CHAIRPERSON:	Representative Sean Scanlon
SENATORS:	Lesser, Hartley, Kelly, Anwar, Bizzaro
REPRESENTATIVES:	Dathan, Pavalock-D'Amato, Delnicki, Floren, Hughes, Nolan, O'Neill, Riley, Rosario, Turco, Vail

REP. SCANLON (98TH): We will go ahead and reconvene the March 3rd Public Hearing, and we will start with the legislator's agencies and municipalities. A friendly reminder that the exits are on either side of the room. In the event of an emergency, just please proceed with caution toward those.

And we will start our morning off with Representative DiMassa.

REP. DIMASSA (116TH): Good morning to the esteemed leadership, my fellow colleagues, on the Insurance and Real Estate Committee. I'm Representative DiMassa, proudly representing the 116th district; New Haven, West Haven.

I come before you today in strong support of the HB 5369 regarding the donor breast milk and the related insurance coverage. This is a fantastic bill. It's a step in the right direction for the state. I must admit that I had to do a lot of research on this bill. I'm certainly no expert, but I will tell you that I have a constituent today coming to testify before you and a number of public health professionals who would certainly be able to answer

your questions a lot better than I probably can, but it's a great bill. And the reality is this; there are many instances where a biological parent is not able to provide either enough breast milk or any breast milk and studies have shown that breast milk, the nutrients in breast milk, certainly for say premature births for example have many beneficial impacts that far outweigh other options. So it's certainly something that we should be looking at the insurance and Medicaid coverage for, as well as the public health screening process.

And with that, I will conclude my remarks.

REP. SCANLON (98TH): Thank you Representative. As a new dad, I am very familiar with the importance of breast milk and certainly understand the importance of it for women that are not able to produce it because they have brought a child into world that's not, you know, fully developed. So we look forward to hearing more testimony about this bill today and thank you for being here.

REP. DIMASSA (116TH): Thank you very much.

REP. SCANLON (98TH): Any questions for Representative DiMassa? Senator Lesser.

SENATOR LESSER (9TH): Representative DiMassa -- thank you Mr. Chairman -- Representative DiMassa you weren't going to get off that easy --

REP. DIMASSA (116TH): -- I was hoping --

SENATOR LESSER (9TH): -- No thank you for your advocacy for this issue. As I read it, and this bill seeks to do two different things. So one is to provide insurance coverage for breast milk and for breast banks, and I think that is a worthy and

important goal. That's what I heard you talk about in your testimony.

There's a second part of the bill that seeks to have the Department of Public Health regulate breast milk. We got a lot of testimony about that second part from folks who are concerned that that might hurt the volunteer-run breast banks we have in Connecticut. Is that something -- I didn't hear you mention that in your testimony -- is that something you have a strong opinion about either way?

REP. DIMASSA (116TH): I personally do not have a strong opinion either way, but like I said I do know of one expert that will be testifying before you later that could probably answer that better than I can.

SENATOR LESSER (9TH): Great. Thank you so much Representative.

REP. SCANLON (98TH): Thank you Representative. Next up is Representative Jason Doucette, who I do not see. Oh there he is, yep. As a Chairman point of order, I do see Representative Doucette.

REP. DOUCETTE (13TH): Good morning everyone. Good to see you. Senator Lesser, Representative Scanlon, Ranking Members Kelly and Pavalock-D'Amato, I am Representative Jason Doucette from the 13th assembly district of Manchester and Glastonbury. I'm here to testify on HB 5361, AN ACT LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS.

It was my plan to be here today and yield my time to my constituent Mrs. Pam Greenberg who suffers from MS. Unfortunately, she recently had to have some surgery and couldn't make it here today, but working

with her I was able to get her to submit her testimony which is short. So I'd like to read it as if she was here with me and read into the record. You have my testimony, I believe the Committee is probably familiar with this bill. We passed a similar bill last year, 6096, in the House.

Currently, healthcare insurers are allowed to add or remove drugs from plans or formularies at any time or change the coverage tiers for drugs with 60 days' notice. This bill would place limitations on insurer's ability to make those changes in the middle of a plan year without giving consumers the option to potentially switch their coverage plan. These changes can be devastating to vulnerable patients who are faced with the choice of coming up out-of-pocket to make up the difference or accepting a less effective alternative medication or perhaps even discontinuing their medication when the coverage is lost.

