things, there's a real fear already on the coronavirus and one of the things that ironically did come up is you know does my insurance cover that and I know we've never had the term before, but it sure would be nice to have some explanation from somebody at a level of knowledge to provide some comfort in the fact if it ever does happen. The likelihood I would say being a non-expert is probably zero, the possibility is very high. When I look at the number of students who travel back and forth to Europe and Asia, the engineers from Pratt Whitney are an example who on a routine basis do that, the salesman who do that type of travel through Connecticut, that's part of our livelihood and so it's part of their job. They have to go back and forth to Europe. We thought it was Asia. Now it's half of Northern Italy so there is a lot of attention being paid to this seriously and that's one of the questions you know, what happens? There is no vaccination. The information so far is wash your hands a lot so you can keep washing your hands but I don't know if that's something you can even address, but it would be nice if we could get some comfort level out there.

TED DOOLITTLE: Sure, well I'll say what I can, Senator Cassano. Thank you for the question. So I do believe that the coronavirus treatments or testing would follow directly under the essential health benefits that are covered by the ACA so from that perspective, the plans will be covered. That of course doesn't mean you won't have to pay for

that as a deductible. I will mention that there are, I have seen some comments by federal legislators, notably Jack Reed, the Senator from our neighboring state of Rhode Island around concern which he is absolutely correct, that there are what folks call junk health insurance plans being promoted by Washington, D.C. that might not cover those essential health benefits. Those could include healthcare sharing ministries, association health plans, and short-term health plans. Senator Reed is concerned about that. I am as well. There are a number of limitations to those policies and actually, people need to be aware. This is another - the coronavirus, COVID-19, is another example of what people have to be aware of, it would be covered under an ACA compliant plan, but might not be covered under alternate policies that seem like they're a good deal cause they offer a lower premium but then when you get the COVID-19 and it's not covered, you realize it wasn't such a bargain to begin with.

SENATOR CASSANO (4TH): Thank you very much.

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

TOM DOOLITTLE: Thank you for your time.

REP. SCANLON (98TH): Next up I have Representative Perillo followed by Representative McCarthy Vahey.

REP. PERILLO (113TH): Representative Scanlon, Senator Lesser, thank you very much for the opportunity to say a few words in favor of House Bill 5256. I just, just to introduce briefly and I'll move over to Jerry Schwab from High Watch Recovery Center in a second but this is an issue I

didn't know anything about until a few years ago when I actually went to work for High Watch. You know it's not one of those things you think about, but Representative Scanlon, I think you said it this morning in your presser, you don't think about it and the fact that we're here discussing these issues of substance abuse and mental health today is significant and the treatment that individuals get and the length of stay and the continue of care is so important and the fact that 5256 addresses that, I'm very appreciative and at this point, I'll cast it onto folks who know a lot more about this than I do and this Jerry Schwab from High Watch Recovery Center.

JERRY SCWHAB: Thank you, Representative. Thank you, Representative Scanlon and Senator Lesser. I appreciate your support and efforts on this bill. While I'm only prepared on 5256, given all the other bills related to this topic, we would also support them and I applaud you for your efforts. I'm Jerry Schwab, President and CEO of High Watch Recovery Center. We are the country's oldest 12-step-based treatment center. We were founded by the founders of Alcoholics Anonymous back in 1939 so this is our 81st year in business. We're very proud to be providing services in the state. I'm also a person in long-term recovery. I am an alumni of the facility so it's very near and dear to myself.

We are specifically about the issue of medical necessity and minimum benefits that are provided to people suffering from substance use disorder. You know this isn't just about opiate addiction. I just want to point out you know we have about three times the amount of deaths annual from people who suffer from alcoholism and alcoholism-related illnesses and

deaths whether it be medical issues or accidents. I think it's just a much more socially acceptable disease. When it comes to addiction it often gets lost but about 80 percent our clients at any given time are primarily alcoholics.

Having said that, we deal with the insurance companies on a daily basis. I was before you folks a year ago testifying on a similar bill in an effort to get this. I'll you all know a couple of weeks after I left, we got a massive insurance audit so that lets you know how some of these insurance companies operate. So it's very difficult for us and I'm a practical person with regards to trying to explain the nuts and bolts of how it specifically works so I'm going to turn Representative Scanlon into an alcoholic for the today. So Representative Scanlon wants to get help. He calls his insurance company. He says these are my issues. The insurance company comes back to him and says absolutely a covered benefit. These are the facilities you can go to under the plan. Representative Scanlon calls up High Watch and says I want to come in for treatment. We do a screening with him and that screening will dictate whether or not based upon our experience with insurance companies the services will be covered. We say we think it'll be a covered service, you can come in, we admit you. He comes in, he gets an assessment. I also have with me today our Vice President of Clinical Services, Amy Sedgewick and our Vice President of Medical Affairs, Dr. Gregory Borris. Amy's been treating folks with addiction for over 20 years. Dr. Borris is board certified in addiction medicine and emergency medicine so he's seen a lot. He comes in, gets the assessments from those folks'

staff. We report that to the insurance company typically within 24 hours of admission and then we wait. The person's in our facility, they're under our care, we're providing them services. The next day, a day later, we might get a notification from the insurance company that says you're authorized to be here for three days. You're authorized for an outpatient level of care. So now they're already in our facility in a residential level of care and the insurance company comes back and says well based upon the medical necessity, they are more appropriate for an outpatient level of care and I don't want to take a lot of your time but I think it's really important to understand the specifics of how this works. So if they're in our care, they've been with us for a couple days, you know most people discharge the patient. The patient then has to go to an outpatient program. We don't do that. We're a non-profit. If we commit to somebody, we're going to give them treatment. We'll charity care them for the three weeks' minimum. We'll give somebody at least a three-week stay with us but that's not everybody. A lot of facilities will discharge the patient but imagine being the patient who has a substance use disorder who needs to get treatment for underlying issues and that might be previous trauma, psychological or psychiatric conditions that you don't even know how long you're gonna be in the facility. You know, three days? We don't even tell the patients what their authorizations are because we don't want them to be stressed out about it and be anxious. You know we'll guarantee a patient that they're going to be with us for three weeks regardless of what the insurance company does and we work with them from there but that is not how most facilities operate.

I myself 11 years ago called my insurance company up similarly and said, you know, I haven't used anything in two days but I really need to go in and get treatment. The insurance company came back to me and said well if you haven't used in a couple of days, we're going to recommend an outpatient level of care so I personally went through. You know I've been in recovery for a while now but I'm not going to get into my whole story but it's really, really difficult and disheartening and you know to really address the addiction crisis in this state, like this is a huge step forward to helping people address the root cause of addiction by having them in a residential level of care.

As far as the appeal process with insurance companies, providers are --

REP. SCANLON (98TH): Mr. Schwab, if I can just ask you to summarize this part so we can get some questions that would be good.

JERRY SCHWAB: Understood. Insurance companies, I mean we're very reluctant oftentimes to appeal insurance companies to this state because there's retaliatory efforts sometimes back from the insurance companies so it's difficult for the providers.

REP. SCANLON (98TH): Thank you for your testimony. Obviously, Representative, thank you for joining with this. I guess I have a question that I'm going to feel comfortable asking you because I know you're a person that also has some lived experience which is that all too often, I think the Morrissey's testified to this earlier, I'm very familiar with this intimately from a family's perspective, but people who are struggling with their sobriety and to

maintain their sobriety, the last piece of news you would ever want to give somebody who's saying I'm not ready to go back to where I was is I'm sorry, but you can't get the coverage for it, there's nothing else I can do. Are you prepared to say that someone is more likely or less likely to relapse because of something like that happening to them, than if they were to continue getting the treatment that they want and deserve?

JERRY SCHWAB: I mean they are absolutely statistically proven more likely to relapse especially if the client is telling you I'm having continued cravings, you know I can't go out into the real world yet, I'm not ready, they're absolutely more likely to relapse.

REP. SCANLON (98TH): And wouldn't it cost insurance companies less if that person survives that relapse which is a big if because we know there's terrible stories that we've heard today already about that being not the case, but wouldn't it cost the insurance company less if they were actually to listen to the providers that are delivering that treatment and let that person stay for a longer period of time to try to get the treatment that they deserve than to have a person repeatedly coming in and out for the short periods of time that they're prescribing?

JERRY SCHWAB: Yes. We're currently studying now and it'll take a while to provide the data but we're showing less emergency room admission, less in hospitalization stays for those clients that are with us 90 days and more cause that's when the, when the success rate really gets significant, it's 90 days or more. We track with them a year out on

other hospital readmissions and other hospital services and other services that are provided to them. You know, staying with us a longer period of time is much cheaper than some of the hospital admissions and some of the other incidents that come pickup.

REP. PERILLO (113TH): And just a thought on that cause I've asked myself the same question but if you look at it, gone are the days for going to work for GE and staying there for 40 years and GE having the same insurer for those 40 years. People move from job to job all the time. You know the premiums are high so employers are always searching for lower premiums so if you're insurance company A and Jerry is an employee you know somebody you cover, you would -- if Jerry were going to be with you as a, you know, as a member for 40 years, yes, you might be concerned about that but the fact and the reality is, next year they could have another insurer and I hate to be skeptical but the reality is maybe the insurance company doesn't really care so much about long-term cost because they're only with Jerry for a year and again, I hate to be skeptical but that's sort of the conclusion you might lead to.

REP. SCANLON (98TH): Thank you. Any questions from the Committee? Seeing none, thank you both very much. Representative McCarthy Vahey and then we will be just, for purposes here, we're coming up on noon which means that we will be turning to the public portion of the Insurance and Real Estate hearing. Representative?

REP. MCCARTHY-VAHEY (133RD): Good morning.

REP. SCANLON (98TH): Good morning.

REP. MCCARTHY-VAHEY (133RD): Senator Lesser, Senator Scanlon, members of the committee, thank you so much for having me here today. It's good to see all of you including my esteemed co-chair. I'm here today in support primarily of one bill, 5247, AN ACT CONCERNING EXPLANATION OF BENEFITS, but I would also like to lend my support to 5248, the task force for peer support and as some of you may recall, I have been before this committee in the past asking for coverage and support for peer support services. My other role is to chair a local prevention in Fairfield, Fairfield Cares and we know and see and certainly you're hearing today and talking a lot about the need for supporting those in recovery and there's a ton of great research to show how important this form of treatment and support is, and so I strongly encourage us since we haven't been able to quite get the actual coverage piece across the finish line, perhaps some conversation and a study and task force will help us to do that.

AN ACT CONCERNING AN EXPLANATION OF BENEFITS. I do not have written testimony at this point in time, but I'm going to use just an example. As a parent of a college aged student, actually a recent graduate, when I pay the tuition bills for her university, we did not have access to her grades and so this bill I think makes sense. As a parent, paying for a premium or having access to explanation of benefits, it doesn't make sense that we would then have access to personal health information that even as an 18-year-old or my own daughter is now 21, a full adult in the eyes of the law. Particularly when it comes to mental health, there is already enough stigma. There is already enough fear and concern that people have in the office going to seek

the supports and services that they need so I think it's really important that we allow young people the opportunity to, and encourage them to go get the help they need and not have any concern that the information about those services is being shared even with their parents. So that's really all I have to say today and I'm happy to take any questions and engage in conversation about it. Thank you.

REP. SCANLON (98TH): Thank you. Any questions from the Committee? Seeing none, I just want to thank you for your continued advocacy for this. You and I have been at this for several years now and hopefully this will be the year when we can get some progress on this.

REP. MCCARTHY-VAHEY (133RD): I hope so. Thank you very much.

REP. SCANLON (98TH): Thank you. Okay. We will now turn to the public portion of the bill or the public hearing. We're starting with HB 5248 with Ben Shaiken followed by Lynn Kovack:

BEN SHAIKEN: Hi, good afternoon Senator Lesser, Representative Scanlon, and members of the Committee. My name is Ben Shaiken. I work at the Connecticut Community Nonprofit Alliance. We're the statewide association of community nonprofits. As many of you know I'm sure, community nonprofits provide essential services to over half a million people Connecticut residents. We employ about 12 percent of the state's workforce.

I'm here today on four bills. The first one happens to be the first one on your agenda so I'm going to try to touch on all of them very briefly in my three

minutes. I'm here because community nonprofits provide behavioral health services, both mental health and substance abuse treatment to people across Connecticut. They are an important part of what makes Connecticut a great place to live and work and you know many of the people served by community providers are Medicaid recipients, but many more, many others are served by commercial insurance, and so that's why we find ourselves before this Committee to talk about behavioral health legislation that you're considering every year.

So we are here to support three bills, House Bill 5248, this bill to create a Task Force to Study Insurance Coverage for Peer Support Services as well as 5254, which is AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR MEDICATION-ASSISTED TREATMENT, and finally, 5247 that Representative McCarthy Vahey just spoke about, Explanations of Benefits. We also have concerns with some of the language in House Bill 5256 which I can go into detail if I have time.

So just briefly, about peer supports, these are services that are provided, they're recovery-focused, they're provided by specialists who have experience themselves recovering from mental health or substance abuse conditions. There's a growing body of evidence and experience that shows that these services are effective both nationally and in Connecticut. We don't require that commercial insurance companies cover these services, and they're not allowed to be billed in Connecticut's Medicaid program. So while this important service should be available to everyone, we acknowledge that there are some outstanding issues, particularly how to certify someone as a specialist, how to say yes,

this person is a specialist or no, this other person hasn't met the requirements and skills so we think the task force is a good idea and while we don't usually weigh in on task force bills one way or another, we think this one in particular does have some really good work to do.

I would just draw your attention to House Bill 5233. Section 2 of that bill, this is in front of the Human Services Committee and was heard on Tuesday. It would impact the Medicaid system side of peer supports and so I just encourage this Committee to work with your counterparts on Human Services to add Medicaid to this task force because tackling this once and for all for both commercial insurance and Medicaid is the way to go and frankly, would ensure our Medicaid programming will allow Medicaid recipients the same benefits that people who have commercial insurance get once this is finally implemented in Connecticut.

On 5254, this would require that insurance companies do not have step therapy or prior authorization for Medication Assisted Treatment or MAT. MAT is FDA-approved medications that are used to treat Opioid Use Disorder. There are three drugs, I won't get into detail about them. Look, simply put, MAT saves lives in Connecticut every single day and most patients have a preference for which of the medications that they prefer. Methadone they usually get administered every day. Buprenorphine and Naltrexone, commonly known as Suboxone and Vivitrol are the other two drugs. They can be administered by a primary care physician in a prescription or in a long-acting injectable. While we don't believe that there's a widespread practice to have prior authorization or step therapy for

these drugs in Connecticut, we do know that sometimes, those exist especially for methadone and so we think it's really essential that these services are available to everyone who wants them as soon as they want them without having to go through any kind of appeals process or step therapy or even a prior authorization determination. Just as you are aware, opioid deaths increased 20 percent last year. They had been flat for a few years; high, but flat and so anything that we can do to expand access to treatment, we would really encourage.

And then finally, on the explanation of benefits and our support, it would allow commercial insurance enrollees to request that mental health and substance abuse treatment not be disclosed to the primary policy holder. For example, it would allow a young person who is on their parents' insurance still to seek opioid addiction treatment from a community nonprofit without having to tell their parents about that. Another example, it would allow a spouse to go and see a Marriage and Family Therapist employed by a community nonprofit you know prior to seeking separation or divorce without their spouse finding out about it and so we think it's a good idea for sensitive health treatments where privacy is something that a patient might want, to be able to request that privacy.

And the finally, I know I said finally already, I haven't heard a bell.

REP. SCANLON (98TH): Uh, she told me the bell broke and she's trying to find it, a new one [laughter] so you're at three minutes but if you could just summarize, Ben, thank you.

BEN SHAIKEN: Just my last piece is our concerns about 5256, we recognize that medical necessity is something that is often fought over between providers and insurance companies and that benefits especially for substance abuse services especially for higher levels of care like residential treatment are often denied and this is a huge problem and we really encourage the legislature to address it. We are concerned with how some of the language is drafted. We read some of the, so the deletion of medical necessity and then the addition of a listing of different types of treatment that must be covered, we read that language to add some annual and lifetime caps to things and we are very concerned about the, for example placing of a lifetime cap on residential detox treatment. Like recovery is a lifelong process and unfortunately, people may need multiple stays and extended stays in residential detox in other programs and so we just encourage this Committee to address the problem of insurance company denials of essential substance abuse treatment in a different way so thank you. Sorry for breaking the bell.

REP. SCANLON (98TH): That's okay. Thank you. Any questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, and thank you for that last comment. I'm glad due to our inadvertent equipment malfunction we were able to get that commentary in because I think it is important that, I don't know if we could impose lifetime caps on policy for the ACA but we shouldn't so I appreciate that. So thank you very much and I look forward to working with you.

BEN SHAIKEN: Thank you.

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chair, and thank you so much, Ben, for your explanations and your testimony today and thanks for all you do for the residents of Connecticut and this important issue. I have a question just on your experience with the peer support. This is something that I'm really supporting as well personally because I have seen so many people really tackle these issues working with somebody who's been there and gone through this. I have a lot of anecdotal stories but would love to know if there is any sort of data maybe to support how peer support services do help reduce the number of maybe long-term stays or anything like that. Does your organization have access to such data?

BEN SHAIKEN: We don't have the data directly. I would sort of direct you to a number, a few different things that are going on in Connecticut right now, I think largely paid directly through federal grants. In particular, I think the Department of Mental Health and Addiction Services has some information regarding a program that they have stood up with state opioid response dollars which is federal money from the substance abuse and mental health administration or SAMHSA, and they have placed peer support services in emergency rooms to help triage folks coming in with opioid addiction and I think they have some really promising initial data out of that. I can definitely look into some national information and get back to you with some studies that show it working elsewhere and like I said, there are other states that are already, that have built this into their Medicaid program already

and so there is information out there about those program's successes in those other states.

REP. DATHAN (142ND): That's great. Likewise, on the House Bill 5247, the explanation of benefits bill, does your organization have any data to talk about maybe young adults or other people who have been faced with not getting treatment as a result of the stigma that may be associated, that their policyholder might find out about their treatment? I know you talked about not just mental health issues but also domestic violence issues.

BEN SHAIKEN: That's a good question and thank you for it. I don't have any information. I don't think it's a piece of information that most of my members collect with that sort of specificity. You know we do know when we look at people with serious mental illness and ask them to report why they may or may not access care, they do report a number of factors and stigma is one of them. Because we're in the Insurance Committee, you know by and large the thing that people report when they're facing barriers accessing care, the barrier they face is the inability to pay for that care even with commercial insurance, but I don't have any information about the prevalence of folks who are feeling like they are unable to access care because of privacy disclosures. I will say that substance abuse and mental health treatment are subject to different federal privacy laws in addition to HIPAA protections that medical professionals follow which is outside of the insurance companies and federal 42CFR has different privacy requirements, more stringent privacy requirements for behavioral health and substance abuse treatment than for physical healthcare.

REP. DATHAN (142ND): And I just found in my own research that 75 percent of mental health issues develop before the age of 24 so this is a group of young adults that are facing this every day and if they're experiencing a stigma like you're talking about, you can imagine a great deal of them wouldn't be going to get the help that they need so thank you so much for your testimony today and thank you, Mr. Chairman.

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

BEN SHAIKEN: Thank you.

REP. SCANLON (98TH): Next up we'll have Lynn Kovack followed by Brittany Waldron and please, my apologies, if I ever pronounce your name wrong. Just please correct me when you get up there and state your name for the record.

LYNN KOVACK: My name is Lynn Kovack from Newtown, Connecticut. I'm here in support of House Bill 5248, 5254, and 5256 regarding a task force to study health insurance coverage for peer support services in the state, health insurance coverage for medication-assisted treatment for opioid use disorder, and required health insurance coverage for detoxification and substance abuse services. I am also in support of the Brian Cody Law.

I'm here today because I was a mother of Mindy, who died at the age of 30. I had two children. One night, I ended up with one and then the following day I ended up with three of her children, a 5-day-old, a 15-month-old and a 7-year-old that I had to bring home to care of. She had tried many times for

insurance for rehab but it was hard with the three girls, but we offered to do it but it was hard getting it and she couldn't so after all these fights with everything, she ended up starting to buy stuff on the street and she ended up overdosing.

An insurance company wanted to make these decisions, yet she had seen a caregiver for 10 years for anxiety and depression due to a domestic violence relationship she was in so she had started these medications and then after a while it just was getting too much to where she was taking too many and then the insurance companies were denying her treatment completely and then she just went and got it elsewhere. So I got a call to come down and identify her in the ICU because she had overdosed on heroin which I had no clue she did till the day she died and with that, I couldn't just be quiet. She was a very successful mother of three, 30 years old, bought her own house making \$67,000 dollars a year. It can happen to anyone of you and she just chose to take this, and we brought it to the police with her phone and with that, we were able to put a man behind bars for four years and prevent another mother from going through something like I did and I'm very with the Brian Cody Law because Tracy is my cousin and after her seeing me suffer the loss of my daughter, I then had to see her suffer the loss of her son in August who also she has two grandchildren who she's helping raise too. So something has to be done with these insurance companies. You need to get these people in there for treatment. Now, I'm a grandmother and mother of three that I'm going to be raising for the rest of my life at the age of 53 which is okay, but if the insurance company would've helped her, she might be here today just like Brian

Cody and many other people who have tried to get into treatment and it just doesn't work. The insurance companies do not listen.

REP. SCANLON (98TH): I want to thank you for being here today and just echo what I've been saying to everybody which is thank you for telling your story and your daughter's story and your family's story and the two of you sitting next to each other is exactly what we keep talking about which is that this touches every single family and even if you don't think it's gonna touch you, it's gonna touch you. This is a disease that doesn't quit, doesn't discriminate as Representative Buckbee said. It touches everybody and we're gonna keep at this and if it doesn't pass this year, we're gonna keep fighting for this until we can get this done. We just can't give up on this so thank you for joining with the Brian Cody Law campaign and everybody that's involved in this and keep telling your story and help us by telling that story. Thank you. Any questions? Before you go, Any questions from the Committee? Thank you so much.

LYNN KOVACK: Thank you.

REP. SCANLON (98TH): Brittany Waldron followed by Henry Sozzafava.

BRITANY WALDRON: Hi, I'm Brittany. I am Brittany Waldron. I am Brian's sister. I'm in recovery and I'm here to talk about the MAT, the insurance and the peer to peer. After losing my brother, I realized my life was just unmanageable with the drugs. I thought with having two experiences, I would be able to get a bed faster. It didn't work like that. I got denied from several places. Finally, after hitting rock bottom and being denied

from place to place to place, I didn't give up and I got into a place. I met with the MAT program. I am now in that so I think that's a success for anybody that actually wants to be sober. It is out there and it should be out there. I have a nurse that goes to my house every day and doctors can prescribe if you go onto nurse services. You can be in a sober house, you have nurse services that go there and that way you don't get triggered, you don't have anything that shouldn't have. I have peer to peer, I have a sponsor, I work the system and I just have other people, women outreach lady, those are all people that are in recovery that I talk to and I think that's awesome.

REP. SCANLON (98TH): Thank you, Brittany, for coming here today and I know it's hard to get through this but you're doing an awesome job so I hope you know that. If I can just ask you, I don't know if you heard the story that I told downstairs, but my dad was an alcoholic in long-term recovery and alcoholism is very, very prevalent in my immediate family and I understand the value of that talking to somebody with lived experience. I'm just wondering if you can talk to why that's so important versus talking to somebody who might not have any idea what you're going through and what you're feeling?

BRITANY WALDRON: I think because you hear a lot about they have the same struggles that you've gone through so you know that you're not alone and it actually makes you feel a little better.

REP. SCANLON (98TH): And would you say that the person that's got that lived experience probably understands what you're going through a little bit

more than somebody working for an insurance company on the other end of the phone?

BRITANY WALDRON: Yeah.

REP. SCANLON (98TH): Yeah. Okay. Any questions from the Committee? Thank you again for being here today.

BRITANY WALDRON: Thank you.

REP. SCANLON (98TH): Henry followed by Maddy.

HENRY SCOZZAFAVA: Good morning. Thank you for the opportunity to be able to speak here. My son, my name is Henry Scozzafava by the way. My son was Henry Scozzafava. He had a pretty normal life, not anybody's special kid, just an average kid. He had a gym accident and it took out his eye and broke part of his skull and he got hooked on the medication. Nobody told me that it was gonna be that dangerous. You know, I figured you know it'd help with the pain and he'd be okay but it wasn't okay. So then he went along and kept taking the medication because he had pain issues and after a while you know it got cut off and then we had to start sending him to rehab places and you know he'd stay a month but it didn't really seem to help. You know he could stay three months here and three months there, go to another place but it really didn't help. I'm seeing that, then he had an overdose and went to the hospital and they released him and not much was really said. You know they don't tell you what you could do. If they gave him the medication that he could take home or even describe how to take care of the situation. You know if you had elderly person and they can't handle themselves anymore, they have like an advocate and

they come and they sit with you and they tell you what can be done and people with you know this issue, they you know, they have them in the hospital and after three days okay, they let him out. There was no description. They give you a bag of medication and you're on your way. So that's a good solution and also you know these rehab places keep them. If they act a little bit or do something wrong, they make them sign themselves out and of course they're gonna sign themselves out. They want to get out there and get more drugs. So what kind of a solution is that? That's no solution. It's ridiculous. You're asking a, you know, you're telling a person that's on drugs and has only been like three days in he's not in his right mind, he's out of mind. Oh you know okay, sign yourself out, say goodbye, okay. You know that's not a solution. And because of the laws they don't call you, right? So he gets out of the, you know they tell him he has to get out of the rehab center because he wasn't cooperative and make him sign himself out and in the middle of the night because that's when you know they told him to leave, he comes home and breaks in the house. I'm sure he got one of his friends or a drug dealer to give him a ride home and give him some drugs and this time, it was laced with fentanyl and I got up in the morning and he's dead in the basement.

If they had some kind of situation where they would describe when he first had his accident what you know would be the issues with the medication you know that they were giving him, you know, that it could present a problem and give you some counseling on it or some way that they could have medication legally given to them you know where they have help,

help for them and explain the situation. I really didn't know about all of this and I really am not, I have attention issues, I have dyslexia, I don't focus that well so it's hard for me to understand. I wouldn't drink and I didn't even like taking medication because I have issues you know with being able to communicate and understand but I'm here today because I can't do nothing for Henry, but if I don't say something, they're dropping like flies. The police came to the house and it wasn't till like I don't know he was, I went in the morning probably around 8:00 and they had like 13 deaths to that point in the state the cops say so it was probably around 5:00, 6:00 before the coroner came and took him out. In the meantime, I'm staring at his body lying on the basement floor but the thing that I'd like to see is at least, and it might be even cheaper if they could give him and have some kind of thing where they let them out, every time they let them out they don't tell you about alternatives. They send them with a bag of medication. Educate the person that's responsible for taking care of them in some way, have some kind of an advocate there. It might even be cheaper if they could give him some medication that he could take at home that would relieve the situation instead of just letting him go and then letting him go out to a drug dealer and get illegal drugs. That would solve a lot of the issue with them taking this fentanyl stuff you know and it would, if they could go to a doctor and get a prescription, I think he would've been perfectly fine instead of just not even informing me you know and letting him out in the middle of night and him breaking into the house and me finding him dead in the basement in the morning. I don't know if that's a good solution, do you?

REP. PAVALOCK-D'AMATO (77TH): I want to thank you. Can you pronounce your last name? I don't want to.

HENRY SCOZZAFAVA: Scozzafava.

REP. PAVALOCK-D'AMATO (77TH): Okay. Scozzafava and did you also want to talk? If you can state your name for the record as well.

MATT SCOZZAFAVA: I'm Matthew Scozzafava. I'm mostly just gonna summarize. The biggest issue here is that there's no connection between the hospital and the insurance company. The insurance company's not approving to get him the treatment cause he basically almost overdosed before he went to this last treatment and they basically did nothing to get him the right care there. The insurance would not approve anything for the hospital. In reality, the doctor saw that happening, they should've put him in a detox. Detox was gonna last three days so they figured if there was any rule breaking, they'd just throw him out so they're just trying to cycle beds and they just basically cycle them out. At the same time with the extended care, you can't get any extended care either cause he's out in a month to less.

REP. PAVALOCK-D'AMATO (77TH): And I know with hospitals, we've had this discussion in this room that there are, let's see, hospitals always gauge what their relapse is and they do want to do, at least in other situations, with other patients, a followup and I don't think this is treated the same. You know from what you're saying and that's unfortunate because it should be you know the same type of followup, the same type of standards making sure that the patients are taken care of even once they leave.

MATT SCOZZAFAVA: It's just almost like a suicide, someone just almost wants to kill themselves basically. It's very similar.

HENRY SCOZZAFAVA: If they followed up on it and they gave you more information, it'd probably be cheaper in the long run than him going to multiple places and staying three months at a time and then being bounced out and nobody being there to give you some kind of a service to let you know what you could do you know and that's why I'm, I come here today. I mean I can't do anything for him and I'm not going to say he was anybody special and I'm not gonna cry about it but I am going to open my mouth so that somebody else doesn't have to go through what I went through. Maybe I can help somebody else. I can't help him but if nobody says anything, and there wasn't that many people here. People should open up their mouth. I'm not afraid to talk because I don't want anybody to go through what I went through. It's not a party.

REP. PAVALOCK-D'AMATO (77TH): But he was somebody special and he was somebody special to you.

HENRY SCOZZAFAVA: He was just an average kid. You know I'm not gonna say it was like, he had super potential, just an average kid.

REP. PAVALOCK-D'AMATO (77TH): I just wanted to ask, does anybody have any questions? We do want to thank you for coming and again, you know I recently had a son and you know the chairman is also a new father and they're special us and we all want our, you know want to do what's best for our kids and I'm very sorry for your loss and I think coming here does make a difference.

REP. O'NEILL (69TH): I do have a question, maybe two. In the course of the treatments you said your son had undergone in a facility, a rehabilitation facility for two or three months and then another one at a different time, during the course of this, did you ever, do you know if your son was ever prescribed Suboxone as something to help deal with the, I assume you were talking about heroin.

HENRY SCOZZAFAVA: Yes.

REP. O'NEILL (69TH): Cause I don't think you ever actually mentioned the drug that was involved.

HENRY SCOZZAFAVA: I really don't know all the drugs. Matt might know that more than me.

REP. O'NEILL (69TH): Go ahead.

MATT SCOZZAFAVA: It was declined for that. He was only really allowed to get methadone and he was, that was not his preferred option so that was another big factor as well.

REP. O'NEILL (69TH): Okay. So because Suboxone is something that you can, that they can give you a prescription with, you can take it home and it's considered to be a pretty useful therapy for opioid addiction so during all of the, as far as you know, Matt, your brother was never given a script for Suboxone as a sort of maintenance thing to help him stay away from drugs?

MATT SCOZZAFAVA: He only had in the facility. Once he got out, there was no prescription at home for it. It was never approved. It never went through at all.

REP. O'NEILL (69TH): Okay. And was he ever in a facility outside of Connecticut? Any treatment?

Cause there are a lot of facilities that are set up in Florida and other places like that.

MATT SCOZZAFAVA: Probably the first facility he went to was in Florida but that was a year previous to all these events.

REP. O'NEILL (69TH): Okay. And how old was your brother when he died?

MATT SCOZZAFAVA: 24.

REP. O'NEILL (69TH): Okay. And this had been, the mention was that there was a gym accident that sort of started this whole process of being prescribed some things like oxycodone or hydrocodone or oxycodone things that like, right? Narcotics?

MATT SCOZZAFAVA: Yeah.

REP. O'NEILL (69TH): How long was the initial prescription given to him for the pain? Do you recollect?

MATT SCOZZAFAVA: I don't recollect but it was probably for a long time because it had to be for probably months because the issue was, after the damage was done, his eye was also causing pain issues so it was also a maintenance thing for the eye pain cause when his eye pressure went up too high, it would be an extreme amount of pain from that so he was on an extended, probably past a month on it.

REP. O'NEILL (69TH): Okay. Cause you know one of the things that we tried to deal with legislatively a few years ago that doctors were encouraged to prescribe you know 90-day supplies of fairly powerful narcotics and we've pulled quite a bit,

limited their ability to write those kinds of scripts. When was this injury to your brother?

MATT SCOZZAFAVA: I believe at 17.

REP. O'NEILL (69TH): At age 17 so he was dealing with this for about seven years.

MATT SCOZZAFAVA: Yes.

REP. O'NEILL (69TH): Okay. And when he first started turning to, after he got shot down as far as getting refills of the prescription drugs, he then started to use heroin I assume. Is that how it went?

MATT SCOZZAFAVA: Yes.

REP. O'NEILL (69TH): Okay. And when he was doing that, he went into a rehab or hospital or something at some point I assume.

MATT SCOZZAFAVA: Probably, I don't know, years later after he was in and out cause he basically had money from the settlement and he was using that up to purchase drugs and you know generally do whatever he wanted to do at that point.

REP. O'NEILL (69TH): Okay. But at some point something that happened that he either, he got arrested or he overdosed or something happened that he kind of got into one or other of our systems I assume.

MATT SCOZZAFAVA: You would know more than me on that one.

HENRY SCOZZAFAVA: Well he really didn't get arrested. He really, I just started to notice, he had gotten hooked on the drugs and we were trying to force him to go to other places you know to the

rehab, but the biggest thing is, I didn't really understand what was really going on and every time that we dealt with a place there was not much information given and the thing that I would like to see done is there would be like a followup if you went and picked somebody up, that there would be somebody there who would educate you and when he got out of the hospital, somebody be there to you know, your prescribing this medication, I didn't realize how dangerous it was because I never finished a bottle of pain pills in my life. I would throw them away you know, I'd take two or three pills and I says you know this is not gonna cure me so I really didn't understand and I can't even remember the names of anything. You know, I mean, I just, I have a disability so I didn't really do well. I'm not an educated person like everybody here.

REP. O'NEILL (69TH): Okay. But just going back though, when that first prescription given, neither the doctor or I assume he was in the hospital provided or pharmacist, anybody like that provided sort of a warning that this is highly addictive stuff and if you start becoming addicted, we need to start taking steps to try to deal with that?

HENRY SCOZZAFAVA: No.

REP. O'NEILL (69TH): Nothing like that at all?

HENRY SCOZZAFAVA: No. That's what I would like to see happen, that they really, somebody, when you're prescribed this and they give it to you right from the start, tell the people you know so that you know what to look for. That would be very helpful.

REP. O'NEILL (69TH): Thank you.

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

HENRY SCOZZAFAVA: Thank you for letting us speak.

REP. SCANLON (98TH): Next up is Maddy Frade.

MADDY FRADE: Hi. So today I'm here because --

REP. SCANLON (98TH): Maddy, can you just say your name for the record for us, please?

MADDY FRADE: Maddy Frade.

REP. SCANLON (98TH): Thank you.

MADDY FRADE: I'm here today because I lost my brother, Brian, to a drug overdose and you just need to help like other people who have to deal with this.

REP. SCANLON (98TH): Thank you for being here today, Maddy, and I hope that you know your brother is really proud of you for being here today and telling his story because by doing that, you're gonna get other people help and I hope you know that. Does anybody have any questions for Maddy? Thank you for being here today, Maddy. We really appreciate it.

MADDY FRADE: Thank you.

REP. SCANLON (98TH): Strongbow Lone Eagle?

STRONGBOW LONE EAGLE: I'm Strongbow Lone Eagle. I'm president of my class, 2022, at Henry Abbott Tech and just like he said earlier, it is true that peers speak more to their friends than their parents. I've heard over the last two years I've been president that kids do come from families who

deal with people that have addiction in their family, whether it's alcohol or opioids. Brian had two little kids. One was 1 and one was on the way. Every day his 1-year-old wakes up and asks for daddy. Mommy, where's daddy. Every time he walked in a room, everyone's faces just lit up with smiles. He was that type of person that no matter what happened or no matter what happened earlier that day, everyone always was happy to have him around. Coming from a family that is full of people that come from that and having friends that have told me stories, I've talked to several of my teachers who've dealt with that, I'm not disclosing them cause that's not my business but some teachers have granddaughters and friends no matter if they were blood or not tell me stories about what happened.

One thing I remember Brian coming out one time. I was working with a pool company. I tried to help him get a job so his mind was focused on the job a lot. We worked many hours together and that definitely secured a bond so when he tried to get help and they declined him, I knew he wasn't ready and he was scared so it was a week before his second child was born. So now they're going to wake up every day without dad and will one day walk down the aisle without daddy.

REP. SCANLON (98TH): Strongbow I want to thank you for being here today. Did you get elected class president?

STRONGBOW LONE EAGLE: Yeah.

REP. SCANLON (98TH): I can tell why cause you're already a leader so obviously people are willing to follow you, right?

STRONGBOW LONE EAGLE: Yes, sir.

REP. SCANLON (98TH): I want to thank you for being here today. Thank you for telling your story and your family's story and you know we're gonna say this till we're blue in the face, we gotta get this done. We all know that and you know that. I appreciate you helping us to tell the people of Connecticut why we have to do this so thank you. Any other questions today? Seeing none, thank you guys. All right. Suzi Craig followed by Sally Arnott.

SUZI CRAIG: Representative Scanlon, Senator Lesser, Members of the Committee, thank you for the opportunity to speak. My name is Suzi Craig and I represent Mental Health Connecticut. I also represent the Connecticut Parity Coalition. I want to thank you for your efforts in getting the Parity Coalition bill through last year. All of the bills that are up for discussion today really follow on the heels of that when we're talking about access and we're talking about removing barriers so people can get the help that they need so thank you so much for continuing to be champions.

Mental Health Connecticut has been around for 112 years. We offer advocacy, community education, and direct services. We continue to invest more of our time and energy into prevention and intervention because we have seen the impact of what happens to people's lives when they have been in the system for 10, 20, 30 or more years. So I want to focus on a couple of bills that will help us you know shift our thinking around you know where we put our time and energy and we really believe it's in prevention and intervention.

The peer support bill so HB 5248, Representative Dathan was asking some questions around the impact of peers. There are tons of case studies and evidence to support that peer workers help to lower health costs. They provide alternative to hospitalizations. They reduce the length of hospital stays and prevent re-hospitalization and there's tons of case studies that I can help provide so you can kind of dig into the data a little bit. They are a part of the healthcare team and the reason why we like this task force bill is because we really do need to sit down and bring all the players together to talk about what is the best way to bring more peer workers to the table. Mental Health Connecticut, our mother ship is Mental Health America and they provide a national certification. It does not compete the certification in the state. It's intended to help with the career path of a peer so this is something that is a nationwide effort and something that I would love to see Connecticut become a leader on. So that's peer.

Moving onto medication-assisted treatment. I mentioned the Connecticut Parity Coalition and our efforts around that. I want to thank this committee for continuing to find areas where we can improve access and ensure that people have choice in getting the treatment they want and I know I'm probably running out of time here so moving onto HB 5247, AN ACT CONCERNING EXPLANATIONS OF BENEFITS. Talking a lot about access as a barrier. Before access you know what comes first? Self-stigma and before someone can actually look for a treatment they first have to get to the point where they're looking at themselves and saying okay, I can do this, right? Representative Dathan mentioned some statistics.

I'm just going to throw a few more out there; 70 percent of youth living with major depression are in need of treatment and not receiving it; 70 percent. 50 percent of all lifetime mental health conditions develop by age 14 and then Representative Dathan also said 75 percent by age 24 so young adults on their parents' insurance, you know imagine knowing you're struggling with something, imagine looking for treatment and then thinking ooh, I'm not ready to talk to my parents about this. This is about confidentiality and choice and access so I think this one is a no-brainer. That's all I have to say.

REP. SCANLON (98TH): Thank you, Suzi, and thank you obviously for being a great member of the Parity Coalition and actually the organizer of the Parity Coalition and for helping us in this fight the last couple of years. Anybody have any questions for Suzi? If not, thank you for all your help. We've been joined by two Senators, I want to acknowledge Senator Bergstein first to come testify followed by Senator Slap and then we'll go to Sally Arnott and Ken Arnott.

SENATOR BERGSTEIN (36TH): Thank you so much chairs, ranking members, and other members of the Insurance Committee. I am here to support Bill 5247. I wanted to frame this bill from the perspective of a domestic violence victim. You have to understand that domestic violence victims are in their situation not by choice but because they are terrified. They've been scared into submission. They do not have the agency, the power, the support and resources necessary to leave their situation. They're often there because their partners have threatened to take their children or perhaps taking their income or threatening them, intimidating them

with all sorts of coercive controlling behaviors that can make a person feel powerless and it takes an enormous, I would say a super human amount of strength for a victim to actually summon the courage to leave. But what happens when they decide to leave? Oftentimes they go to the court and they ask for a protective order and we know from data that these protective orders are often denied. So we I think have a responsibility to help victims by giving them the resources, the tools, the support needed in order to make their claims heard and be believed and one of the most important ways we can do that is to offer them the ability to seek help from healthcare providers, from medical providers confidentially.