Furthermore, I see this bill as an important piece of our efforts and I know the committee is working hard on this to generally control the price to consumers and accessibility of life-saving prescription drugs.

And again, I'm here merely representing my constituent Mrs. Pam Greenberg who is living with Multiple Sclerosis. She has been an advocate with the MS Society on this issue, and many others for years. She brought this issue to my attention last year. Pam's situation is also typical of many Connecticut residents living with chronic conditions independent on life-saving medications. This bill can make a significant improvement in their healthcare options and quality of life.

And again you have Mrs. Greenberg's testimony. She says, "My name is Pamela Greenberg and I am from Glastonbury, Connecticut. I am also a person living with multiple sclerosis (MS).

As a person living with several chronic conditions, I rely on a good number of medications daily. Unfortunately, I also must spend a large amount of money on co-pays to control my conditions each year.

Non-medical switching is the practice of insurance companies removing a drug from a covered formulary or moving it to a higher cost-sharing tier during the plan year.

I have been subject to this several times in the past. As an example, I have had my cholesterol medication changed from a tier 2 to a tier 4 without notice from my insurance company. A prescription that I paid $30.00 a month for went up to $125.00 a month.

I ask that you pass HB5361 which would guarantee that insurance companies stick to the contracts we sign up for at the beginning of the plan year."

So that's that. While I'm also up here, I'd also like to comment on 5369, which I know Representative DiMassa just spoke on, which is the breast milk depositories. I had the opportunity over the weekend to attend an opening for one of these depositories at a physican's office in my district. I learned a little bit more about it, learned about this bill at that event, and I did want to flag; I am far from an expert on it, I did want to flag that provision I believe it's Section 2 of that bill which talks about regulating and screening the breast milk which I understand can be cost

prohibitive for some of the non-profit operators in this field. So we want to obviously encourage breast milk donation and just take a closer look at that section of the bill and make sure it's not unfairly treating those non-profit operators in the field currently. Thank you.

REP. SCANLON (98TH): Thank you Representative, and I think that that's a great thing that we are certainly going to do as part of this hearing today and make sure we get to the bottom of that, and thank you for your testimony from your constituent. That is an issue that this committee has been trying to solve for years now, and hopefully this will be the year that we finally make that practice no longer a practice.

Any questions for Representative Doucette? Seeing none. Thank you so much.

Commissioner Mais.

COMMISSIONER ANDREW MAIS: Thank you. Senator Lesser, Representative Scanlon, Senator Kelly's left for now, but Representative Pavalock-D'Amato and members of the Insurance and Real Estate Committee, my name is Andrew Mais. I'm the commissioner of the Connecticut Insurance Department, and I'd like to thank you for the opportunity to testify today in support of our agency bill. Now with the interest of time, I've already submitted written testimony. I'm happy to read that into the record if you so choose, I can give you a brief summary, or I can simply answer any questions you would have.

REP. SCANLON (98TH): Commissioner, if you are willing to give us a brief summary we would certainly appreciate that.

COMMISSIONER ANDREW MAIS: Absolutely. There are four sections to this. The first section is on Public Health, and what this is meant to do is to provide a parity between the public health fee and the vaccination assessment by adding the same provision to the public health fee. That would allow the department to allow and to impose a late filing fee of $10 -- $100 dollars per day; my glasses aren't that good anymore, for insurers or healthcare centers who do not submit lives covered by September 1st.

There is also a civil penalty of not more than $15,000 which can be imposed if it is determined that there was an other-than-good-faith discrepancy in the number of lives reported. And again, this was simply to provide parity between the public health fee and the vaccination assessment.

The second section has to do with third party performance of department employee duties, and we see this as A; the removal of obsolete language, B; it's been a concern that has been expressed by the NAIC accreditation unit and the accreditation of the department. And what it does is it gives the department more flexibility to access outside expertise to supplement staff when needed.