So I will give you a very concrete example. If a woman has been in any way beaten or assaulted by her partner, this is an example, this is the actual copy of an application from release from abuse that a victim needs to fill out and present to a court and it asks for actual proof, what happened, when it happened, where it happened, and who was present and the only way currently, under current law to seek a protective order and have it be granted is if you are, you feel you are and you can prove you are in immediate threat of physical harm. How does one prove that? If you walk into the courtroom perhaps with a black eye that day, maybe that's visible proof but we know that there are so many forms of abuse that are not visible. So a concrete example would be if a victim is having a confidential conversation with her doctor and maybe the doctor notices or maybe she says, you know, I have injuries and the doctor is available to provide confidential services like a bone scan, like an MRI, something

that wouldn't necessarily be in the normal course of their visit, but could prove that there has been physical harm.

And I would also like to offer the perspective of doctors who would like to have this tool in their toolkit. I did speak to one OBGYN who told me that a patient she had for many years who she suspected may have been the victim of abuse because she often did have broken bones and she had contusions in odd places on her body, but she never actually asked the victim directly because she was concerned about crossing a line and she didn't know what she could actually offer the victim, but if she could offer her confidential healthcare services or even refer her to a mental health provider or some other clinician and the victim could be assured confidentiality, that would be a way to provide true support and resources that could help the victim gain not only the evidence but the confidence, the support, and the courage to actually take the necessary steps and seek legal protection. Thank you.

REP. SCANLON (98TH): Thank you, Senator, for being here this morning to help shed some light on this. My wife runs a nonprofit on the shoreline that deals with helping women and girls in crisis and obviously domestic violence and confidentiality is something she deals with on a daily basis especially in an area like mine where people are often financially dependent on the abuser which makes it very difficult to even have a conversation about those services without any sort of approaching that person for help. I know people have questions so I'll open it up to others. Representative Dathan?

REP. DATHAN (142ND): Thank you very much, Mr. Chairman and thank you so much, Senator Bergstein for your advocacy on behalf of so many women in our state for this issue. You've been a true leader for this and I commend you for your efforts. Thank you. My question is more along the lines, you know you talked a lot about physical abuse but we know that domestic violence can also be emotional control and abuse and be psychological so there may not be any visible scars and causing lots of separate mental health issues. Can you explain, you know, in your experience how women might be apprehensive to go see a therapist or a counselor of some sort in these situations, particularly knowing that her abuser or his abuser in some situations as well might receive this sort of information?

SENATOR BERGSTEIN (36TH): Yes, I'd be happy to and the person who testified before me used a word that I hadn't heard before but I think is a really apt description; self-stigma. So the way that abusers maintain control is by constantly using power and control to minimize a person's self-value so that the person starts to believe that they actually are the cause of problems, that they are the source of whatever it is that's going on that's negative and so it's a form of self-stigma and the only way to break that cycle is to have somebody else validate that person and to say no, no, no. You actually are a worthy person. You do have a right to happiness, to independence, to free will, whatever it is that they are lacking and often that person can be a mental health provider so the ability to reach out and to seek services and support from somebody in that field confidentiality is absolutely critical because if there isn't confidentiality and help is

sought and the abuser then becomes aware of it from the explanation of benefits, that is when you can see retaliation and retaliation as we know can have dire consequences and sometimes fatal consequences. So we don't want to set victims up in this situation where if they seek help they might actually be risking their lives.

REP. DATHAN (142ND): Thank you very much for that and thank you, Mr. Chairman.

REP. SCANLON (98TH): Representative Hughes followed by Senator Lesser.

REP. HUGHES (135TH): Thank you, Senator, for your testimony and your continued advocacy. You really touched on exactly how this bill attempts to update an outdated system of not trauma-informed response, not trauma-informed healthcare and what Representative Dathan was speaking about is that party because of our outdated system, we depend on qualifiers from the professional or police or justice department that looks at physical proof and that external qualifier is the only thing that we'll accept towards exactly that application that is really outdated and not trauma-informed and abusers know this. They know how to make abuse not visible, how to make it successive and chronic over time and hidden. Can you speak to how the explanation of benefits, who owns, who has power over that in this current setting? Who has power over the explanation of benefits?

SENATOR BERGSTEIN (36TH): Well I think the person who should have power over the explanation of benefits is the person who has sought support and help from the medical or mental health community. I think that person's entitled, just as we respect

one's privacy in other matters, we respect privacy in these matters. When somebody needs help and reaches out for it, that communication should be confidential and the services should be confidential so that they, the patient, owns that information.

REP. HUGHES (135TH): Right and so who currently has economic power over the patient?

SENATOR BERGSTEIN (36TH): Right. So the person who has access to that information is the primary insurance holder who has the power and that power can be used for varying nefarious purposes and specifically to restrict people in that household under his management from seeking any care or even any contact outside of the abusive family dynamic.

REP. HUGHES (135TH): And can you speak to when is the most lethal risk time for a victim of domestic violence or intimate partner violence?

SENATOR BERGSTEIN (36TH): The most lethal time, the most dangerous time is when she decides to take that first step towards autonomy and independence. When she goes to the court and asks for protection, when she goes anywhere in public and says this is what's happening to me and I need help so if that is to a healthcare provider and that healthcare provider cannot protect the confidentiality of that conversation and that request for help, then she literally is putting her life in danger.

REP. HUGHES (135TH): Thank you. I used to work in a community mental health facility and when a victim would come to us on Friday for mental health or you know was referred to the hospital with broken bones and so forth and there was that safety assessment and question of how that happened and suspicion of

risk, often by Monday they'd be dead, killed by their partner because of that outing of the situation and often we would, not often, but several times and I remember the victims very well it would be a murder/suicide often because the consequences of being accountable for the violence they didn't want to take so it would --

SENATOR BERGSTEIN (36TH): Yeah, and we've seen that situation far too often in our state. It actually happens routinely and even when victims do raise red flags and say they are in danger and courts don't believe them, then we are literally perpetuating a cycle and giving permission to abusers to escalate so that's the cycle that we need to reverse and we need to empower victims and not empower abusers so we can break the cycle.

REP. HUGHES (135TH): And I just wanted to finally highlight how often, I know personally victims will not leave because their abusers have their health insurance for themselves and for their children and without that autonomy, without that very basic elemental protection, they are literally trapped.

SENATOR BERGSTEIN (36TH): Yeah, they are trapped. Yeah. So the economic benefit of access to healthcare, confidential access to healthcare for oneself and especially also for one's children is a primary driver of why people stay in dangerous and unacceptable conditions.

REP. HUGHES (135TH): Thank you.

REP. SCANLON (98TH): Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you, Senator Bergstein for your testimony and explaining I think an important part of this bill

which is keeping survivors of domestic violence alive. We know that people who access healthcare are often, that is often an initial trigger for violent acts and this bill could address that. You know last year you and I worked together, we got this through the Senate. This year it's a House Bill so hopefully the House will take its first steps and then we can work on it again and I just want to thank you for being here, for talking about a very important part of this bill and why this bill is so important to keep people safe in this state. Thank you.

SENATOR BERGSTEIN (36TH): thank you.

REP. SCANLON (98TH): Representative Nolan.

REP. NOLAN (39TH): Thank you and through you, I just want to say I appreciate you coming forth and speaking out on this. I live this every day in my job as a police officer and I see people held hostage because of this and with many of the things Representative Hughes talked about in regard to even police being trapped when we do our reports or when we do our outreach to help a person because sometimes you don't see the physical marks. It becomes difficult for us trying to push stuff into the court, for the court to see that there is definitely a need for a person to have control over their own benefits or be able to get access to them without having to go through the person who is abusing them and now, we're seeing more and more people being taken advantage of because they aren't able to control their benefits so I really thank you for supporting this and I definitely will be a supporter of this. I think it's time that we start

helping the victim and not those who are creating hostility for them. Thank you.

SENATOR BERGSTEIN (36TH): Thank you and if I may make one last comment, I think it's important to recognize also that the current statute and basis for seeking protective order is limited to fear of physical harm and threat of physical harm and that is far too narrow a view. We know that domestic violence and abuse takes many forms that are not visible, financial control, intimidation, threats, etc, so I'm hoping that we can expand the definition so all forms of abuse and control can be recognized and the appropriate protection can be granted by police and the courts.

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

SENATOR BERGSTEIN (36TH): Thank you.

REP. SCANLON (98TH): Next up we have Senator Slap. Following Senator Slap, we have Sally Arnott.

SENATOR SLAP (5TH): Thank you and I would ask if I could bring up one of our town counselors, Beth Kerrigan, to testify with me and she was the one who actually brought this issue that I'm gonna describe to my attention so with your indulgence, if we could do that quickly, that would be great.

REP. SCANLON (98TH): Absolutely. Councilwoman Kerrigan has a standing invitation to appear before the Insurance and Real Estate Committee, always good to see her.

SENATOR SLAP (5TH): Thank you very much. So, thank you, Representative Scanlon, Senator Lesser and

ranking member, Representative Pavalock-D'Amato and to all my friends and colleagues on the Insurance Committee. I know that you heard testimony earlier from Representative Gilchrist and Senator Formica and probably the most powerful testimony from Robin Brennan about Senate Bill 205 which aims to prohibit the exclusion of suicide as a covered cause of death by travel insurance policies and I have submitted testimony. I won't read it all. I just want to summarize my position on the bill and then hand it over to Councilwoman Kerrigan.

I did have the pleasure of meeting with you know officials, executives from the travel insurance industry and we talked about the policies that exist, very specific details and then kind of larger picture and in this case, you know it's heartbreaking obviously that what happened to Robin and Robin's family and Sean and you know, they had one type of travel insurance that did not cover suicide. There was another option I was told where by which it would and the issue with that of course is that nobody would you know expect that that would be something that they would need take travel insurance out for, right? So the buyer beware doesn't really work in this dynamic and I have a copy of the insurance policy, the travel insurance policy here and it says that, very specifically that it covers unforeseen events including the death of family member or travel companion. But then if you flip back to I guess it's page 16, there's exclusions and limitations and it says intentionally self-inflicted, suicide being one of them, while someone is insane and/or sane and I would argue that it's time that we rethink, and I know you all on this Committee are doing that, are helping to lead a

conversation about rethinking about how we talk about mental illness and this to me highlights that you know there is a problem here. When we look at it as one, an act, intentional by an insane person. I think we can do better and we have an opportunity, you all do to you know to advance this bill and to show that we look at mental illness and we look at suicide in a different way and we're gonna act with more compassion.

The argument that I think you'll hear if you haven't already against this legislation is that there's a cost, right, to consumers and that might be true. You know I think it's negligible. I would challenge the industry to you know have their actuary show us what that cost is, but even if there is a very small cost, I think it's one that's worth it for us to really take a stand, to help protect the Brennan's and other families that have gone through this horrific tragedy and to treat them with some level of compassion. So I'll leave it there and hand it over to Councilwoman Kerrigan.

BETH KERRIGAN: Thank you, Senator Slap. This is so sad sitting here hearing these stories after stories but I look at you and I'm filled with hope knowing that you really are getting it. And I'm also filled with hope because my car was illegally parked outside and I went out and the Capitol Police cut me some slack and said you're in luck, I moved my car, and so that worked out well.

Just so you know, my background is in insurance. I built my livelihood in selling insurance, probably the most contentious of all insurance long-term care insurance and my wife retired from the Hartford Insurance Company. I understand premiums, claims,

policies, exclusions, the concept of pooling risks, and it's all built on a promise. It's a trust and it's a reputation so much so that when I started my agency [inaudible - 01:53:30] purchased it, Sandy Weil at the time chose to merge Citigroup, Citibank with Travelers to form Citigroup and we wanted more than anything was the red umbrella because what that represented was I trust. I trust when I hand you my premium, you are gonna do good by your promise and I will say what happened to the Brennan family, it was a breakdown of their trust cause in good faith, they gave them \$188 dollars of premium in hopes in the event that there was a weather event or the such, an accident perhaps, that they would reimburse for the cost of the vacation which amounts to about \$2500 dollars. So when you think about it, AIG basically sold their red umbrella, their trust for \$2500 dollars. Now, here's a company, AIG back in 2019 in the third quarter earned \$648 million dollars. In 2008, the taxpayers bailed out AIG to the tune of \$180 billion dollars so that in 2009, AIG could pay out their executives a bonus of \$165 million dollars. Much like the Brennan family, our family loves vacation. There's nothing better. I swear I work for vacation, it's where family comes together to create memories and put behind all the chores and stuff and we buy also travel insurance and the first time we got to use it, our son developed the flu. It was a ski vacation and we got our money back, no arguments so I'm a big believer in travel insurance. We were not too long ago in Jamaica on vacation again, that volcano went off I think it was in Iceland and there was a whole bunch of people there. There was a family that was getting ready to go on the QE2 cause all the flights couldn't go through because of the ash in the sky, they had travel

insurance and it paid for them to get on the QE2 to go home because of this weather event so I believe in insurance. The difference between traveler's insurance and say life insurance is the opportunity for fraud. They're not individuals that are trying to make money by buying traveler's insurance. What they're trying to do is be sure that in the event that their moment to have fun, if something happens and they can't do that, that they don't also suffer the loss of the money that they paid for that trip.

Exclusions in the long-term care business, when I first got involved in it, included mental nervous psychoneurotic deficiencies and the argument was well what about Alzheimer's, what about dementia and they were forced to remove that. No one ever imagines that a loved one will choose death over life so just as Senator Slap mentioned, to have someone read a policy and say I'm going to choose the policy that specifically says it covers you in the event of suicide, I can't even fathom it just like I cannot fathom AIG would choose to say for yes, \$2500 dollars we're gonna sell our reputation and put the Brennan in more pain by not paying out their claim. I just want to leave with this, you know, I wrote this out on Met Life pad, which as I said I was in the insurance business, and on the top it says for the if in life so with respect to travel insurance, if the if isn't an accident or weather but instead a silent illness like depression, where those affected find that their only cure is to end the suffering by ending their life, I ask that you help them out. Thank you so much.

SENATOR LESSER (9TH): Thank you both for your testimony and I'm still in awe of the strength that Robin showed this morning in speaking at the press

conference and then also sharing her story with us. You know, Senator Slap, I know you had a conversation with the insurance company. I think it's very similar to a conversation that I had where they explained that this all could've been avoided if the Brennan family had chosen an advanced purchased a special I guess suicide rider in the event that a family member had you know or did choose to commit suicide. To me that's not how anybody would act. Obviously nobody purchases travel insurance to make money off of it so I'm sort of puzzled as to why we even have to be here. It seems like this shouldn't have to result in legislation but I appreciate you both advocating for the Brennan family and for addressing this issue and I'm hoping we can move swiftly and expeditiously to put this behind us. Are there questions or comments from members of the committee? Yes, Representative Delnicki?

REP. DELNICKI (14TH): Thank you, Mr. Chair and thank you, Senator, for bringing forward a witness here. Do you think the simplest solution is to have a standard level of coverage? Kind of like what we do with automobile policies, they have to have the following coverage, a standard level of coverage in this type of insurance policy to ensure things like this are covered?

SENATOR SLAP (5TH): I think that's a terrific idea. We see that with health insurance as well and you know people that they have some basic level of insurance and then something happens and then they realize you know they don't have what they thought they had and I think that this would make absolute sense. I would agree with that, Representative.

REP. DELNICKI (14TH): Well thank you for the answer there because I've been hit with, I'm trying to think of a tactful way to put this, I've had interesting dealings with the insurance industry in a variety of areas including peoples' homes crumbling, peoples' lives crumbling, and peoples' welfare crumbling and I'm struck by the fact that in some way, they're crying out for us to step in and say you have to cover the following things when you sell a policy and I can't help but think that that could very well be the simplest solution to a number of issues we have before us.

SENATOR SLAP (5TH): Yeah, I would agree and I think the crux of it is, why is suicide treated differently and that's really, it's fascinating to me and as we are right changing the way we look at suicide and mental illness, that we segregate it from the other types of illnesses and treat it still in this policy as a stigma and even the way people are described as being insane. We don't talk like that anymore so I thank you for your comments and for your leadership on this.

REP. DELNICKI (14TH): And thank you for coming forward with the testimony here. Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you, Representative Delnicki and you know I'm struck by the fact that I think that, my understanding and I'm not an expert on this is that the industry has evolved in leaps and bounds on another form of insurance, life insurance and it used to be that life insurers would universally exclude suicide. I think that case law, the practice in the industry is much more nuanced now and I think there's a lot more sensitivity to

evolving standards of how people use insurance and insurance's role in society. I think it's more complicated now and that's a very different kind of product where a family could actually materially benefit and this is just a very different situation and so again, it's surprising to me. I sort of take note of Councilwoman Kerrigan's comments that you know the most important thing in this industry is trust and that's something that might have been abrogated in this situation so I'm hoping that the industry will work to reestablish trust because people should buy travel insurance. It's a good thing.

BETH KERRIGAN: I would venture to say they probably didn't read the policy and most people, I've been in the insurance business for a long time, they trust unfortunately or fortunately, whatever, that it's about travel. If I can't make the trip, then you're gonna pay me back and I take the risk so. Thank you.

SENATOR LESSER (9TH): Thank you both. Are there questions or comments from members of the committee? If not, thank you both for your time. Moving back to the public portion of the testimony, we have Sally Arnott followed by Ken Arnott. You're coming up together? No, please do.

SALLY ARNOTT: Good afternoon. My name is Sally Arnott. On September 9, 2015, we lost our 39-year-old daughter, Erin Christine, to addiction disease. She was a smart, beautiful, gifted painter, writer and chef. She was a kind, giving, loving person. Drugs too easily gotten from doctors' prescriptions and on the street left her unable to survive.

These drug dealers are selling death with no regard to the people they are killing. The same scenario plays out in every town, every state, and every country worldwide and has become a pandemic. Something must be done to stop this scourge. Too many precious children and adults have been loss because everyone knows someone whose life has been touched by this disease. We had the ability to be standing beside our daughter, holding her hand as she died, hooked up to a respirator, dialysis, an EEG machine that showed that she was brain dead.

Too many other parents do not get to be with their loved ones as they lay dying. We wish this to never again happen to any other parent. Thank you for your consideration.

KEN ARNOTT: Erin had a work injury which ended with a semi-successful --

SENATOR LESSER (9TH): I'm sorry can you just state your name for the record?

KEN ARNOTT: Oh, Kenneth Arnott, New Milford.

SENATOR LESSER (9TH): Yes, go ahead.

KEN ARNOTT: Erin had a work injury which ended with a semi-successful elbow surgery. Erin took opioids as her doctor prescribed. That started her down the road. As a result of Erin's surgery, she broke her collarbone. At this point, she was living with all the wrong people, unable to work and thoroughly addicted. Erin ended up in jail. Two surgeries were unsuccessful for her broken bone. They were arranged by Niantic Women's Prison. Finally, Erin was shipped out from Niantic unconsciousness and unresponsive to Lawrence Memorial Hospital. They sent her by Life Star to Yale New Haven Hospital

where she died on September 9, 2015. Erin went to a number of ER's when she overdosed. We would go to those ER's all over Connecticut. Each time we asked for help, none was given. She was known as a frequent flier and dismissed from the ER's at the first opportunity. Every addict is treated the same, witnessed last year's overdose fiasco on the New Haven. If Erin lived now, Erin would have had a better chance for survival. New Milford has employed an officer to work with addicts and families to secure treatment and to work with the courts. That's a good thing. Another good thing is the creation of Brian Cody's Law. The approach taken with Brian Cody's Law is excellent. Why no one has gone this far to this point is difficult to understand. Sally and I thoroughly agree with the proposed laws which include stricter penalties for drug dealers, closing opioid trap houses, developing an overall addictive drug inventory control, and an expanded support system.

I have a few notes here that I'd just like to throw by you guys, not directly related to Erin, but directly related to this problem. Up until recently, the maximum number of rehab beds was 126 for all of Connecticut. Trying to find her a bed was impossible, messages not returned, inaccurate information given. That's one. Two, the court's handling of addicts has to be modified. Some states employ drug courts which seem to work well. Number three, school rules have to be toughened. Erin had no trouble getting alcohol in school and that affected her performance when she was in high school. I'm sure it's easier to sneak drugs rather than alcohol into middle and high schools now. Teachers and staff should be able to monitor and

enforce rules without danger of parental interference and lawsuits. Unannounced drug searches by police and dogs should be allowed as well without danger of parental interference and lawsuits.

That's enough of that but for the last three years, we have attended meetings put on the CARES group and this has been a significant lynchpin for a number of people. The purpose of the group is to support the families of addicts and help their addicted family member who wants to go into rehabilitation. We have seen many success stories come out of the group. It is a way to have family unite and fight the addiction and its many consequences. Finally, it's my hope that the Connecticut government will unite in a nonpartisan spirited fashion to protect our young and to do what is necessary to stop the drug epidemic in Connecticut. Up until this point, the government seems to be more bound and is unresponsive to the over 1200 recorded deaths from drugs this year. Sally stated and I agree, we are in a pandemic. Just like the flu, it's just as bad, it's just as deadly, probably a lot more deadly and quite frankly, if they spent one hundredth of one thousandth of the money that they're going to do on this flu, we wouldn't have a problem.

SENATOR LESSER (9TH): Thank you for your testimony and for being such incredible advocates for Erin and for other people like her all across the State of Connecticut and my hope is that it makes a difference. You know in listening carefully to your testimony, I'm struck by the fact that you know we are just the Insurance and Real Estate Committee, one of many committees in this building and there are things that we can and should do and will do to

help do our part to address this horrible epidemic. I don't know if you heard my comments this morning, but Connecticut ranks number 10 in the country, in the top 10 for our death rate for overdoses and it's a sign that we're not doing anywhere near enough. We passed some bills last year but we're not doing enough. But it was striking in your testimony that basically every committee in this building should be doing its part whether you're talking about what happens in schools, the education committee and all of the other different parts of government that intersect with this crisis in one way or the other so it is a public health crisis, you're absolutely right and regardless of which hat you wear in this building, we need to all come together to address it as seriously as I think it needs to be addressed so thank you for your advocacy. Are there comments from members of the committee? Yes, Representative Hughes.

REP. HUGHES (135TH): Thank you. Thank you, Mr. Chair and thank you for your testimony. You touched a little about the CARES groups and I've worked very directly with them as a social worker with them. Can you just tell us a little bit more? Do they charge for services for those families and are they reimbursed by insurance?

SALLY ARNOTT: CARES group is Community Addiction Resource Education and Support system so they find beds that are available, counselors, they have done interventions. They have helped people through the system, through the insurance system mostly finding beds out of state such as in Pennsylvania and Florida where more services are available. CARES does not charge for the guidance.

REP. HUGHES (135TH): That's what I wanted you to testify to, yes.

KEN ARNOTT: They are a true non-profit.

REP. HUGHES (135TH): Exactly. And so how did it come to be? Do you know? How did the CARES group get formed?

SALLY ARNOTT: A lady named Donna DeLuca and her son, Matthew, a recovered addict founded it and she's been doing work in this field for 20 years. We met the Morrissey's through the CARES group. Our daughter's been going for 4-1/2 years. We found the group after a year after she had passed and we attend meetings in our town and we all support each other and lean on each other and know their stories because there all the same. Maybe they're in a different place than we are, most of them have not lost children but there are a few in our group that have.

REP. HUGHES (135TH): Do you think that if you and your family found the CARES group earlier in the process, that would've made a difference?

SALLY ARNOTT: I definitely think so. Yeah, we do definitely think it would've helped and she would be here today probably.

KEN ARNOTT: I spent a lot of time on the phone going through this, that and the other trying to get some kind of help for this young lady but could not do it.

SALLY ARNOTT: When they need help, they need it immediately. They don't need it next week or next month or when a bed becomes available. They need it

now. They say I'm ready, they need a bed, they need a service.

KEN ARNOTT: Up until this point and I think it's still going on there's a lot of, as I said, inaccuracies coming back at us and not telling the truth about what's available, who it's available to and why.

REP. HUGHES (135TH): So the CARES group and advocates are really essential navigators to getting access to a very byzantine system that is just not set up to support people in crisis.

SALLY ARNOTT: Absolutely.

KEN ARNOTT: That's a good word.

SALLY ARNOTT: And if they don't have private insurance and they can find state insurance, they can be helped as well.

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

SALLY ARNOTT: Thank you so much.

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

SALLY ARNOTT: Thank you very much.

SENATOR LESSER (9TH): Those are all the speakers we have signed up to testify on House Bill 5248. If you have not signed up to testify, you can still certainly do so with the Committee Clerk, but proceeding on to the next bill on the agenda, House Bill 2520. We have Daniel Morgan followed by Dr. Steve Madonick. Okay. Is Dr. Steve Madonick in the, yes.

STEVE MADONICK: Thank you, Senator Lesser and Committee. Good afternoon. My name is Dr. Steven Madonick. I am a psychiatrist and President-Elect of the Connecticut Psychiatric Society. It's an organization that represents 800 psychiatrists in Connecticut. I'm also the Medical Director of Community Health Resources (CHR). We support House Bill 5250 to improve the safety and possibly save the lives of some of our most vulnerable patients.

Suicide rates have been rising in the United States for the past 20 years. Some suicides are planned. Many suicides occur impulsively. When they occur impulsively, in terms of dealing with this, an important strategy is to prevent access to the means of self-harm. For example, if a clinician performs a risk assessment and finds an elevated risk of suicide, we wouldn't allow for somebody to have, we wouldn't recommend for somebody to have a weapon or a gun. It's also not a good idea for somebody to have a 90-day supply of prescribed medication, which can be as lethal in certain circumstances.

There are enormous differences between attempted suicide by ingesting a 90-day supply of medication a 30-day supply of medication, and a 7-day supply of medication. Some medications and combinations of medications are far more dangerous than others. Respiratory suppression, neuroleptic malignant syndrome, serotonin syndrome, seizures, cardiovascular effects and other life-threatening consequences of overdose are much more likely with higher doses of medication. So 90-day supplies of medication should really never be mandated, provided or incentivized by pharmacies and insurance companies when patients are at elevated risk of suicide. Psychiatrists have first-hand knowledge of

these patients, access to medical records and other clinicians. Therefore, psychiatrists should make the decisions about dispensing potentially lethal doses of medication.

If somebody shouldn't have a weapon or a gun, because they are at an elevated risk of suicide, they should not have a 90-day supply of medication or at least that should be up to their doctor and their therapeutic team. In a world for convenience and economy we are happy to work with insurers and pharmacists. We have no objection to 90-day supplies of medication in most circumstances. What we do object to is insurance companies assessing financial penalties such as higher co-payments for patients who heed their doctor's advice and obtain shorter, safer prescriptions in times of elevated suicide risk, in those specific times. This is unneeded interference in the doctor patient relationship. In the area of suicide assessment and prevention as well as other areas where large quantities of medication pose a risk, we professionals need to be the ones determining both risk and quantity of medication dispensed. In an era of rising suicide rates, this is a medical concern and a matter of life and death.

SENATOR LESSER (9TH): Thank you, doctor, for your testimony. I just have a couple of questions. One, we did get some I guess, you know, I understand this bill to be intended to limit the amount of medication to be prescribed.

STEVE MADONICK: Which should be up to the physician, not the pharmacy to extend it without a clinical exam.

SENATOR LESSER (9TH): Yeah so I guess the question, the written testimony that we received in opposition to this sort of outlines I guess what I would characterize as a parade of horrors where a physician could prescribe a lifetime supply of psychotropic medication. I'm sure that's not what the intent of the bill is to do.

STEVE MADONICK: No, no. It's to, when you write a prescription, right, you write the medication, you write the dose and then you write the quantity and that's the way it should be filled. Now if I have somebody who recently got out of the hospital and I know they're still at high risk or somebody that I feel is at high risk for suicide and I write that they should have a 7-day supply of medication, a pharmacist should not be able to say oh, would you like a 90-day supply of medication and an insurance company shouldn't be able to say listen, we'll have a lot cheaper co-pays for you if you have a 90-day supply of medication. For most people that's fine. Listen for me, for my patients, I have no problems with people having 90-day supply of medications. It's often very economical but when somebody is at a particular risk and they can, you know, and the doctor's order can be overwritten and instead of getting a 7-day or 14-day or 30-day supply of medication, it's potentially lethal. It needs to be filled as written by the doctor.

SENATOR LESSER (9TH): Just to be sort of precise on the question, I guess the question, you could override a doctor in either direction, either by dispensing less medication than the doctor requests or more of the medication than the doctor requests and I sort of understood the intent of this legislation to address that latter part which is

when, if the doctor believes that a patient needs to be supervised for their safety and a 90-day supply would be dangerous, it would be attempted to focus on that particular issue and I'm just responding to, obviously I understand it's the position of the medical profession that nothing should come between a doctor and a patient. I understand that and I respect that, but I just want to make sure that you're not also asking, you, whether or not you would be concerned if there were restrictions in the other direction, if an insured decided to prescribe, to dispense less than the doctor recommended, if that would have the same concern.

STEVE MADONICK: I don't think they should be altering the quantity. I just don't think they should be doing that. It's part of the prescription. That's what we write, that's what we do. If they have a concern or an issue, you know they can take it up with us I think but I don't think a prescription that we write and that we give should be altered by anybody you know without good reason and discussion.

SENATOR LESSER (9TH): I think the reason in that case would be again in the interest of patient safety so if a doctor wrote a prescription, again, a hypothetical situation --

STEVE MADONICK: Like a non-opiate for example.

SENATOR LESSER (4TH): Exactly, we're going to give you a year's supply or a 10-year supply and the insurance company says or the pharmacist or someone else comes in and says we don't think that that's a safe, you know that a patient should be more closely managed that that.

STEVE MADONICK: I think that's -- you know that's the opposite case. I mean I think -- you know there are standards of care. I mean I don't think giving more than a year's supply of medication is within the standard of care and I think that if that's the case, that something that should be reflected back to the doctor and if it's a problem then the practice can be put to the medical board for example but I, you know, I think my concern is particularly in the issue, with regard to the issue of suicide. If we say that somebody really shouldn't have more than a 7-day supply of medication, I've seen it happen you know Walgreen's and CVS have a policy now they'll say well, would you like a 90-day supply and the insurers will say oh it's much less of a copay for a 90-day supply rather than a 30-day supply with a couple of refills. We really need to be able to control that in this small group of people that we're talking about because we don't want people you know having access to lethal means if they're likely to impulsively commit suicide at that specific time in their life.

SENATOR LESSER (4TH): And the bill sort of specifies, as I understand it the bill is limited to psychotropic medications. Certainly there are other medications that pose safety risks and I assume that all psychotropic medications pose significant risks and so I'm just trying to think of how we should think through which pharmacies are included in this bill, which pharmacy benefits are included in this bill and which ones we should not.

STEVE MADONICK: I mean the psychotropic medications are you know, there's a question of access and there's a question of legality, right? The psychotropic medications are, you have access to

them, right? So people will impulsively use them. If you have a large quantity, that makes them dangerous. They're not necessarily the most dangerous medications. Psychotropic medications have become much less dangerous over the past 40 or 50 years. It takes a lot, a large quantity to seriously hurt yourself with many of our medications. Some of them are quite lethal but not many of them. I mean there are non-prescription medications that are much more lethal such as Tylenol and aspirin. I mean you can hurt yourself very severely with a bottle of each of those medications but these are medications that people have when they're in a situation where they're acutely suicidal and I think the quantities need to be determined by the professional at that time and not be overridden, at least not without some sort of a process in place. That's my concern.

SENATOR LESSER (9TH): All right. Thank you. I appreciate it. Are there questions or comments from members of the committee? Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you, Mr. Chairman. I also want to thank you for testifying because I completely agree with you. My father's a dentist and I've seen that. My dad has always been pretty strict with you know the doctor has the relationship and when there is a doctor that is, you know not within those standards of care, then that's what the medical board is for and that's what losing their license is for. But I think some of the questions as far as whether it should be just this or expanded, I'm not sure if you answered that. I understand your concern why it's specifically a

psychotropic drug, but are there other ones that you think should be included or should it be expanded?

STEVE MADONICK: I think that when a physician writes a prescription for any medication, they have to consider the risk and the legality and if a mental illness is involved, if suicidality is involved, they have to consider that and how much of a quantity of medication they're gonna give somebody and when they do that, that quantity needs to stand and that needs to be their decision with their patient and not a decision that's made by the insurance company or by the pharmacy outside of that because they don't have access to the same information, the same evaluation that's been done.

REP. PAVALOCK-D'AMATO (77TH): Right. I completely agree. Thank you very much.

STEVEN MADONICK: Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Just one last question from me. Obviously the term in this bill is psychotropic, that's the term used in the bill. Obviously there are drugs that are controlled substances that are psychotropic and there are controlled substances that are not psychotropic. How do -- I don't know a whole lot about the controlled substances law. How does that sort of intersect with this proposal? Is that something you know?

STEVEN MADONICK: I think the basic thing is that we, you're making a clinical judgement with what medication you choose, how often you choose to give it, what strength you're going to give it, and what quantity you dispense you know and some patients you're gonna dispense a 90-day supply because it's

not a problem. They're doing fine, they're very stable, right? Some patients you know may have had a suicide attempt recently and may have just come out of a hospital and you're gonna dispense a 7 or 14-day supply of a certain medication and I think that part of your clinical judgement needs to stand and not be reinterpreted arbitrarily by an insurer or by a pharmacy.

SENATOR LESSER (9TH): Other questions from the Committee? If not, Doctor, thank you for your testimony.

STEVE MADONICK: Thank you very much.

SENATOR LESSER (9TH): Is Daniel Morgan here? We will move to the next bill on the agenda, House Bill 5254. Is Destiney Stackhouse here? Following Destiney, we'll have Dr. Sheila Cooperman. Good afternoon.

DESTINEEY STACKHOUSE: Hello and good afternoon Senator Lesser and members of the Insurance and Real Estate Committee. My name is Destiney Stackhouse and I am a UConn MSW student. I am here today to speak about House Bill No. 5254, which is AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER and why I support the bill.

As a future social worker, addiction and drug abuse are challenges that my future clients may face when I am out in the field. The combination of medication, counseling, and behavioral therapies can help people sustain recovery. With the passing of this bill, many Connecticut residents can get the help they need to stop the problem before it leads to a tragedy.

According to a story by the University of Connecticut in Science Daily, the rate of opioid overdose deaths in the state is higher than the national average. In 2017, Connecticut had the eighth highest rate of opioid overdose deaths in the nation. According to the Office of the Chief Medical Examiner, in 2019 there were 1127 opioid related deaths in Connecticut. Requiring health insurance companies to cover medication-assisted treatment for opioid use disorder will help combat this issue in Connecticut.

This bill should be supported so that Connecticut residents can get the help they need with little worry about the financial burden that can come from seeking help. Thank you.

SENATOR LESSER (9TH): Thank you so much. Are there questions or comments from members of the committee? If not, thank you very much for your testimony. Next up, Dr. Sheila Cooperman. Following Dr. Cooperman, we'll hear from Cynthia Samokar.

SHEILA COOPERMAN: So good afternoon. I am Dr. Sheila Cooperman, an Addiction Psychiatrist and President of the Connecticut Psychiatric Society. I wanted to thank Senator Lesser for supporting the Mental Health Parity Bill. This is very important to us and thank you to the Committee for listening to this testimony today. You know I started with you this morning in the press conference so I don't want to repeat a lot of the things people had mentioned this morning, but the Connecticut Psychiatric Society supports 5254 and 5256.

What I wanted to highlight about the medication assisted treatment bill is that clearly, a number of people have mentioned that there are medications to

treat opioid use disorders and fortunately, we have those available at this point in time. However, there are a number of people who cannot get access to those medications partially due to some of the junk insurance forms that have been, those high deductible insurance policies make it prohibitively expensive for people to access those medications and for those high out-of-pocket expenses and that is a tragedy given the death rate due to the opioid use disorders.

Also I think what's complicated the issue right now in Connecticut is not only is there heroin on the street, but a rising rate of fentanyl and carfentanil which is much more powerful than heroin and makes it much more imperative to begin medication assisted treatment. Part of the reason we need support for 5256 is that I've been treating people struggling with substance use disorders for nearly 30 years and when I first started in this field, there were not very many medication-assisted treatments available. There was methadone and there was Antabuse. Now we have these wonderful medications but we don't have the support that we need in treatment settings.

SENATOR LESSER (9TH): You can summarize. That's okay.

SHEILA COOPERMAN: Okay. So I stopped on time but you know I think the piece that's been really striking in working in this field is that you know when I first started, people went to rehabilitation programs for six weeks, two months, three months, six months, a year. There were therapeutic communities for treatment of opioid use disorders where people remained for a year and their success

rate was 90 percent. Now, if someone goes in for an insurance-covered 1-2 days detox, for opioid use disorders the relapse rate within two weeks is 90 percent so clearly, we need the support of a continuum of care. Not everybody needs to go for inpatient detox. They may have a safe home environment where home induction on Suboxone is necessary; however, you've heard from a number of the families where if you don't get treatment at the moment that someone is motivated, you know, a legality is pending. So you know, I think you heard very compelling testimony from a family where they really didn't know you know what are the consequences of opioid use disorders and you do need to involve the family. The family can be key in recovery for people who are addicted to a multitude of substances so involving them can increase the rate of survival. I think the other piece that people really need to pay attention to is how highly seductive opiates are, that putting limits on the number of rehabs, the number of detoxes I think can be falling down a rabbit hole and may not get people to the recovery that you want them to. But again, it is a chronic brain disease that you need a lifelong recovery, that there are a number of different times along the course of recovery that there are relapses and the family needs to know that and the patient needs to know that. You know the beauty of having people who are motivated for recovery is that if you can get them into a program where they can start to heal and introduce them to sobriety, let that system cool down, allow them to start to heal, introduce them to 12-step programs, I think you increase the rate of their recovery, you introduce them into doing 90 meetings in 90 days. Again, this increases their chances of remaining

sober. You know certainly there are peer recovery coaches that are available now. You know fortunately, here in Connecticut, what we have, I think Dr. Steven Wolf at St. Francis is really a star in having people who come in with an opiate overdose into the St. Francis Emergency room, they will connect them with a recovery coach. They will put them on Suboxone in the emergency room and they will hook them up with aftercare so this kind of model is life-saving and we need the insurance support for this.

SENATOR LESSER (9TH): Thank you. That was a good summary. It was a lengthy summary, but it was a good summary. Thank you, Doctor, and as you know, it had been our intention last year as part of the parity bill to address coverage of medication-assisted treatment and in the interest of passing something quickly, we were not able to include it but it's something that is incredibly important and that's why it's back before this Committee. Are there questions or comments from members of the committee? Yes, Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair, and just a question cause I keep hearing safe homes and support services from family and friends. What percentage do you think there are out there of folks that have a safe home or some kind of a social support network that they could tap into? And I realize this is a tough question.

SHEILA COOPERMAN: That is a very tough question so I think I'm gonna answer that by saying a safe home is one where there are not other people who are not actively using and who have some understanding of

the disease concept of addiction so what I will tell you is that certainly a lot of people believe that addiction is a family disease, that in some ways because it affects the family, but in others because there are some rates of predisposition to inheritability of substance use disorders so I think you have to look at each home individually. What looks good on the outside may not be so healthy on the inside.

REP. DELNICKI (14TH): And a followup to that and this is probably a tougher question for you. For the individual that has the problem with the opioid addiction, how many of them would be afraid to share that with a safe home environment and would actually avoid that only because they were in fear of some kind of stigmatizing in a situation like that or being judged for the problem they have?

SHEILA COOPERMAN: Well you know I think there's another piece to this, that may be more elusive and that is, you know as I mentioned, you know opiates are very seductive so I think one thing that is very difficult is that for a lot of people who fall into dependence on opiates, a lot of people believe that if they go in for detox for example, that they don't need medication after they leave, that they're never gonna use it again, they have every intention of staying clean and they don't want to have anything to do with methadone, with Suboxone or with Vivitrol. You know, a lot of times these are young people who you know believe that you know they can conquer this and that they're not powerless in the face of you know these substances.

REP. DELNICKI (14TH): And another question pertaining to the methadone because it seems like in

some areas it has had some kind of success but it's not really utilized in a fashion of get the person totally away from everything, whether it be the methadone or the opioid.

SHEILA COOPERMAN: So I think that is a really good question or you know a really good point because methadone actually has, people who participate in methadone maintenance programs actually have a higher retention rate in treatment than some of the other forms of medication-assisted treatment. However, what that requires though is that people have to go to the clinic every day to get their dose and eventually work to get medication for passive but there's real stigma attached to standing outside of a methadone clinic so it's been easier for people to have Suboxone be prescribed and they can get that in their doctor's office. So I think that there's a lot of stigma attached to people who can't believe that they are really a victim to these types of drugs but what I'll tell you is that Vivitrol can be used for people who have the concern about being dependent on Suboxone or methadone. Vivitrol does not work on the opiate receptors. Vivitrol works in a very different way and you're not dependent.

REP. DELNICKI (14TH): Okay. Well thank you for your testimony and answering those questions. I appreciate that. Thank you, Mr. Chair.