Now I do have to let you know we have a staff covered by this. It's a fabulous staff. I love them. They are as good as you will find anywhere. My concern is succession. Over the next few years, a significant number of those were eligible for retirement and the way it works with insurance it takes awhile to get up to speed and what we need is to have the resources to properly regulate insurers on behalf of consumers as they do. This is not

intended, and I want to make that absolutely clear, not intended to replace any current staff.

Then there's the insurance data security law, which was passed last year. These are technical changes. We've met with all the stakeholders and these are technical fixes designed to insure that the law performs as expected.

And finally, domestic insurance company assessment. Right now, we require our companies to pay in installments. Companies pay assessments that will cover the operation not only of the cost but the operation of the department. We do not -- what we've tried to do is to make this as friendly to our companies as possible. So especially for the smaller companies, they would have the option to pay once and not incur the administrative burden of having to make multiple payments. And that is what we have suggested. Thank you.

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

SENATOR LESSER (9TH): Yeah, thank you. We did receive some testimony, I know you said that -- with regard to the House Bill 5365, that it wasn't the department's intent to replace any current staff with outside contractors but there was some testimony that we've received in concern from folks who are representing some of the insurance staff who expressed concerns, and I just didn't know if you had had a chance to review their comments and respond?

COMMISSIONER ANDREW MAIS: I have not had a chance to review their comments, though I have had a chance to discuss it briefly with our representatives and

as I told that Representative we are willing to discuss this after the session to make sure that we can relay any concerns and come to a mutually agreeable resolution.

SENATOR LESSER (9TH): Thank you, and I do note a number of the bills that really focused on bringing this into compliance with NAIC requirements, I note that the department was recently re-accredited by the NAIC. Congratulations on that.

COMMISSIONER ANDREW MAIS: Thank you Senator. Again, I do have to give the credit to my staff who have done a wonderful job.

SENATOR LESSER (9TH): Thank you very much. That's what I have for right now, Mr. Chairman.

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

REP. PAVALOCK-D'AMATO (77TH): Thank you Mr. Chair. The -- I'm looking at the beginning of the bill with the penalties for the failure to report the annual report and one other I believe, if there's any discrepancies, that section. And just because I don't have the definitions in front of me; healthcare center, would that include -- what would that include? I am wondering if it includes some of these walk-in clinics or places like that, smaller businesses.

COMMISSIONER ANDREW MAIS: I can get back to you on the specifics of that. I do not have that at this point, but as I mentioned the idea behind this is to impose parity, essentially. We've got two different sections of the law that are conflict and we would like a level playing field for everyone.

REP. PAVALOCK-D'AMATO (77TH): Okay, because my only concern would be if it does cover some of the smaller ones -- if I had one in my district that's owned by an individual it's not a conglomerate of some of the bigger ones, that it you know, that could be pretty hefty for them.

COMMISSIONER ANDREW MAIS: Well let me -- again thanks to my crack staff here, healthcare centers are synonymous with HMO's --

REP. PAVALOCK-D'AMATO (77TH): -- Oh, okay. All right, great --

COMISSIONER ANDREW MAIS: -- so that would be the definition of --

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

COMMISSIONER ANDREW MAIS: -- particular area of the law.

REP. PAVALOCK-D'AMATO (77TH): Oh, thank you very much then.

REP. SCANLON (98TH): Senator Lesser for the second time.

SENATOR LESSER (9TH): Thank you Mr. Chairman for the second time. I have questions on two bills that you did not testify on, and at the risk of surprising you, I just had a question. One, there's a proposal No. 9 on the agenda, 5363, which requires the insurance commissioner to study regulating third-party marketers of health insurance and Medicare supplements. Is that something that the department has looked at in the past to your knowledge? Is that something that you are willing to take on?

COMMISSIONER ANDREW MAIS: I can -- let me hedge a little bit, we would be willing to take it on provided we were given the resources to do it. We simply do not have the resources at this point in time.

SENATOR LESSER (9TH): Okay great, and I think that the -- there has been you know -- we had at our last hearing some discussions of sharing ministries. We are also seeing a surge of complaints, at least coming to us, I'm not sure about the department, about practices from some third-party marketers and so I think as the market evolves, I think we are looking to keep working with the department to address problems and the way they crop out.

COMMISSIONER ANDREW MAIS: With the healthcare administrates.

SENATOR LESSER (9TH): Well with the healthcare administrates and then today with some of the third-party marketers.