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

REP. HUGHES (135TH): Thank you for your testimony and your witness this morning at the press conference. As your expertise indicates, not just around this but the timing should not be dictated by arbitrary restrictions on you know 28 days or 2 days

or 5 days. Like the timing is completely dependent on most of the individuals and are usually the longer they're immersed in a program, the better outcomes and we see that with data but that's not the way the insurance industry works.

SHEILA COOPERMAN: No and the other piece I wanted to mention about this is you know having worked in emergency rooms also and you have someone who comes in who's in withdrawal and you have to wait and argue with the insurance company about why you think that this person needs to come in and be detoxed while the person is in withdrawal, they want to leave the emergency room because you're not treating them, you're not getting them to the place that they want to be to right away and that is very destructive to the patient and also to their family.

REP. HUGHES (135TH): And I would ask you one more question, as a provider, how much of your time is spent arguing with claims and insurance people to treat versus actual in-person treatment of your patient?

SHEILA COOPERMAN: So when you have people who are on private insurance, too much, too much time. Any time spent on that is time that you're not spending with a patient and I know that I represent the Psychiatric Society on this. Any time whether you have to do pre-cert or an admission or whether you have to do an authorization on medication, that's time that you're taking away from patients.

REP. HUGHES (135TH): Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Are there questions or comments from members of the

committee? If not, thank you, Doctor, for your testimony.

SHEILA COOPERMAN: Thank you very much.

SENATOR LESSER (9TH): Next up, Cynthia Samokar followed by Lisa Winjum. Good afternoon.

CYNTHIA SAMOKAR: Good afternoon, Senator Matthew Lesser, and ranking members as well as distinguished members of the Insurance and Real Estate Committee. My name is Cynthia Samokar and I am a Graduate student at UCONN's School of Social Work. I live and vote in the downtown area of Middletown, Connecticut and I come before you today in support of H.B. 5254, AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR MEDICATION ASSISTED TREATMENT FOR Opioid Use Disorder.

The opioid crisis is a huge part of what is impacting many Connecticut residents, and the consideration that health insurance could cover the medication assisted treatment would be phenomenal. It is listed in a small part of section 1 in the bill that states such coverage shall include medically necessary behavioral therapy and counseling in combination with prescription drugs that are prescribed by a physician or physician assistant. I whole heartedly agree with this because this is what I believe would be beneficial.

Why am I so passionate about this? I once had a client that had to go to the methadone clinic every day and was lucky enough to have Medicaid cover her medication assisted treatment. Her addiction was so strong that she lost job, custody of her two children and her marriage ended in divorce. She spoke with me about her story every day and there

was always a new layer added to it. She wanted to have more for herself and didn't want to live the life that she had suffered from for so many years. She was ready for change and was taking steps in the right direction to get there. If it weren't for her insurance covering her medication assisted treatment, she wouldn't have been able to focus on those goals. I believe that it's only right for other insurance companies to give others this right. I believe that everyone has a right to a second chance in recovery. And that's it. Thank you.

SENATOR LESSER (9TH): Thank you so much and before I mispronounced your name, I wish I'd known you were a constituent of mine so apologies for that.

CYNTHIA SAMOKAR: Oh yeah.

SENATOR LESSER (9TH): Thank you so much for your testimony and for sharing why this is so important. Are there questions from members of the committee? Of not, thank you very much. Next up Lisa Winjum. Good to see you again.

LISA WINJUM: Good to see you again and thank you for having me this morning and thank you for raising this medication assistant treatment bill this year, as it was left out of the mental health parity bill that passed last year. I'm Lisa Winjum. I'm the Executive Director of the NAMI Connecticut. For 35 years, we've been providing hope and help to people in Connecticut through our support groups, education programs, and advocacy. We envision a world where all people affected in any way by mental health conditions experience the best possible quality of life and where mental health is accepted as an integral part of overall wellbeing. We support HB 5254 requiring health insurance coverage for

medication assisted treatment for opioid use disorder.

This bill takes care of the provision that didn't make it into the bill last year. One of NAMI's top policy priorities is ensuring insurance reforms for mental health and substance abuse disorder coverage in every health plan at the same level as other health conditions. Without parity, people do not get the care they need to experience recovery. Mental illnesses often coincide with substance abuse disorders. Connecticut is experiencing an overall rise in opioid-related overdose deaths. Insurance coverage of MAT including medically necessary behavioral therapy and counseling will save lives. Without it, Connecticut will continue a history of unequal treatment of substance use services that result in often fatal consequences and puts barriers between people and recovery.

Studies have shown MAT can increase the likelihood a person stays in treatment, reduce the risk of overdose and gives the person the possibility of a better life. NAMI Connecticut has also submitted written testimony in support of HB 5248, TO ESTABLISH A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR PEER SUPPORT SERVICES IN THE STATE, and in support of Senate Bill 205. Thank you for all that you are doing to stop insurance practices that discriminate against people with mental illness. Thank you again and I'm happy to answer any questions.

SENATOR LESSER (9TH): Thank you so much for your testimony and we appreciate working with NAMI Connecticut on this and any other issues. Just as a way of thinking about, this was originally part of

the mental health parity bill that we passed last year as you mentioned, do you see the parity legislation as potentially leading to MAT coverage on its own or is that something that could be addressed through that mechanism aside from the merits of potentially passing this standalone legislation?

LISA WINJUM: I would hope that one day it could but we would be better off if we could pass this standalone medication assisted treatment legislation.

SENATOR LESSER (9TH): Thank you. Other questions from members of the committee? If not, thank you so much for your testimony. Because this is not a hugely long public hearing we're going to be a little loosey-goosey with the rules and go back to House Bill 5250 at this point because I believe Danielle Morgan has joined us. Good afternoon.

DANIELLE MORGAN: Thank you, Senator Lesser, particularly for your flexibility. I was stuck in a methadone clinic admitting several patients late today so I apologize.

SENATOR LESSER (9TH): That sounds important.

DANIELLE MORGAN: [Laughs]. So my name is Danielle Morgan. I'm a Psychiatric Addiction Specialist here in Connecticut and I'm presenting the Connecticut APRN Society on Bill 5250, and I want to thank the Committee for raising this bill. We incepted this concept language last year and I want to thank Representative Scanlon for being so fabulous to argue the bill in the House last year, it was great, and bringing it forth again this year.

There's been a pretty common practice, it's become standard of care in the State of Connecticut for health insurance companies to mandate a 90-day supply of psychotropic medications to be filled after the first 30-day has been dispensed by any provider really so pediatric provider, obstetrician, psychiatric provider, geriatric provider, anybody that writes for a psychotropic after that first 30-day fill for any patient, child, adolescent, adult, geriatric, is then mandated to write a 90-day supply. We're in opposition of this. We've been fighting this for decades now it seems and so we come to the legislature to get some help with this.

I saw there was an opposition letter to this and we were unclear about that because none of us want to dispense a lifetime supply of medication. That wouldn't be the point of this bill or this language. The point actually would be to allow the clinicians, we who made the medically complicated decisions every day with patients in our office, taking in all kinds of data, the communities that we're serving, the people in the homes that live with our psychiatric patients, the psychiatric state that they're in, whether they're post-hospitalization or in detox, whatever state they're in, to deem the appropriate quantity of medication that they need. If a 90-day supply is appropriate, we're happy to dispense that. If a two-week supply is appropriate, we need to dispense that. So that's what we're hoping to target with this legislation. Thank you.

SENATOR LESSER (9TH): Thank you and I'll sort of ask a similar question of what I asked earlier which was if, obviously I assume you would like it to be able to prescribe whatever quantity under any circumstances, but if the main purpose of this

legislation, the main thrust is to protect patients from getting excessive quantities of medication, would you support a safeguard in only one direction as a potential way of addressing it? So if you were to say write a prescription for a 90-day supply would that allow an insurer to dispense a smaller quantity? Is that something that you could live with understanding that sort of the point of the legislation is to prevent the reverse from happening which is you write a two-week prescription or a 7-day supply and then the insurance dispenses a 90-day.

DANIELLE MORGAN: We could live with that.

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

DANIELLE MORGAN: Uh-huh.

SENATOR LESSER (9TH): Are there questions or comments from members of the committee? Yes, Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chairman and thank you for coming forward with your testimony on this issue. Can you just go into a little depth on how a 90-day supply dispensed as it currently is could be dangerous to the patient?

DANIELLE MORGAN: Sure. So there are some psychiatric medications that when taken in greater supplies of two weeks could result in death so any medication that we, any of those medications that we might prescribe particularly for patients who are suicidal which is often how psychiatric patients present, those medications might be lifesaving when taken over the long term and treating their conditions. In the short term when they initiate them and they're not yet stable could be very deadly

so we don't dispense them in large quantities until they've reached efficacy and psychotropics don't reach efficacy in short of periods of time. They need longer periods of time to work so we like to hold tight on those quantities that we dispense.

REP. DELNICKI (14TH): So then is it an accurate statement that it's important that the clinician is interacting with the patient so that they can make the determination quickly as to whether or not the long duration of the supply is a problem?

DANIELLE MORGAN: So that brings up an excellent second point; 90-day supplies often give patients a sort of pass/go kind of point of view that they don't really need to keep their appointments with their clinicians so then we're not able to monitor them as frequently which might be appropriate when you're monitoring someone's blood pressure or their glucose control. A three-month appointment might be appropriate, but that's not necessarily the case with psychiatric care. It's multi-dimensional and psychosocial interventions that are given at regular intervals, every two weeks, every three weeks are very, very important so yes, that's an excellent point.

REP. DELNICKI (14TH): And just as a followup to the medications themselves, can they have any interaction when it comes to different chemicals in the bloodstream and things of that nature without regular testing?

DANIELLE MORGAN: We do monitor various metabolic parameters with various psychotropics so yes, we're monitoring that generally two, four and sometimes six and eight-week intervals so yes.

REP. DELNICKI (14TH): But if you were doing a 90-day supply would you still be doing that?

DANIELLE MORGAN: We would try but again, when you're giving patients pass/go's with those 90-day supplies, it's harder to engage patients in treatment when they're already dealing with a highly stigmatized illness that doesn't encourage compliance with caregivers.

REP. DELNICKI (14TH): Okay. Well thank you for your answers and thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you, Representative. Just for purposes of clarifying and I think maybe elucidating on Representative Delnicki's question, would you say that the main purpose of this legislation is to ensure active monitoring of a patient's condition by using access to the medications to ensure that there's a relationship, an ongoing relationship with a patient to make sure that they're in recovery or is it more motivated out of the safety question about the medications themselves? I think there's just two different ways of looking at why it's important to ensure an ongoing relationship. Which would you say would be the more important question that we're looking at here?

DANIELLE MORGAN: I don't think either is more important. I think it's multi-pronged so I think it's important to maintain a relationship with the patient for clinical reasons, for medical reasons, for safety reasons so those are all equally important.

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

DANIELLE MORGAN: Great. Thank you so much again for your flexibility as well and being disruptive.

SENATOR LESSER (9TH): So moving on to Senate Bill 205, we have Duke de Haas and I believe the other two people who signed up to testify already testified so. Good afternoon.

DUKE DE HAAS: Good afternoon, Senator and members of the committee. Thank you for the opportunity to appear. I'm Duke de Haas and I am here on behalf of the US Travel Insurance Association and I've heard all the testimony and I want to start on a personal note. I would express my condolences to the family. The testimony and circumstances that led to the bill being submitted were tragic. I have four children of my own and I cannot imagine having to deal with losing one of them especially under these circumstances and I'm sorry to call her by her first name, I didn't hear the last name, but the mother Robin said, I would not wish that on my worst enemy. So let me start by just expressing my condolences.

Secondly, just to point out a few things, I know I have a limited amount of time, just to remind everyone that travel insurance is not health insurance. It's a discretionary product and things like for the example the Affordable Care Act which is the law of the land, has an exemption under federal law. There's regulations that [inaudible - 02:57:59] travel insurance out as an accepted benefit because it's not a typical health insurance product and just again to emphasize, travel

insurance is a completely discretionary product that no one has to buy.

We agree in part with some testimony that was submitted by Mr. Cook that this law could lead to some unintended consequences such as higher prices and more frustrated consumers. Our consumers buy hundreds of thousands of policies in Connecticut and our members pay millions of dollars in claims. The types of travel insurance purchased are as varied as the types of customers who purchase them. From a bare bones travel insurance policy to take a trip on a plane across the country overnight to a much more robust policy that I can cancel for any reason or cancel anytime product which gives you a lot more flexibility and of course is more expensive.

While the situation before you is tragic, as Mr. Cook recognized in his testimony, there are different types of travel insurance products and we would suggest a one-size-fits-all solution is not what's best for consumers. And finally, let me just say we rely on our submitted electronic testimony and refer you to that as I'm not going to read it all and go over the same points again, but in the event that a patron, Senator Lesser or others on the Committee or the department for example wants to delve into these issues in more detail, we're ready to work with everyone on this and certainly understand what's behind it and what's gone into it. Thank you. I'm happy to answer any questions.

SENATOR LESSER (9TH): Thank you and I appreciate your testimony. You know I just got, during the course of the hearing I got an email from a constituent, not a constituent, a resident of the state who was concerned about the testimony this

morning saying that if we were to move forward with this legislation, it would not be possible to purchase travel insurance. In her email to me, I know you don't have it, but it's been emailed to me, she expressed a lot of concerns about unintended consequences of this product no longer being available and I guess I'm surprised by that because it sounds like the industry does provide and does underwrite policies today that have coverage for this type of situation. Is that your understanding, that that's currently available in the marketplace?

DUKE DE HAAS: Absolutely, Senator Lesser. Certain types of products that cover just about everything. I won't say you know there may be certain exclusions depending on the company, depending on the product they're gonna apply even if you purchase a cancel for any reason, there's gonna be some things maybe that aren't covered even though that's sort of the terminology. I wouldn't say that people can't write the product. I certainly wouldn't represent that. I think what it does mean as you understand and I think you've heard from other people including the councilwoman who testified and who I thought obviously had a good insurance background and sort of gets it on that level, it means the products will be more expensive. So the people who purchase a cancel for any reason product know that going in. The products, multiples of a typical travel insurance product and that's what it's going to lead when mandates start getting added so no, I'm not going to give you a parade of horrors that the policies can't be written, but it will make them more expensive for Connecticut consumers compared to other folks where these exclusions don't apply.

SENATOR LESSER (9TH): And how I mean since there are policies that exist that have this coverage, do you have a sense of -- so we can weigh it, right, so we can help make an informed judgement, if we were to include this as a mandatory exclusion what would that mean? How much more expensive would it cost someone looking to purchase travel insurance?

DUKE DE HAAS: Sure. Good question. Unfortunately, I don't have the data for the entire industry that would lead to it'll go up 6 cents or something like that that you could easily then say well from a public policy perspective, it's a no-brainer, we're gonna pass it. Unfortunately, I don't have that information. I would say that our rates have to be actuarially justified. Those rates are based upon certain exclusions applying. Certainly again, I represent on behalf of the industry that if these things wanted to be looked at in more detail we could get together. I just, I'm sorry I don't have that information. I know more about my particular company cause I've delved into it a little bit, but again, I couldn't give you the answer without talking to actuaries about how much a particular policy would go up.

SENATOR LESSER (9TH): Obviously I'm not an actuary and I haven't looked into it. I would just be surprised if this were something that were particularly common and that's why I would you know be surprised if it had a huge impact on rates but you know we are going to be looking at overall our regulation of travel insurance. Actually the same company that had issue in Ms. Brennan's circumstances also requested that we overhaul our travel insurance laws so that's something we could perhaps look at, at a public hearing I think next

week we're like to do that. I don't know exactly what the date is but you know this might be a good opportunity to have a more in depth conversation about how travel insurance works and how we address it as a state. Are there questions or comments from the Committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman and thank you so much for your testimony. I've been a consumer of travel insurance throughout my life and I know my mother also is a consumer and one time, had an accident while we were traveling and her travel insurance covered not just you know the getting her back into, we were in Italy in Palermo and had an accident at the airport and had to be air-vacced back to the UK and the travel insurance paid for that as well as her medical benefits so I just want to know is that sort of standard with the policies, that they cover other things apart from travel?

DUKE DE HAAS: Yes. Thank you for the question. That's absolutely the case. Again, because of the nature of the testimony and sort of what's been heard here, I didn't want to make it sound like a commercial at all because it didn't seem like the right forum. We had a case recently where we had a gentleman who was from New York and purchased a \$70-dollar policy and got ill in Italy actually. It was not Palermo but it was in Italy and he had to be medivacked. They actually had to, he had a stroke and they had to set up a pod on a Lufthansa flight and it cost \$70,000 dollars to get him back to the United States and of course, that's a success story and we do take care of our customers. And so it does cover additional things besides sort of standard trip interruption, trip cancellation.

There are plenty of tragic stories as well. There's plenty of things that are not covered. Again, not speaking to the current situation but yes, it's a product that can have very robust coverage for it.

REP. DATHAN (142ND): So saying that, do travel insurance rates change based on your age or where you're traveling or if you have preexisting medical conditions?

DUKE DE HAAS: So in general, no because travel insurance, as a point I made in the beginning, it's not an individually underwritten product like health insurance at least used to be. We don't ask people for their preexisting conditions, what mental health issues or other physical issues they might have at all. I won't get into the discussion of the pre-ex exclusions and waivers cause it's more complicated and this is not the time to do it but typically, we do not ask those questions. There are some age banded products so there are some products, if you go for example directly to a travel insurance website as opposed to buying it an ecommerce setting you may get questions about your age and there may be some changes based on how old you are.

REP. DATHAN (142ND): So saying that someone has heart issues, high cholesterol and hypertension, they wouldn't be charged extra but if you have a mental health issue and you ended your life, you wouldn't be covered. In the first instance you would be covered, but in the second instance with another disease, you wouldn't be covered? Is that what you're saying under most policies?

DUKE DE HAAS: To the extent I understand your question, I think generally policies probably almost universally probably have some sort of suicide

exclusions. It's typically sort of in the same category it's different. I understand it's different but it's sort of in the same category as what are considered intentional act exclusions which is sort of the idea that the insurance company doesn't have any control over it so it's sort of carved out from the policy cause they can't pool the risk for it. So I'm not sure if I'm answering your question but typically it can be handled slightly differently and then in some cases, these preexisting conditions, whether they're mental health or physical health can be waived if certain conditions are met when you purchase the policy.

REP. DATHAN (142ND): So more of my question was getting to, so it sounds like to me from what you're testifying is that travel insurance companies don't price their products based on preexisting conditions, but they do look at diseases of the mind differently than they look at diseases of body in how they pay their claims?

DUKE DE HAAS: I don't, I think that's a fair assessment. I think there's some differences and no question, typically anxiety and some other mental disorders are excluded. We just don't price for those on the front end so I think that's fair.

REP. DATHAN (142ND): So you're aware that in 2019 we passed a mental health parity bill to ensure that health insurance covered diseases of the mind the same as they would cover diseases of the body.

DUKE DE HAAS: Sure and I'm not familiar with the details of Connecticut's law. I'll be the first to admit that. My son got into Wesley and we were going to spend a lot of time up here, he didn't end up going but I'm not as familiar with Connecticut

but you know the federal mental health parity law which exists is the law of the land as well as the Obamacare, that doesn't apply to travel insurance as I understand it either because of the type of product that we have but I hear your point and I understand what you're saying. We just don't price for that on the front end cause we don't ask those questions.

REP. DATHAN (142ND): But you don't ask questions on issues of your body you were saying.

DUKE DE HAAS: That's correct but if it was a mandated coverage, we had to cover everything no matter what the mental health issue was, no matter what the physical issue was, it would just make the products more expensive.

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

SENATOR LESSER (9TH): Thank you, Representative and we heard earlier from Senator Slap that some of the language used in policies is out of date and no longer reflects current ways of describing behavioral health questions. Is that something that the industry has looked at or are going to look at?

DUKE DE HAAS: Absolutely willing to look at. I heard the word insane and I thought that was kind of odd too. I did hear from somebody else that that's actually apparently still a clinical term that is used. I don't, I'm not a doctor. I don't have any medical training. I think the exclusion is insane or sane doing certain things and that's probably just used in that context, but absolutely would be willing to look at terminology and that kind of

thing. We try to look at it regularly but we don't always keep up probably.

SENATOR LESSER (9TH): I'm going to turn it over to Representative Delnicki. I guess you know you had mentioned earlier you didn't want to make this an ad for the industry and I understand that. Obviously the industry is trying to get people to purchase travel insurance as they should. That's the line of work that you're in and given how unusual this event is, it's my understanding that folks in the industry often try to work with a person and I am not sure why that didn't happen in this case and I know that you don't work for the company that was an issue here, but I'm sort of again, sort of frustrated that we're in this place today. That's a comment, not really a question. Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair and thank you for coming forward with your testimony. I missed when you began your testimony. Are you representing a particular company or the industry?

DUKE DE HAAS: I'm here on behalf of the US Travel Insurance Association. My day job is I work for Allianz Global Assistance in Richmond, Virginia but I'm here on behalf of US Travel Insurance Association. Our normal person was unavailable for travel reasons and so I'm the fill-in. Pardon the pun, right?

REP. DELNICKI (14TH): So in the course of your normal employment, not representing the industry per se, does the company you work for actually write policies for travel insurance?

DUKE DE HAAS: Yes, sir, we do.

REP. DELNICKI (14TH): Okay. Can you address the cost differential from the standpoint and perspective of what your company would charge for a policy that did provide that kind of coverage we were talking about versus a policy that didn't?

DUKE DE HAAS: Do, very good question. I think I was told to try to avoid references to my company as much as possible so here I'm am, I'll have to answer for this later but in general, the policy question that you're asking for our company, and we write hundreds of thousands of policies you know all over the country. I'm told that there weren't any claims of this sort in Connecticut but there are claims of this sort that we've had in other places in the United States. So again, I don't have, I didn't delve into for this hearing, maybe I should have, I didn't delve into what's the actuarial impact if all of a sudden we have to include this so I'm sorry, I don't have that information. I can try to sort of get some more granular information for you but I guess what I would say, I have to fall back generally on the comment that a product that's gonna have certain things mandated is generally gonna just be pricier. I don't know what the extent of it is. I'm sorry.

REP. DELNICKI (14TH): Okay. Let me rephrase the question in a different fashion. You do offer that kind of coverage that would cover an individual that perished by that means; is that true?

DUKE DE HAAS: We have what's called, our company has something called a cancel anytime product. I don't want to say it doesn't have any exclusions at all in it and for example, somebody might say well that means that you can cancel whatever and get 100

percent of your cost back. I don't think that's the case. I think it's 75 percent or something that's in the fine print but I don't, so I don't have a specific answer. I can check on our policy for that particular issue. I don't, I think our cancel anytime product wouldn't exclude you on that basis. I believe that to be the case but I have to check.

REP. DELNICKI (14TH): Look, so I can appreciate the fact that you probably weren't expecting to get the question asked specifically, a policy that covered it and a policy that didn't, what would the price differential be. When do you think you could get us that information just so that we can look at the numbers that I realize that's only your company that would be providing that initially, and I would also ask since you represent the Travel Insurance Association that you should be able to provide us with information pertaining to how a number of companies handle that issue and what their policy cost differential is from a plan that would cover that to a plan that wouldn't. Does that sound right?

DUKE DE HAAS: I will absolutely take your questions, Representative Delnicki, and the other questions that I've heard back to the Association and we will seek to get the information before you especially because you've got other bills to consider dealing with travel insurance as well as this one so I certainly am going to communicate the message back, yes, sir.

REP. DELNICKI (14TH): And with your company that you actually work for, what do you think the turnaround time on that kind of information would be? It sure be fairly quick I would think on just

your company cause I realize it would take a while for the industry to actually come up with numbers depending on how many folks you have in that group.

DUKE DE HAAS: No, I understand. I think we would be able to come up with it fairly quickly. Again, you're asking for impact only in Connecticut on a particular exclusion is that [crosstalk]?

REP. DELNICKI (14TH): Yeah, if I was to go up to Bradley Field and I was looking to buy a policy that had that coverage and a policy that didn't, and I was dealing with your company, what would the price differential be if I'm say flying to California just as a case in point?

DUKE DE HAAS: I understand the question.

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

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the Committee? If not, thank you for your testimony. Oh, I'm sorry, Representative O'Neill.

REP. O'NEILL (69TH): Yeah, my question is sort of related to Representative Delnicki's question in that the cost differential, what you're going to be looking for and I heard in the earlier testimony was that the company that's involved in the specifics of the case that we heard about actually had two policies that were available. One had the exclusion and one didn't have the exclusion which would have apparently provided the coverage and so that's why I was hoping -- I'm not sure your cancel at any time policy is necessarily the exact parallel comparison that I was looking for but I was wondering if your company has a policy that just doesn't include that

particular exclusion? And the answer may well be you don't have a policy like that. You've got the sort of base model, you know no frills addition which is one price and then the Cadillac which has almost on exclusions of any kind for almost anything or very few exclusions, the cancel anytime policy. So you may not be able to do any apples to oranges which is what I'm looking for comparison. It may be apples to golden apples kind of comparison but if there is a policy that you have that would be like the next step up so to speak but not necessarily the Cadillac policy in terms of the price differential, I'd be curious about that. And the other thing and I don't know if when you're looking at it the language issue that cropped up. When I heard that I was upstairs listening to the testimony and it crossed my mind that the use of the language, whether you're insane or not insane and then they go on from there to say there's the exclusion, that sounds to me like some case, somewhere a judge ruled that the exclusion didn't apply in one of those two categories so it got added to the policy as a way to cover a case that had come up so I'm just, so it may well be and I'd be curious if that's the source of this kind of language in the policies because they may not have control in a sense that if they start ripping out language like that, they're gonna expose themselves to some old case law that is still out there somewhere. My impression is a lot of insurance company policies are written with the exclusions tailored to try to address a specific case that cropped up at some point in the past because insanity is usually considered to be a legal, not a medical term so that's where I'm suspecting that particular chunk language, but there may be other language as well and it's gonna look

very odd to us today but it was stuck in there because some case, somewhere said something that basically allowed a recovery when the company was arguing that it didn't but a judge and jury came to a different conclusion and so that's why the new language or that language got stuck in there. So if you're gonna be responding to us about that, I'd be curious as to if, and especially with that particular language cause it was cited here in the hearing, whether its source is some sort of effort to address case law that came down.

DUKE DE HAAS: If I could, may I respond?

SENATOR LESSER (9TH): Yes, absolutely.

DUKE DE HAAS: Thank you for the questions, Representative O'Neill. I think, I'll certainly dig into, I believe it's going to be harder on your first question. I don't think there's a product where somebody can go down the list of possible exclusions or coverages and tick ones that they want or don't want. We just don't have that level of granularity. The best sort of that can be offered is if you go to our website, you can buy different sort of I'll call them gold, silver, bronze. That's the right terminology but you can decide sort of if you want to tailor your coverage a little bit, you want to get a little more robust coverage, you can get certain things. You want to get the bare bones policy. You know what you want. You're a sophisticated shopper. People do that. The cancel for anytime is obviously a pricier product for the reasons I stated already. I don't believe there's an opportunity to buy a product that has a suicide inclusion versus a suicide exclusion only, but I'll double check on that.

Your second question, I obviously have some research to do. I think you're probably right as far as the origin goes and certainly we'll look into sort of you know what I can find out about why that's there as it applies to our policy. I guess if I could, Mr. Chairman, if you'll indulge me, I will just say on the person who had this tragic situation, one of the reasons, I used to work for the state in Virginia and I used to be a prosecutor many years ago and worked with domestic violence victims and others, one of the reasons I like working in travel insurance is I feel like we pay more claims that we have to. I don't like the idea or the concept of insurance companies as people who squeeze folks when they actually need them, when they've been paying premiums for years. Travel insurance in my experience hasn't worked that way. We typically pay way more than we have to. I've got a letter here from somebody in Wethersfield, Connecticut. I don't know where that it is --

SENATOR LESSER (9TH): In my district.

DUKE DE HAAS: Okay. I didn't do this research beforehand but that's great and she bought a trip to Seattle and had a family member pass away and canceled the trip and complimented us on the handling of the product. This is what gets put up in our claims operations area cause people take pride in taking care of the customers and so I know, again, I'm sorry for lapsing into a commercial but I do want to say we take what you hear seriously. Y'all have a tough job and I hear you're listening to people, you're hearing these concerns, and you have to make the policy decisions accordingly and I respect that so thank you.

SENATOR LESSER (9TH): Thank you. Yes, Representative O'Neill.

REP. O'NEILL (69TH): You said earlier that you came here from Richmond?

DUKE DE HAAS: Yes, sir.

REP. O'NEILL (69TH): How long did it take you to get here in terms of the flights?

DUKE DE HAAS: So I didn't have a terrible experience. I flew through Philadelphia. I got lucky on the first delayed flight and I didn't have to sprint but I had to move quickly. I made my connecting flight. I think about six hours total. I probably could've driven it, but then there's New York City to contend with.

REP. O'NEILL (69TH): Cause I was talking to somebody who said that sometimes to get a flight from Connecticut to Richmond is like 12-18 hours and you end up flying to the west coast or something before you get here.

DUKE DE HAAS: I hope it's not that way on the way back. Thank you.

REP. O'NEILL (69TH): Thank you very much.

SENATOR LESSER (9TH): Thank you for your testimony. So that concludes the testimony on Senate Bill 205. We're now proceeding to House Bill 5247. First up we have Susan Halpin followed by Jay Sicklick. Susan, is this your first time testifying this year?

SUSAN HALPIN: It is.

SENATOR LESSER (9TH): That's remarkable.

SUSAN HALPIN: [Laughs]. You've missed me.

SENATOR LESSER (9TH): Good afternoon, Susan.

SUSAN HALPIN: Good afternoon, Senator Lesser, Representative Dathan, members of the committee. It's a pleasure to be before you today for the first time. My name is Susan Halpin for the record. I'm here on behalf of the Connecticut Association of Health Plans. Our association represents Anthem, Aetna, Cigna, ConnectiCare, Harvard Pilgrim, and United. I'd like to comment first on HB 5247. We did submit testimony in opposition really as a placeholder to this bill from our perspective. We do believe we could probably work with you on this bill and would welcome the opportunity to do so.

Our concerns really are about overlapping regulation. We have a number of requirements that are on us in terms of issuing explanation of benefits in terms of HIPAA, in terms of appeals processes, in terms of how folks use the OB's to administer their HSA plans, etc. We do believe that it probably could be done a little simpler than is spelled out in the bill, but we would welcome the opportunity to work with you on that legislation. So again, I think it's more of a question of how it's drafted than perhaps the intent and we would certainly be willing to enter into those conversations with all of you.

Just briefly, I'd like to comment on some of the other bills that are before you today. First, like the former speaker, I'd like to say my heart goes out to all the families and friends and colleagues, etc that testified before you earlier on a number of these bills. I would like to say for the record that with respect to medication assisted treatment, I'm not aware of any plans that don't cover MAT

treatment. For your information, it's a little bit dated because it's last year, we did attach to our testimony some examples of all of the initiatives that have been undertaken by the various health plans around the opioid crisis and ways to health plan members through medication assisted treatment and other means and I would encourage you to read those and I'd be happy to get those updated as times goes on so you have a better understanding of how the health plans have acted in response to this crisis.

In terms of 5256, I appreciated the things that were said. I'm not sure that the legislation before you accomplish what was expressed to be quite honest you. I'm not looking, you know the first adage in lobbying is don't make a bad bill better and I say that not flippantly but the bill, the language that's being struck from the underlying bill requires that we cover all medically necessary services and the way that I read the bill at least before you, it puts limits on certain treatment and I'm not sure that's the directly frankly that you really want to go in so I would certainly urge your opposition to that. I have requested from the health plans information about the prescription for limited numbers of pills if you will, you know 7-day supply versus a 30-day supply versus a 90-day supply. I think the question comes down to whether things are considered maintenance drugs. There are psychiatric drugs that are used for off label purposes that are maintenance drugs so it is a little bit more confusing than it looks here on the surface but from what my early research has indicated we do cover limited supplies of prescription drugs as was explained. Again, I'm not

sure that's what the bill before you says. I think my testimony was referenced by one of the speakers earlier about a lifetime. I think the legislation essentially says that anything a prescriber prescribes would be covered so again, our opposition really ties into some of the language that's actually before the bill. I know many of you, like us, you know you're looking at all the different language and things have been fast and furious this short session so my response to some of the legislation is really about what's on the paper less than the intent, but we do have concerns and I would be remiss if I didn't say please be careful about mandates because they do add appreciably to the cost of premiums, and then I would also caution you, and I know this is a favorite of the chairman's but what gets passed here only applies to about 30 to 35 percent of the market which is the fully insured market that's regulated by the state so the more we make that more expensive and fully insured, the more likely folks are to gravitate towards the self-insured market. So I just want to leave you with those comments and thank you for your indulgence, I know I went over my time and I'm happy to answer any questions.

SENATOR LESSER (9TH): Well thank you and it's probably more efficient to have you testify once than to have you testify 18 times on 18 bills or 6 times on 6 bills. I just before I get into a couple of questions, I do want to express a little disappointment. I understand you have questions about the wording of the explanation of benefits bill as you did last year when you testified. Last year you expressed neutrality on the bill while indicating a willingness to work with the Committee.

This year you phrased your testimony differently and said you were testifying against it. Obviously I have no control over the testimony you submit on any given bill but I obviously would rather have a constructive relationship when we're trying to figure out how to make a bill better and address those issues. I also think this bill, correct me if I'm wrong, is this the same language that passed the Senate because I do think that was our intent and I think at the time we had worked with you on that language and just wanted to get that cleared on that point.

SUSAN HALPIN: Sure, I'd be glad to resubmit language that says that we're happy to work with the Committee. In drafting a lot of testimony I am fondly known as the no-no girl so I typically stop with, start with opposition but I'd be glad to submit revised testimony to the Committee on that accord and to be very frank with you, I have not had the time with the volume to kind of go back and compare with the previous bill that passed the Senate and it was my intent at some point to do that.

SENATOR LESSER (9TH): Thank you and I guess it's my turn to apologize to you for the volume of the legislation cause we did draft a lot of bills. I'm very much aware of that and then just for clarity I think I heard you say this, but regarding number 2 on the agenda, House Bill 5250. It sounds like you are, I think I heard you say this, but you are supportive of what you understand to be the idea of the legislation which is to prohibit excess dispensing of dangerous medications. Is that, I don't want to put words in your mouth.

SUSAN HALPIN: Honestly, I think the devil's in the details so I just, I would just, I'm still researching. We have six carriers obviously. I've heard back from a couple but I haven't heard back from all so there may be operational issues and that's you know administrative issues obviously, you know time table is important for implementation on things. I don't, I wouldn't want to support something or say I can work on something that we can't administratively accomplish, you know, within the time frame so I'm happy to get back to you on that.

SENATOR LESSER (9TH): Thank you very much. Are there other questions or comments? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you for your testimony and it's nice seeing you again, hopefully at a nice off session. Just wanted to check, presumably the carriers that you represent also do business in other states apart from Connecticut?

SUSAN HALPIN: Correct.

REP. DATHAN (142ND): So there's several other states, this is in regard to Bill 5247, the explanation of benefits bill. There are other states that do have similar legislation in place, states like Washington and California and Massachusetts and I'm presuming that your carriers do business in those pretty populous states?

SUSAN HALPIN: You are correct. They may not do a significant volume and I'm not sure that every carrier operates in every state. Take for instance you know Anthem. Anthem is a Blue Cross Blue Shield plan, but they are not the same company in every

state that they operate in so I am happy to, you know and I have received that feedback from some of our carriers to say yeah, if you could model it after you know this state or that state, you know we could probably accomplish it again. You know I have received some suggestions from some of our carriers. I just haven't had a chance to kind of compile them together for submittal.

REP. DATHAN (142ND): That's great. That was actually gonna be my point is when you know we work together and I'd love to talk to you more about the bill, that you come prepared with some of the things that are happening in some of the other states because you know we do want to make sure that this isn't an onerous thing for the industry, but at the same time making it a consumer protection bill for patients and for people who are in precarious situations. Does anybody else have any questions? You're off easy today.

SUSAN HALPIN: Understood and I just want to let you know that I did already reach out to some of the proponents to have the conversation as well about the language so happy to continue that.

REP. DATHAN (142ND): Wonderful. Well thank you so much.

SUSAN HALPIN: Thank you. Thank you all.

REP. DATHAN (142ND): Have a good rest of the day. Next we have Jay Sicklick and he will be followed by Joseph Wagner. And if I mispronounce your name, please feel free to re-pronounce it for the record.

JAY SICKLICK: Members of the committee, my name is Jay Sicklick. I'm an attorney and the Deputy Director of the Center for Children's Advocacy,

Connecticut's largest organization dedicated to fighting for the civil and legal rights of children and youth. I'm here as we were last year which I believe is almost the identical language as bill 977 from last session, on behalf of our medical and legal teams to testify in favor of Bill 5247, a measure that will enhance healthcare access to the most vulnerable and susceptible individuals in our population. I want to focus on three reasons in my testimony and why this bill is not only important, but necessary in order to encourage and expand healthcare access for youth and young addresses.

First, as all of you well know, the opioid and substance abuse crisis which we've heard so much about in the hearing continues to wreak havoc in our state and as Senator Bergstein so eloquently and thoughtfully articulated, the ability to access services specifically in the area of intimate partner violence counseling. Although it may seem like a small step, allowing individuals who are legally capable of consenting to legal critical healthcare, services such as mental health or substance abuse treatment, or intimate partner violence counseling, they should have the right to determine where and how an explanation of benefits should be sent as it is an important piece of the confidentiality crisis process to which all individuals are entitled.

Despite Congress through HIPAA and other privacy statutes in the Connecticut legislature, which has gone to great lengths to ensure that eligible individuals are entitled to privacy and confidentiality, there is still a significant stigma as we heard earlier today attached to seeking these services. And not only young adults but minors who

may access these services in a legally recognized and confidential fashion. We know that those individuals who are covered through their parents' or guardian's policies are often deterred from seeking those services when the prospect of a mailed or electronically sent EOB is present. This bill, albeit a small step, would be a giant leap toward providing that assurance for those vulnerable individuals that they are protected.

We want to give clinicians every opportunity to serve vulnerable youth and encourage frank and open mental health, substance abuse, and intimate partner violence conversations and treatment. This is an important step in furthering addressing this critical issue.

Second, I want to remind folks that this bill does create or extend any legal rights; it merely guarantees that the bedrock principles of privacy and confidentiality that already exist are honored. Without this small measure, individuals, specifically young adults and eligible minors will like not exercise those legal rights for fear of not having confidentiality and privacy maintained. We should not have a two-tiered system where individuals whose health insurance coverage is provided in one column, for example in the Medicaid program, are assured of confidentiality in this area while those who are covered under another column, a commercial policy for example, may not be.

Third, and I'll wrap up with this, is many of these important confidentiality and privacy measures, Connecticut would not be the first state to enact these type of protections as you just stated in your question to the previous testifier. While I cited

three or four states in my written testimony, there are several states that recognize confidentiality where communication is maintained. I know my time is expired but I'm happy to expound on that a little bit further and give you a little bit of an overview of the landscape of the states that do provide these protections and why that was not a problem as you stated specifically with the carriers in those other states to work with legislators to enact these protections. Thank you.

REP. DATHAN (142ND): Thank you very much for your testimony and you must be able to read my mind cause that's exactly, I had a couple of questions for you myself. Since we're on the topic, you know I've done a little bit of research and I've seen that there are other states that have this ability in place. Could you please expand on how many other states do this and in my reading that you know there's kind of different degrees of what they do allow and what they don't, so if you could also discuss that, that would be great.

JAY SICKLICK: Yes, I'd be happy to do that. Thank you. So as you said, there are different degrees and different areas in which these confidentiality protections are maintained through the communication portal. So you can take, I think if you want to take a viewpoint of states that would be good models and very analogous to the proposed legislation in 5247, we would be looking at states such as California, Oregon, Washington, and Massachusetts because those are the broadest statutory and regulatory provisions that have been enacted that do almost the identical thing that the Connecticut statute proposes to do. Just briefly, so the Massachusetts Patch Act is the most recent and

active piece of legislation which was passed in the 2018 Massachusetts session and went into effect just last July, July 1, and the Patch Act is really a comprehensive set of criteria that allows an individual who is covered under a particular policy, who is not the named policyholder but a beneficiary and a user of that particular policy to allow for the, either the suppression of an explanation of benefits or have it sent directly to them or to another address, a physical address if they should so choose, if it was a sensitive health information or even not, and for those individuals who are provided that access by law, they have the same exact rights as others, for example who would be able to do so, a partner or spouse of an individual who is insured.