COMMISSIONER ANDREW MAIS: Yes, and we -- I absolutely appreciate it. As you know, we issued a cease and desist against one of the healthcare administrates and we are looking at the TPA's and one of the TPA's that worked with them, and we are going to continue our vigilance on behalf of consumers.

SENATOR LESSER (9TH): Thank you very much. And then I can't help but ask about No. 6 on the agenda which would seek to move the regulation of bail bonds agents completely out of your department over to Judicial Branch --

COMMISSIONER ANDREW MAIS: -- We would strongly support that. [Laughing]

SENATOR LESSER (9TH): Well I'm not sure we're gonna be able to do that for you, but I couldn't resist asking about that.

COMMISSIONER ANDREW MAIS: We've tried to get some bills on bail bonds changes passed in the last six or seven years, I think. We would be happy to share our expertise with the Judicial Department.

SENATOR LESSER (9TH): I'm sure the Judicial Branch would love that.

Well thank you, thank you Mr. Commissioner, I appreciate that. Thank you Mr. Chairman.

COMMISSIONER ANDREW MAIS: Thank you.

REP. SCANLON (98TH): Okay, is there any further questions? If not, Commissioner thank you for being here today.

I do not see anyone signed up to testify on the first bill on the agenda, 5374; anybody looking to testify on that? Seeing none, we'll move onto 5366 and Ann Pratt is our first person to testify, followed by Anna Doroghazi.

ANN PRATT: Good? All right. Thank you very much. It's a pleasure to be here testifying in support of House Bill 5366, AN ACT CONCERNING COST OF PRESCRIPTION DRUGS, and 5361, AN ACT CONCERNING LIMITING CHANGES IN PRESCRIPTION DRUG FORMULARIES.

My name is Ann Pratt. I'm the director of Organizing for Connecticut Citizen Action Group.

In September of 2010, my husband and soul mate of 35 years was diagnosed with pancreatic cancer. He was given 1-2 months to live. Ken and I met many years ago. We shared a passion and a belief in creating a

more just and equitable society through community organizing, and an understanding that to do this we had to fight like hell to bring such a world into reality. Ken was a great organizer, and a gifted, passionate fighter. He applied that same tenacity and strength to fight his cancer. In spite of the 1-2 months' diagnosis, he lived for another year.

Ken was one of the fortunate ones in his fight against cancer in that he had quality, affordable insurance that covered the cost of his healthcare fully and consistently. The array of cancer drugs Ken received along with his pain medications he used to provide essential comfort in his last year of his life were extraordinarily expensive, but they were covered and they were covered consistently. This gave us an incredibly important opportunity to focus on his treatment, his quality of life and on saying goodbye to one another.

Every single individual in this country should have that same dignity and opportunity. The pain and emotional turmoil our American health care system can bring upon individuals and families experiencing health issues is immoral. The role that rising prescription drug costs play in this broken system needs to be addressed with urgency and vigilance. The ultimate solution, in my view, is to treat health care as a human right.

Until we get such a solution in this country, I testify in support of these two very, very important bills. These bills will take steps toward lowering prescription drug costs, create stability and peace of mind for individuals and families in their fight against serious diseases and chronic conditions. I urge you to support these bills that I thank you for

this committee of all of the incredible work that you do to help people get good coverage consistently and affordable. Thank you very much.

REP. SCANLON (98TH): I want to thank you and I had the pleasure of knowing your husband and you and him were very gracious to help me learn the fifth district when I was starting out as an aide to Chris Murphy [phonetic] 11 years ago. So thank you for all of that, and he was a true fighter and a champion and we miss him today, but we know you're here carrying on that great partnership and legacy. So thank you for that.

My question for you is, in the work that CCAG does how often -- and this is a leading question I know -- how often are you hearing from people who are just struggling to afford the cost of prescription drugs? Is it something that you hear regularly from people?

ANN PRATT: Practically every day. Practically every day, in a community you just have to ask about healthcare and the stories break my heart. And frankly as a person who has had coverage, I know what that means now. I mean, it's just, you cannot avoid it. The difference in the lives of people who have insurance and don't, and the fact that it's not equitable in this -- makes no sense. It's just -- it's torture for them and for people who know that having insurance makes such a difference every day.