In addition, some of the states, for example like Oregon and Massachusetts deal with some of these sensitive issues that are protected under the Affordable Care Act that do not require a copay so these are preventative health services such as STD treatment, intimate partner violence counseling as Senator Bergstein was talking about, and mental health treatment specifically certain types of mental health treatment. Those states provide that these particular services should be provided and that those EOB's are either done in a generalized fashion such as office visit, or they're suppressed completely. Oregon was the previous state that enacted a very similar statute and I won't go into too many of the details, but it follows a very similar organized fashion where the individual who is the consumer of that particular health insurance test or diagnosis or treatment or interaction has the right to pick and choose the manner in which the

explanation of benefits is sent or not or diverted. And again, it's a very small step if you think about it. It doesn't, it neither creates nor expands existing rights, but it allows the individual to thoughtfully engage in that treatment without the potential worry or stigma of knowing whether or not a piece of paper is sent to an address where there may be someone who is in fact opposed to that treatment or who may be part of that scenario that Senator Bergstein talked about in that intimate partner violence scenario. Other states have dealt with this on the Medicaid side so if there is a Medicaid situation where managed care companies as Connecticut had in the good old, bad old days, those managed care companies are prohibited from sending EOB's as per is their policy under commercial scenarios. So New York for example, Maryland, Colorado, those are the states where Medicaid is most specifically invoked.

So if you look at the total, it's really about seven or eight states that do it in some fashion and Connecticut for example has this patch work so under the STD statute, 19a-216, we actually have made a determination that individuals have the right to that STD treatment in a confidential fashion and that is the notion that individuals have this guaranteed confidentiality and they may do so without anyone else knowing if they have the legal and appropriate right to access that care.

REP. DATHAN (142ND): Thank you very much. I know California is pretty extreme in this. We moved from California when my children were young and my son got some medical treatment there and I was going back to see a specialist when he was 13 and I couldn't even access the records on my own. I had

to get my 13-year-old child to write a waiver and sign a waiver so that his parent and the person who was paying the bill could get access so in other states, are there any sort of age allowances for this sort of disclosure?

JAY SICKLICK: Not in the same manner as California but what the other states have done is they have defined the treatment as one that is already protected by the minor's right to access that treatment under law so it doesn't differentiate between an age for example but in a certain state, if an individual has the right to access treatment by law, either through a statute or through constitutional protection, then the insurance company is required to honor that confidentiality in the communication realm.

REP. DATHAN (142ND): Great. That's really useful. A lot of my concern really stems in the mental health field and I'm wondering if you could explain how this EOB bill would provide greater access for young adults and adolescents to get the help and the treatment that they need, that they might not be able to get for living in fear or stigma with any mental health or substance abuse issues.

JAY SICKLICK: I think that's a fair question. I don't know if I can give you the exact answer of how it would affect the access to certain care and treatment for those young individuals who are trying to access mental health services if you took a look at it in the realm of these commercial policies where there are high deductibles or large copays, but it's the first step in guaranteeing the individual the idea that you have the right to go at least engage in this treatment in the present system

that we have. So you know there has to be the reality that we've engaged in a system of commercial coverage that is so far differentiated between policy A, B, C and D that it's difficult to make the generalization, but in answer to your question specifically, individuals who want to access mental health treatment that is available under a policy that would be, they would be the beneficiary and appropriate user of that insurance policy to have that covered, they would at the very least have the ability to engage in that service. If you're 18 and above, they certainly would by virtue of their ability to engage in that, or if they're under 18, we have a very specific criteria for access to mental health services for young individuals and if they met that criteria, then they would be eligible for coverage. The question would be you know what type of coverage but that's really the second step that I think is you know, that comes down the road and Massachusetts is still grappling with, but I'll go to Senator Bergstein's example, for example if you used the fact scenario and we've worked with young individuals in our office cause we represent kids in juvenile justice, child welfare who have that connection to a parent or guardian with this kind of commercial policy, and if they have the ability to access that particular service and if it's for example preventative health services that is covered under the Affordable Care Act as a preventative service for intimate partner violence, then they have the right to engage in that service without the idea and that treatment, without the idea or notion that is this something that is going to be revealed to somebody in my household. Is there somebody in my household who is part of this dynamic that is creating this scenario for the need

for mental health services counseling or even a quick consultation. And I think that's where the avenue is appropriate, to open up the door to the ability of what services are available for the individual who may be of a certain age or even a minor who's eligible for those services. I mean what pathway might be the most appropriate for that particular individual may be at a school-based health center where you're dealing with a different kind of encounter. It may be at a community health center where there is going to be an independent co-located mental health professional or somebody in the community who provides that, but it's the first step to open the door so that that stigma or that barrier is removed to get someone in the system where that person can have that interaction that could lead to that more significant and therapeutic intervention.

REP. DATHAN (142ND): That's really, really helpful. Thank you so much. Does anybody else have any questions? Representative Hughes.

REP. HUGHES (135TH): So let's just play out this bill gets passed and we do provide some measure of protection for privacy for young people, explanation of benefits especially in those preventative services that you just talked about. How would we communicate with the public? What would you suggest to shift that you know to shift that perception that nothing is private?

JAY SICKLICK: I think that the models for example that Massachusetts and Oregon have utilized in terms of public campaigns and social media website access were the most effective tools that got the word out to individuals not only in the policies, but in the

communities where these policies were in effect so Massachusetts provided several access points for individuals to seek information on the bill through kind of their department of you know analogous public health, their department of insurance, etc. Oregon formed a very significant website where individuals were invited to learn about what these privacy and confidentiality protections really meant. I think that young individuals have I think a notion that they're entitled to confidential health services to a certain degree, but I don't think they have a clue as to how it's paid for, for example, if they're in a commercial setting with their parent or guardian who's providing that particular coverage. I think the notion of reaching out to all touch access points through requests and working with, as the individual before me talked about, working with the carriers to notify their insured and working through school-based health centers, colleges and universities, other access points where young individuals who do access care and most importantly in these sites where youth tend to or young individuals tend to get care either on college campuses or community health centers or in school-based health centers, that information should be provided up front and it can be done in conjunction with the carriers and the state that can provide these access websites where people can learn about what this all means. I hope I answered the question.

REP. HUGHES (135TH): Yeah, it's kind of a shift in culture I think, you know, that we're moving from again, the control of who owns the basically insurance policy to who owns the information to who owns their privacy to accessing service and we know

especially with young people, I'm thinking specifically the rate of suicide attempts in the LGBTQ community, people that are just terrified of reaching those access points for fear of denial or ridicule or you know just stigma, all kinds of things so there's already all the barriers to those access points first which ends up resulting in some real lethality which we're trying to open up you know the ways people at risk can get the help they need before those barriers kick into place so you know for lifesaving reasons but also ultimately, cost saving reasons too. So how to work collaboratively with you know all those departments and the insured and especially the young people who are most at risk.

JAY SICKLICK: Yeah. I think, I mean again, I don't have to tell you folks this, you know better than I but we're working in two separate systems, right? We know that. We have a payer system and we have a legal system that provides those guarantees of confidentiality right and neither the twin shall talk to each other or meet and that's the problem. I'll give you a really good example of how this can actually work and those of who you might remember, in the last session, the legislature passed and the Governor signed the bill providing for access to PReP which is prophylaxis intervention for individuals with HIV to individuals under the age of 18, under certain criteria much as they can access HIV treatment and again, that was the selling point. You know, you pay now or you pay later. You pay for the prophylaxis and you now pay for the intimate partner violence counseling in a way that's confidential or God forbid later on, then you're paying for a totally different scenario and that's

why it's difficult to kind of mold these two systems because they're created in different silos and you know we've done that as a result of the way we've kind of engaged our payer systems, but the reality is, this is the one that bridges the gap, this kind of start in terms of that EOB is the first step in getting those two systems to talk to each other and then to try to work out something further down the line as to how this potential either care treatment is going to be fully covered.

REP. HUGHES (135TH): Thank you.

JAY SICKLICK: You're welcome.

REP. DATHAN (142ND): Thank you, Representative Hughes. Are there any other questions for Mr. Sicklick? Okay. Thank you for all your advocacy with center for children's advocacy and thank you for coming today and your patience.

JAY SICKLICK: You're welcome.

REP. DATHAN (142ND): Next, we have Joseph Wagner.

JOSEPH WAGNER: Thank you, Representative Dathan, members of the committee. My name is Dr. Joseph Wagner. I'm a board certified urologist. I'm the Chairman of Urology at Hartford Hospital and past president of the Connecticut Urologic Society. I come before you today on behalf of about 1000 physicians representing various subspecialty medical societies in Connecticut. We oppose House Bill 5247 as currently written.

We fell this bill will diminish transparency and permit insurers loopholes to provide either no or minimal Explanation of Benefits, known in the trade as EOB's. It further calls into question the rights

of providers of care to receive Explanations of Benefits. Thanks to Connecticut's current strong insurance statutes pertaining to EOB's, patients gain access in three key areas: transparency in billing, insurance fraud protection and promotion of healthcare literacy. Line 32 currently reads, not issue explanations of benefits concerning covered benefits provided to such consumer. Why would we seek to dilute and jeopardize our current system?

Rather than scaling back these benefits, we feel that legislation in 2020 should further improve insurer's requirements for transparency and to continue to build on current statutes. This bill if passed would degrade our current system by diminishing transparency, reducing a patient's ability to detect and prevent insurance fraud, and threatening our gains in healthcare literacy. It would also jeopardize the rights of providers of care to receive an EOB. Lines 33 to 34 note the following option, issue explanations of benefits concerning covered benefits provided to such consumer solely to such consumer. Patients often come to me with these letters asking for an explanation. Why not just send me a copy of the EOB since I'm the one who's ordering the test in question?

Providers are struggling in a system where explanations of reimbursements and rejected or reduced claims are already confusing and difficult to grasp. At home I have my wife do it. I have no clue what's going on. Eliminating an EOB for provider will make our office staff further struggle with denials, payments, and it's a burden. This is an ill-conceived notion. This bill if passed will allow insurers opportunities to not provide a

thorough and clear explanation of payments, and confuse rather than clarify patient options.

In closing we feel the purpose of House Bill 5247 should be to require health insurers that provide health insurance policies in this state to always issue explanations of benefits to consumers and providers, and to disclose information concerning explanations of benefits to both consumers and providers. It is essential that we maintain transparency in billing, insurance fraud protection and promotion of healthcare literacy. Thank you for your attention.

REP. DATHAN (142ND): Representative Vail.

REP. VAIL (52ND): Thank you, Madam Chair. Just a quick, I came in as you started your testimony. I just, if I could get your name and who you represent?

JOSEPH WAGNER: Yeah, I'm Dr. Joseph Wagner and I represent the Connecticut Urology society, the ENT Society, Connecticut Dermatology and the Connecticut Society of Eye Physicians.

REP. VAIL (52ND): And how many physicians are in, like do you represent in total in the State of Connecticut?

JOSEPH WAGNER: About 1000.

REP. VAIL (52ND): 1000?

JOSEPH WAGNER: Yeah. Physicians and physicians in training.

REP. VAIL (52ND): That's it. Thank you.

JOSEPH WAGNER: Thank you.

REP. DATHAN (142ND): Any other questions. I just had one question. Do you have relations with other states that might have similar organizations like yours that are working with physicians?

JOSEPH WAGNER: We do. I just want to speak on behalf of urologists just because I know that arena better. The American Urologic Association has a national and state societies in every state. I'm sure other states are grappling with similar issues. What they're doing, I really don't know. I could find out.

REP. DATHAN (142ND): That was really question of you know I do know as I mentioned earlier, I think you were in the room, that other states are doing this and it would just be interesting to know how they're dealing with some of these issues cause I'm also sensitive as a legislator to ensure that we're looking at you know making this a good bill that works for everybody. We're not trying to cover up things and especially you know I understand, I deal with my family's insurance issues and it is, it takes a lot of time and it's a lot more in 2020 than it was in 2000 when you know laws or insurance was a lot different so.

JOSEPH WAGNER: Yeah, I can tell you again, a little sadly as a urologist, but there was a big Lupron scandal where you know doctors were fraudulently billing for things and it really got caught because of explanation of benefits going to the patients and someone looking at it and saying well why am I paying this and he's getting this and it got investigated and put away appropriately.

REP. DATHAN (142ND): Well just to be clear, this bill doesn't totally eliminate explanation of

benefits. It just says who can get the benefit so in that circumstance, a person what was covered, maybe I didn't want, let's say my husband actually was in charge of doing this exercise, I didn't want him to see it, I could still get it and ensure that it is a reasonable expense so the fraud would have been protected in that situation.

JOSEPH WAGNER: True.

REP. DATHAN (142ND): Okay. I think that's it from everybody. Thank you very much for your testimony. Thank you for your advocacy.

JOSEPH WAGNER: Thank you.

REP. DATHAN (142ND): Next we have Rose Ferraro.

ROSE FERRARO: Thank you, Representative Dathan and members of the Committee. I'm Rosanna Garcia Ferraro, Policy and Program Officer at Universal Healthcare Foundation of Connecticut, here in support of House Bill 5247, AN ACT CONCERNING EXPLANATIONS OF BENEFITS.

Our mission at the foundation is to serve as a catalyst that engages residents and communities in shaping a democratic health system that provides universal access to quality, affordable, equitable health care and promotes health in Connecticut. The proposed bill allows enrollees of a health insurance plan to keep their Explanations of Benefits private, if they so choose, by rerouting the EOB to the enrollee directly via mail or email. We support this proposal because it is common sense and protects the privacy of enrollees of private health insurance coverage for any reason when they use their health insurance plan. The Foundation believes that the health care system should be

responsive to those it serves and serve us when we need care. Privacy of medical care received is one way we can ensure that people seek out the care they need, without fear of unwanted disclosure; the doctor and patient relationship is not compromised by privacy concerns; and the insurer is responsive to an enrollee's need for privacy.

There are many situations when someone enrolled in coverage may not want the primary subscriber to have access to their Explanations of Benefits. EOBs contain a lot of information, often including not only the medical provider visited, but the kinds of services received. Some circumstances when someone would want to keep that information private include when spouses who rely on their partner's health insurance for care may not want their spouse or families to know about certain medical services they've received in such situations as, as we've said before, those receiving mental or behavioral health treatment, those receiving substance abuse services, those who are estranged or divorcing their spouse, spouses undergoing tests and who don't want to worry their family; and especially those in intimate partner violence situations who may want to access counseling or other services without their spouse's knowledge. Another situation may be when young adults are still on their parents' plan until age 26 and want to receive medical services confidentially.

Everyone should feel safe and respected when seeking care via their private health insurance plan. EOB privacy is one critical aspect of this safety. We urge you to pass this proposal and thank you for your time.

REP. DATHAN (142ND): Thank you very much. Do we have any questions? Representative Vail?

REP. VAIL (52ND): Did you miss me? [Laughter] No? Okay. Good afternoon. When you mention young adults, what age range are you talking about?

ROSE FERRARO: I'm speaking of young adults that are on their parents' insurance until age 26, so I'm thinking like 18-26.

REP. VAIL (52ND): 18-26 and to your knowledge, and so they're adults, they can vote, they can do all their stuff. What about those that are under 18?

ROSE FERRARO: The only instance I know of when young adults could do, when minors would be able to do this is only when they're legally consenting to their own care and want to receive those specific medical services confidentiality. I don't know which specific medical services young people can consent to. Probably one of my colleagues would have a better answer to that.

REP. VAIL (52ND): Thank you.

REP. DATHAN (142ND): Thank you very much. Any other questions, comments? Great. Thank you so much for your work and your advocacy.

ROSE FERRARO: Thank you.

REP. DATHAN (142ND): Next we have Lucy Nolan.

LUCY NOLAN: Good afternoon. My name is Lucy Nolan and I am the Director of Policy and Public Relations for the Connecticut Alliance to End Sexual Violence. We're a statewide coalition of Connecticut's nine

community-based sexual assault crisis services centers. I am here in support of House Bill 5247, AN ACT CONCERNING EXPLANATION OF BENEFITS.

One out of every six women and one in 33 men have been a victim of an attempted or completed rape in their lifetime. Close to 40 percent of all PTSD cases include a sexual assault. What we have found is that victims of sexual assault have seen how the explanation of benefits have interfered with their being able to get the proper care that they want, that they need. I have one story. I asked our advocates all across the state had they seen this and they all responded and said that one in particular related a story of a victim who was worried about having a sexual assault kit done after an assault. She did not want to get the prescription for the HIV prophylactics, which the victim has to get from the pharmacy because they don't do that at the hospital and she was still on her father's insurance. She was in college at this time. She was afraid he would find out. She did not want to tell him because she knew he would blame her for what happened. This is a story we've heard a number of times, where parents have sent their kids off to school and said don't party, don't do this, don't do that and they get assaulted and it's not their fault but they feel that it's their fault. So she didn't get the kit done, she did not get the prophylactic because she was afraid this was going to go on their insurance. Very quickly, I just want to say for many schools and police, when people get there and say they have been sexual assaulted, they immediately put them in an ambulance to send them to the hospital and that bill goes to their parents or to whomever has their health insurance and sometimes

they don't even know what's happening because of where they're at in their mind at that time and so it's another example of why we really need to be I think you know kids are in college. We don't know who could be sexual abusing someone as well. It could be the person who's holding the insurance. I think it's very critical for these people to be able to say that they're not gonna have it and I just want to answer one of your questions, Representative Hughes. We have our sexual assault counselors who would be able to take this information and give it to sexual assault victims at the hospital when they're getting their rape kit done and say this is an alternative for you if you don't want this or if somebody asks. Often they ask, they said what's gonna happen, is this gonna go on my insurance. So thank you.

REP. DATHAN (142ND): Thank you very much. Are there any questions? Representative Nolan.

REP. NOLAN (39TH): Not a question, just a statement in regard to the line of work that I do. We run into a lot of people who are assaulted and we ask them to make statements and one of the reasons for not making a statement is because they believe the insurance is going to show up in regard to the problem that they have and they worry about relatives finding out along with some the instances that they end up getting involved so that is something that we deal with, yes.

LUCY NOLAN: Yeah, I mean there's a tremendous amount of shame around people who've been sexual assaulted that they have to work through so thank you.

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

REP. VAIL (52ND): Thank you, Madam Chair. Good afternoon. Thanks for saying that and I support what you're saying 100 percent. The hard part is as a parent, if you know, if a person that owns the policy is the abuser, then you know obviously that's one thing, but to not know when somebody goes through that and again, you get to that point where you're still on their insurance, I don't know. I would hope you could at least see, I have reservations about this because I don't want to not know what's going on in my kids' life, not because I'm controlling; because I want to be there and help them out through it, not have to have them rely on strangers. And so obviously if the people that are abusing that own the policy, then that's certainly a case and I see why you guys want to go this route, but why I have reservations is I want to know what's going on and you know maybe when they're 18, they're considered an adult, even though my kids are in college, they're far from independent. They're still pretty dependent but my minor children, you know I certainly would want to be there as their parent to help them through a hard time and maybe they're ashamed and I understand that, and I wouldn't want that to deter them from getting the help they need, but at the same time I certainly want to, I would think as you know a parent that cares that I want to be part of that, you know, with their mother and that's where I get concerned about this. It's not that I don't see, I can see where it is but I feel like we're painting this with a broad brush and I don't know if there's a way to make this a little bit more palatable for me. I'm not sure.

Maybe we can have that conversation but I see where you're coming from with this and some of the other testifiers and I understand that but hopefully you can understand as someone who cares deeply about his children as do many of my colleagues and people out there, we all do, that this is somewhat concerning to me.

LUCY NOLAN: So I too am a mother of three boys who I worried about all the time when they were in college and so I understand. I do get that and I think what's nice and it sounds from your point of view and also I hope from my point of view is that I hope my children came to me when there problems but not every family is like that unfortunately and in some places what we hear from people is that they may get in trouble or something may happen to them if they, if their parents find out and unfortunately, that's the way it is and the other thing I want to say if somebody's 16 or under and they're sexual assaulted, they immediately get referred to DCF and then DCF would take over and see if it's the parent who's involved or not and how that would happen. So there is that kind of protection for that there but I do understand what you're saying. I just think it's just unfortunate, I think that it's unfortunate.

REP. VAIL (52ND): Well again I have an open line, at least I think I do, I have an open line of communication with my kids and if there's more they're not telling me I guess I might be in trouble but --

LUCY NOLAN: You might find out [laughs] when they're 30.

REP. VAIL (52ND): I get it. I wouldn't want them to be afraid but you know kids aren't always wise in the choices they make and they might fear their parents' reaction more than what it is in reality you know cause you have a set of rules but we've all been children before and I'm worried that this kind of takes away parental rights or in some way it does that and that's my biggest concern with this. Again, I see why it's brought up. I just, I think it goes a little too far. I think it could be done a little bit better but we'll see. I'll continue to listen to the testimony and we'll go from there.

LUCY NOLAN: Okay. Thank you very much.

REP. DATHAN (142ND): Thank you very much. One question I had for you. Do you in your advocacy work that you have done, you talked about the young people who were assaulted at college, is there any sort of data that talks about victims that aren't, I mean it's difficult to quantify because they actually don't self-identify but is there any sort of data that might support maybe a university study that talks about unreported situations where a victim may not get treatment in the fear of the one, embarrassment, but also you know fear something would, any sort of retaliation from a parent? Is there anything to support that?