REP. SCANLON (98TH): Thank you. Any questions from the Committee? Seeing none. Ann, thank you for being here today.

Anna Doroghazi, followed by Jill Zorn.

ANNA DOROGHAZI: Good morning Senator Lesser, Representative Scanlon, Representative Pavalock-

D'Amato, Members of the Committee. I am Anna Doroghazi. I am one of the policy directors at AARP Connecticut, and we are pleased to be here today to support both House Bill 5361 and House Bill 5366 which is where I'm gonna focus my comments today.

I'd like to begin by drawing your attention to testimony that was submitted by two of our volunteers, Sophia Forbes from Danbury and Novlette Williams from West Hartford, because I think the stories that they've told in their testimony are really symbolic of what people in Connecticut are experiencing when it comes to the high cost of prescription medication.

Even on a teacher's salary, Sophia struggles to keep up with the cost of the seven prescription medications that she has had to take following a stroke two years ago. One medication in particular, Eliquis, costs about $450 dollars a month. And she really struggles -- especially as the year is getting started, to pay for that medication. Before she hits her deductible, her out-of-pocket expenses are huge. The out-of-pocket cost caps proposed in 5366 would be helpful to her because although she still hit her deductible over the course of the year, it would almost act like a payment plan to help her spread some of those payments out across a few more months.

Novlette is somebody who I sat down with a couple of months ago to learn more about her story, and what she told me was that she has congestive heart failure and one of her medications, Entresto, costs about $416 dollars a month. The first time she went to pick that prescription up from the pharmacy and they told her what it costs, she went home without

out and what she told me was that she went home and she said, "if today is my day to die, God will take me now". She just didn't see a way to pay for that medication. Luckily her doctor made a follow-up call and said, "no, no, no, we're going to figure this out, come in", but that's just isn't a dignified way to get people the healthcare that they need.

Both Sophia and Novlette would benefit from the Canadian Drug Importation Program that's proposed in 5366. Entresto costs about 50% less in Canada, and if you go to a Canadian pharmacy you can get Eliquis for about 20% of what you can get it here in Connecticut.

I think you're probably gonna hear later in the day from some organizations, most of whom I want to note are backed by the pharmaceutical industry. They are going to claim that Canadian drug importation is dangerous. I want to just really quickly respond preemptively to some of the concerns that I think you might hear. First of all on the issue of safety, I think it's worth noting in something that's come up in the news with the Coronavirus is that the pharmaceutical industry is already a global industry. Eighty percent of the drugs -- in the active ingredients in prescription medications are produced elsewhere. So this industry already has drugs coming from China, coming from Canada, coming from all over the world. And we've come up with safe ways to respond to that importation.

I think it's also important to note, you know, when there are conversations around safety around people purchasing drugs off the black market, we need to think about why people are going there. It's not --

it's because they don't want to die. It's because they are desperate and they are looking for solutions.

So thank you for your time. I don't wanna go over, but thank you for your consideration.

REP. SCANLON (98TH): Thank you for being here today, and thank you to AARP as an organization for working with us the last couple of years on legislation impacting seniors and drug pricing.

I would like to ask you specifically about that $250-dollar cap. This is something that I hear about a lot from constituents who are just paying exorbitant amounts of money every single month and we don't control Medicare obviously, but the government hold is a big reality for a lot of seniors. Can you talk about what you think you're members would think about that cap and how they would benefit potentially from a $250-dollar cap?

ANNA DOROGHAZI: Sure, I think a $250-dollar cap allows people to get the full range of medications they need regardless of how many prescriptions they are on. And I think there's room in the language to clarify and sort out is this a $250-dollar per person for everything cost cap, is it per medication, you know what drug plans or tiers does it apply to. But I think knowing that their needs can be met for a set amount of money every month is going to avoid situations that I've heard about where people say, "well maybe I can take a little less insulin this month and maybe a little more of this, or maybe I can fill the prescription this month and save certain amounts", you know try to bridge the gap over the next couple of months. So I think -- I think it would be really helpful.