LUCY NOLAN: Not that I know of but there is a bill right now in Higher Ed to have schools do climate studies to see and they would be asking students specifically have you been sexual assaulted or you know have you, and, and some of those questions could be on there as well and you know how do you feel the campus responded to you, the college responded so to get to some of those things, to make

sure that we're taking care of college students and I will let you know that at UConn, they actually, they may send somebody to the hospital in an ambulance, but they pay for it. It gets paid for so they understand how difficult that can be for students.

REP. DATHAN (142ND): Okay. That's great. Oh, Representative Nolan, sorry for the second time.

REP. NOLAN (39TH): Representative Vail, how are you today, sir?

REP. VAIL (52ND): Fantastic.

REP. NOLAN (39TH): Just out of curiosity, do you know of other areas that might have been doing something that you're wanting to mimic or anything that would make you a little more comfortable but at the same time, give the child the rights that they should have to do something in line with this?

REP. VAIL (52ND): I'm not familiar with any because I was not, this was not an issue I personally was pushing for cause I don't know that I see the need. I see you know, it's not something that I've been working on so I haven't done that research. I don't know, maybe if we had information from, I know we have a lot of people testifying on this, if we could get the information of where this legislation or anything like this legislation is passed in other states and have that information and see how those statistics are borne there, I don't know but it's not something I've looked at personally cause I have not supported this measure so it's not something that I was looking to find an answer for.

REP. NOLAN (39TH): I only ask because it would be great to do some bipartisan and I know just from my

work experience how often I run into issues of such and I will continue to try and find research and maybe meet with you in regard to it.

REP. DATHAN (142ND): Representative Hughes. Thank you, Representative Nolan.

REP. HUGHES (135TH): Just again, I wish that youth under 18 weren't facing instances of intimate partner sexual assault, dating violence. We know from statistics that you know, upwards of somewhere between 70, 80, 90 percent are known people to them so there are --

LUCY NOLAN: 80 percent?

c Yeah, somewhere in that range and we also know that so many of the suicide attempts are made in that younger than 18 range. It's become a really, I forget what the statistic is now but it's just horrifying so we have to find ways to make sure that interventions and help, like remove the barriers and the stigma and the fear. You know from the developmental asset surveys which we've done, seventh grade, ninth grade, and eleventh grade in many, many school districts across the state, it's astounding how many are exposed to getting in a vehicle with somebody who's been drinking or drugging or how many people have witnessed violence in the home, how many people, I mean this has just become so normal from those anonymous surveys that we've gone through, Developmental Asset Institute, that we know it's happening but we also know they're not getting services so you know this is one of the reasons. It's because nobody wants their parents to find out that, that, and that seems silly but keep in mind, that's a young brain that is not weighing the lethality and the risks, the risky behavior that

they're taking with, against the consequences of being found out and potentially helped so.

LUCY NOLAN: I will just say very quickly that one of the most heartbreaking things I heard yesterday was somebody came to my office and said I just have to tell you this woman said I'm not gonna go, I'm not gonna go because it's gonna on my, is it gonna go on my insurance and she's like I can't tell you that's it's not and then she said well then I'm not going to a hospital and this was an advocate, this is what she does, right? She holds peoples' hands and helps them through this. She couldn't help her so that really stuck with her.

REP. DATHAN (142ND): Thank you very much, Representative Hughes and thank you, Lucy for your testimony today. Next we have Kathy Flaherty.

KATHY FLAHERTY: Good afternoon members of the Insurance and Real Estate Committee. My name is Kathy Flaherty and I'm the Executive Director of Connecticut Legal Rights Project, the co-chair of Keep the Promise Coalition and a member of the steering committee of the Cross Disability Lifespan Alliance. I actually submitted written testimony in favor of four bills, but I'll focus now since you're talking about 5247, the ACT CONCERNING EXPLANATION OF BENEFITS.

We already know that people don't go to get the mental healthcare they need either because they can't access it or because of what we so often refer to as stigma, which is really ultimately discrimination. And if what we want to do as a state is encourage people to access the care that they need, we need to remove the barriers to that care and Representative Vail, I did hear your

question and I do think that in your families like yours, your children whether they're minors or young adults, would come to you and would feel safe coming to you telling you what their issues are, but there are too many families of my friends, of my clients where they just cannot do that and they don't feel safe doing that. I'm 52 years old. My mother is 80. There are things I've never told her and I can't tell her now because frankly, it would probably kill her so I don't and if we say you know we must disclose these things on explanation of benefits. There are gonna be too many young adults in our state who do not get the care they need so I would definitely urge you to move forward on this bill along with the peer support and the all the treatment for substance use disorder. Thank you.

REP. DATHAN (142ND): Thank you very much. Just anecdotally in your experience, I have been looking a lot into the peer support issue. Do you have any data or if it's just anecdotally, that's fine, to support the peer support services and how it's preventing re-admittance into extended care or other hospital stays?

KATHY FLAHERTY: Do I have that with me today? No, I don't, but I certainly can reach out to my colleagues and get you that data. There are more studies around the country but people really, when you think about the concept of peer support, AA has been around for how many years? There are peer support recovery groups that Advocacy Unlimited does, that NAMI Connecticut does, that Depression and Bipolar Support Alliance does. It works. I'm a person with lived experience in recovery from a

diagnosis. There is no question in my mind the fact that the peer support services met on the grounds of McClain Hospital and when I had the privileges to get off my unit and I could go to a peer support services during my first hospitalization, 30 years ago, there is no question in my mind that I wouldn't be where I am today if I didn't see the living examples of people who could live the diagnosis and I think that's really important. I do know that there is a split and why I think a task force is such a good idea. There are some people who think you can make it reimbursable if you make it insurance has to pay and it has to be medically necessary, that it puts what something that should be not medical, medicalized and there's some real issues with that but other states have been able to get beyond that and I hope that we can do that here in Connecticut because right now, it's funded by certain hospital systems who can afford to pay for it and it really should be something that's available to everybody. It's one of the rare times I'm in favor of a task force.

REP. DATHAN (142ND): Thank you very much. Are there any questions or comments? Representative Vail.

REP. VAIL (52ND): Thank you. I'm not a big fan of task force. So just the point you made to me and again, I like to think I have an open relationship with my kids. That still doesn't mean they're not gonna be afraid to come to me and you know just not having that knowledge, I feel it's almost like we're trying to do something, I feel it really is on the borderline of parental rights and we you know when your kid's going through something traumatic, you certainly want to be there for them and they might

still even though because they don't feel good about what they did or what's going on or all these different things that they might, there might be inherent fear there because they're 13, 14, or 15 years old and that's just the way it goes and they don't want to disappoint you. They don't want to do, other reasons and that really concerns me and that's again my biggest fear. It's not even so much that you know, certainly I try to keep open lines of communication as I'm sure most parents do these days, that they still might have that fear and so that's where my concern is with this. Thank you.

REP. DATHAN (142ND): Thank you, Representative Vail. Thank you so much, Kathy, for your testimony and your advocacy. I think this is either Ashley or Sally Fren? Apologies, if you could just correct your name for the record.

ASHLEY STARR FRECHETTE: Yeah, hi, I'm Ashley. Thank you, Representative Dathan and members of the committee. My name is Ashley Starr Frechette. I am the Director of Health Professional Outreach at the Connecticut Coalition Against Domestic Violence. We are the state's leading voice for victims of domestic violence and those who serve them. Our 18 member organizations provide essential services to nearly 40,000 victims of domestic violence each year.

I'm here today in support of House Bill 5247 and the reason for my support of this bilateral is that EOB's are currently automatically by health insurance companies and sent to policyholders, not directly to the patient who actually sought those services. The inability to control this automated statement disproportionately impacts vulnerable

patients like victims and survivors of domestic violence. Nationally, one in four women and one in seven men have experienced severe physical violence by an intimate partner at some point in their lives. Intimate partner violence takes an incredible toll on the physical and emotional health of victims and survivors and leads to an increased need for medical services.

Unfortunately, many victims of domestic violence share a health insurance policy with their abuser. If victims are unable to control where their medical appointment information goes, it can have extreme negative consequences to their health and their safety. I am confident that no medical provider in the State of Connecticut would ever try to send home patient notes from an appointment that outlined disclosures of abuse. This would jeopardize the health and safety of that individual. So why should this be any different when it comes to how insurance is able to provide that EOB? As part of my day-to-day job, I go out and train health professionals on how to screen and use resources with all their patients that have encountered IPV, and I hear this concern about this confidentiality of documentation on a daily basis. The way that Connecticut is currently allowing EOB's to be automatically generated and sent directly to the policy holder, not the patient, can put victims of domestic violence in further and serious danger. This can prevent them from seeking necessary medical attention and things that they need to get the support that they need because of the fear the abuser will see that notification. This is especially important to point out because the act of seeking support from a health professional is

important to ending the cycle of violence and this is something we don't want to stand in the way of.

Passing House Bill 5247 would allow victims to choose a safe and appropriate method of receiving their EOB, without the fear that their abuser will get a copy. I strongly urge you to support victims and survivors of domestic violence by passing this measure. Thank you for your consideration and if you have any questions, let me know.

REP. DATHAN (142ND): Thank you very much, Ashley. Apologies for getting your name incorrect. Representative Vail.

REP. VAIL (52ND): Thank you, Madam Chair. Good afternoon. If this bill just covered everything you just talked about, not only would I support it, I'd probably co-sponsor it so it's, I agree with you on that part. It's the other stuff beyond that that I have an issue with so I just wanted to make that statement. Thank you.

REP. DATHAN (142ND): Thank you very much, Representative. Any other questions? Thank you very much, Ashley, for your testimony. Next we have Gretchen Raffa.

GRETCHEN RAFFA: Good afternoon, Representative Dathan and honorable members of the Insurance and Real Estate Committee. My name is Gretchen Raffa, Director of Public Policy and Advocacy with Planned Parenthood of Southern New England testifying in strong support of raised House Bill 5247, AN ACT CONCERNING EXPLANATIONS OF BENEFITS, a bill that is also supported by the Connecticut Coalition for Choice.

Planned Parenthood of Southern New England is the largest provider of sexual and reproductive health care in Connecticut, serving over 68,000 patients annually at 16 health centers and we also are offering primary care at some. As a health care provider and advocate, Planned Parenthood's top priority is ensuring that all individuals have access to the health care and information they need, including the full range of sexual and reproductive health services.

This March, we will celebrate the 10th anniversary of the Affordable Care Act (ACA), whose passage Planned Parenthood worked hard on, and that enabled millions of people to have access to healthcare coverage that they didn't previously have including young adults covered by their parents' health insurance plans up to age 26. However, an unintended consequence of this effort may be breaches of health care confidentiality when EOB's providing detailed statement go home to the primary policyholder, such as the parent or guardian. A significant number of insured young people are accessing covered care such as reproductive health care, behavioral health care, substance abuse counseling and treatment, mental health or substance use disorders under our current law.

Our state law already protects minors' access to such health care including the full range of reproductive health such as birth control, sexually transmitted infection testing and treatment, access to HIV prophylaxis and abortion services. The intent of HB 5247 is to establish other mechanisms to ensure confidential healthcare information is not shared with anyone other than the patient if multiple people are enrolled. This is particularly

important for young people who need access to reproductive healthcare.

The reality is many adolescents proactively involve their parents or guardians in their sexual and reproductive health decision making. Yet, for those who can't, as a family planning provider, Planned Parenthood believes that all young people need and deserve access to this care. Adolescents who are concerned about the confidentiality of their contraceptive care are unlikely to obtain it. In my written testimony, I have referenced several studies but I just want to say that this reality can be particularly pronounced among marginalized adolescents such as those who are experiencing homelessness, identify as LGBTQ or are in the foster care system, and we believe that this bill is just one small step to protecting patient privacy, to access vital healthcare in a confidential manner and is consistent with state law. I'll stop now.

REP. DATHAN (142ND): Thank you very much. Any questions? Representative Hughes.

REP. HUGHES (135TH): So in your experience especially, Gretchen, with the younger population since I think that is a little bit of contention or concern, what would trauma informed point of service look like in this, like how would this help modernize trauma-informed service?

GRETCHEN RAFFA: I'm not a healthcare provider so I will say the importance of this is to ensure that people do not delay care or forego care altogether and that is, the lens that come to this issue on is that there are state laws in place that protect the confidentiality of people to access healthcare including federal law. Until recently, the federal

family planning program, title 10, actually has in its statute a confidentiality clause to ensure that minors who need to access comprehensive reproductive healthcare can access that. And what we know to be true at least through the health centers across Connecticut, that minors do actually include their parents. The majority of minors are including their parents or a trusted adult or a legal guardian. They've already had these conversations with them and it's incredibly important as healthcare providers and as advocates that we're ensuring that the most vulnerable of young people continue to have access especially if they are facing trauma or abuse or just cannot include their parents or guardian because of safety concerns.

REP. HUGHES (135TH): So really the people that this profoundly impacts are those that are already profoundly marginalized. It's really not the majority of the people, like I said that are being served in that. Okay. That helps. Thanks.

GRETCHEN RAFFA: And I referenced a couple of studies that actually show that if minors have access to things like birth control, they're more likely to start birth control or delay the onset of sexual activity which again is really important because not every young person across our state and across this country actually has access to the information and education that they need to make informed decisions so they can live healthy and self-determined lives.

REP. DATHAN (142ND): Representative Vail.

REP. VAIL (52ND): We almost made it. [Laughter]. So again, so we're focused on the marginalized minors and the unintended consequence is that you

get non-marginalized minors that get caught up in that. Like you can say that the majority would do that, but there's still that wouldn't and I still have concerns and I wouldn't even argue with you in the fact that this is consistent with state law, I would agree with that, I just might not think that's, that was a bill that was a passed before I worked here so I do understand that. I see where you're coming from, I just have concerns. I think there's unintended consequences that could happen from passing this.

GRETCHEN RAFFA: Thank you.

REP. DATHAN (142ND): Thank you, Representative Vail. Thank you so much, Gretchen for your testimony today.

GRETCHEN RAFFA: Thank you.

REP. DATHAN (142ND): Next we have Maddie Granato and after Maddie, Lisa Winjum.

MADDIE GRANATO: Representative Dathan and members of the Insurance Committee, my name is Maddie Granato and I'm the policy director for the Connecticut Women's Education and Legal Fund (CWEALF). We're a statewide, nonprofit organization that advocates for and empowers women and girls in Connecticut, especially those who are underserved or marginalized. Thank you for the opportunity today to give testimony in support of House Bill 5247.

Each year, CWEALF serves thousands of Connecticut residents through our Legal Education program, which provides information, education, referrals, and bilingual advocacy to ensure that all individuals in our state have access to legal justice. The majority of CWEALF's clients are low-income women

with at least one dependent, some of whom experience domestic or family violence. Lack of confidentiality is often a barrier to health care services, especially when an individual seeks services related to domestic violence. By protecting an individual's right to privacy, House Bill 5247 will minimize the potential danger caused by the disclosure of these services, specifically for patients at risk of retaliation from an abusive partner or family member.

Access to health care services is essential to healing and treatment for survivors of domestic violence and survivors' relationship with their health care providers is often built on the trust that the information shared is private. House Bill 5247 is critical to so many of our clients and survivors across the state to access the care that they need.

CWEALF also leads a legislative agenda that's centered on women's economic security. Research shows that access to healthcare increases women's educational opportunities and narrows the gender wage gap. Just closing private healthcare information and an explanation of benefits can prevent women from seeking the care that they need which may also lead to long-lasting impacts on their financial success and advancement in the workforce. Healthcare is a human right and everyone in our state should be able to access the care they need without fear of judgement or retaliation. We urge the committee to support House Bill 5247. Thank you.

REP. DATHAN (142ND): Thank you very much for your testimony. Are there any questions? Any questions?

Thank you very much for your testimony. Next we have Lisa Winjum followed by Mary Greenwell. I was going to say I think Lisa testified earlier on another bill so Mary Greenwell.

MARY GREENWELL: Good afternoon, Representative Dathan and other distinguished members of the Real Estate and Insurance Committee. My name is Mary Greenwell and I am a junior from Eastern Connecticut State University along with being an intern with the General Assembly this session. At Eastern, I am a part of Warriors against Sexual Violence and on campus group that advocates for eliminating dating violence and other forms of abuse from our campus and hopefully the broader Willimantic Area. For this reason, I am in strong support of House Bill 5247.

Growing up, I was extremely fortunate to have access to comprehensive health care and get medical treatment when I needed it. I was even more fortunate that there was never a time in which I needed to seek medical treatment without telling my family, or the policyholder of my insurance, who happens to be my dad. However, I can appreciate that in the way my parents my tuition, they do not have access to my grades. When I need to seek medical treatment, they cannot access my medical records and I can appreciate that if I was in a situation in which I did not feel comfortable with them having access to those records.

If you pass House Bill 5247, people who face dangers of sexual violence will have full access to confidential and comprehensive health care, allowing them to seek treatment if they have been hurt. By allowing and informing the patient of their ability

to specify where the explanation of benefits is sent if any is sent at all, people who are in dangerous or threatening situations with their insurance policy holder will be able to seek necessary treatment, without risking their lives to do so.

In my written testimony, I have provided a summary of the legislation that has been passed across the United States, but the most important to me was the no description of sensitive services passed in Massachusetts which includes treatments in reference to domestic violence, mental health, substance and abuse treatment. Thank you.

REP. DATHAN (142ND): Thank you very much, Mary. Are there any questions from any of my colleagues? Representative Hughes.

REP. HUGHES (135TH): Yeah, just one point to clarify. So the sensitive benefits, would that be across the board, the one that you mentioned in your, or only like an opt-in, opt-in/opt-out?

MARY GREENWELL: So from what I understood, the legislation in Massachusetts is patient chosen explanation of benefits distribution so if you seek treatment for an issue involving any of those sensitive services --

REP. HUGHES (135TH): They would ask you.

MARY GREENWELL: Yeah.

REP. HUGHES (135TH): If you want to choose to blah, blah, blah.

MARY GREENWELL: Exactly.

REP. HUGHES (135TH): So it's like an opt-in.

MARY GREENWELL: Yep and you have the full information about where your explanation of benefits can be sent and how your confidentiality will be protected which is an important aspect of the bill.

REP. HUGHES (135TH): So I realize I've been using trauma informed but what I really wanted to be using is the term patient centered care, patient centered care because the control over that information is extremely important to patient centered care, to their care, to their receiving it at all but regardless of the patient's age, it's patient centered care. Thank you.

MARY GREENWELL: Thank you.

REP. DATHAN (142ND): Thank you very much. Just one, you mentioned that you did some research. I don't know if you were in the room when I talked to Jak Sicklick about some questions. In your research, did you find similar results and how many states did you find have such legislation and are there are varying sort of degrees to which different states look at this issue?

MARY GREENWELL: So there are at least ten states that have comprehensive policies involving explanation of benefits. They include New York, Wisconsin, California, Oregon, Delaware, Florida, Hawaii, Maine and Massachusetts. They all have different degrees of these opt-in policies including the option to have your parents have ability or your policyholder have the ability to request the information about your explanation of benefits, and you as the minor, as the dependent have the option to refuse that request.

REP. DATHAN (142ND): Great. Thank you. More anecdotally you said you were in college still and you're a Junior, do you have any stories, anybody that you knew in college that maybe didn't get medical treatment either for mental health issues, addiction issues or any other issues that we've been discussing?

MARY GREENWELL: So personally, my brother experienced a great deal of mental health issues when I was in high school actually. We had a very distinct and very trusting pipeline of information with our parents but the information of what treatment I think that he could've received was less than acceptable and I think more access and more understanding of what he could've done for himself would've really helped him. I also know too many people that I go to school with who suffer from mental health issues and don't have a support system that they can actively reach out to in order to receive these services in order to like get the care that they need and there is a fear, there is a stigma and there is a shame that comes with these issues especially when you're looking at issues of sexual violence or other issues that these like societal norms have presented to be such shameful topics so I think there's too many stories that I could share.

REP. DATHAN (142ND): Well thank you very much for your testimony. I think we're done questions. Thank you very much. You have a good afternoon.

MARY GREENWELL: Thank you.

REP. HUGHES (135TH): And good luck in your studies. Is there anybody else here today that is planning on testifying House Bill 5247? Okay. Is there anybody

that is wanting to testify on the other five bills that we talked about earlier? Okay. It sounds like this concludes our public hearing but I did want to announce on Tuesday, March 3, we will have a Committee meeting here in Room 2D at 11:00 a.m. followed by a public hearing at 11:15 in the morning and if there's no other business, I'm going to conclude this hearing. Thank you very much.