You know I do want to say that I'm pleased that the cost cap is part of a bigger prescription drug package. You know, 'cause we need to get at some of the practices like pay-for-delay also referenced in here that actually could lower the list price of those drugs. So we're not just doing more cost sharing through our insurance premiums.

REP. SCANLON (98TH): Now my next question for you is one of the things that I think I learned last year that just shocked me was that pay-for-delay is a thing at all and this is the practice for those of you who might not know that a brand-name drug company basically pays a generic drug maker not to bring the drug to market because they want to continue making money at the level that they're making it right now. Why is this, from your estimation, for them that we should be getting rid of?

ANNA DOROGHAZI: I think we don't allow it in industries where people aren't dying. Right? Like Starbucks can't pay off Dunkin' Donuts to not open a store next door, but we do have an industry where one company is paying off another company to bring a lower priced product to the market that could save lives and that could -- it could keep people out of desperate situations where they are trying to buy prescription medication you know off the internet or off of a place that's not going to be safe.

REP. SCANLON (98TH): Thank you. Questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Thank you Mr. Chairman, and thank you Anna for your testimony and for your work on this issue. And I think the thing that I -- the question that I get all the time is you know, "why

does AARP care about this issue, didn't Congress pass the Part D program to give seniors coverage for prescription drugs". Why does AARP care about this issue?

ANNA DOROGHAZI: So I think a couple of reasons. When it comes to the pieces of this legislation, you know and again this isn't isolated to Connecticut states all around the country are looking at this issue, AARP is advocating nationally on this issue. If we want programs that do help people like Medicare Part D to be sustainable long term, we can't have programs that are -- we can't have prescription medication that's this expensive.

We have to look at things that are going to actually use taxpayer dollars better, and do we want to be spending the taxpayer dollars on medication that could and should be a lot less expensive than it is.

SENATOR LESSER (9TH): We've spent an awful lot of time in this Committee looking at the cost of healthcare and certainly because it’s the Insurance Committee we do pass a lot of legislation pertaining to the insurance industry, but when we look at cost drivers it seems that other parts of the healthcare ecosystem most notably prescription drugs are some of the biggest cost drivers although we are still working to get data on that. And hopefully this addresses it.

I know Representative Scanlon asked you a few questions about parts of the bill. One of the things I know that Governor Baker, Republican Governor just to our north, has proposed is a cost cap on the growth of generic drugs. I think that's in this bill, is it? Can you just talk a little bit about that and how -- what that would do?

ANNA DOROGHAZI: Yeah, are you referring Section 2 of the bill? Is that the piece related to CPI?

SENATOR LESSER (9TH): Yes.

ANNA DOROGHAZI: Okay, yeah I think capping costs on generics in particular, you know where we have -- generic prices have looked a lot better in recent years than brand-name prescription drug prices. We regularly see brand-name prices far exceeding the rate of inflation year after year. Generics do a little bit better, but having a control like that in place to make sure that we are not seeing you know what we see in the brand-name drug market which is annual cost increases of 8% and 9%, making sure that we have some controls in place for generics I think would be helpful as well.

SENATOR LESSER (9TH): Thank you, and obviously the whole state, the whole world, is watching with concern the emerging COVID-19, Coronavirus, outbreak and one of the provisions of this bill is with respect of certain public heath emergencies when a high price of the prescription drug could cause a public health crisis and seeks to exercise powers that are currently available to the federal government to temporarily waive certain intellectual property protections in the case of public health emergencies. That's something that you could see being valuable to the state of Connecticut in the event of a declared public health emergency when the high cost of a prescription drug could create barriers to protecting the public.

ANNA DOROGHAZI: Yeah, so AARP doesn't have a set policy on that issue. In my understanding, it's that it's sort of an emerging idea in terms of how we can be responsive to the high cost of

prescription medication, especially in emergency situations, but I think it's definitely you know worth exploring and we'd love to be part of that conversation with you.

SENATOR LESSER (9TH): Terrific, thank you so much and I really appreciate the work that you and all of those folks in red shirts do across the state of Connecticut to fight for consumers and to folks who are adversely affected by the high and rising cost of prescription drugs.

ANNA DOROGHAZI: Thank you.

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

REP. DATHAN (142ND): Thank you very much Mr. Chairman, and thank you Anna for your testimony today. I have a mother who is older and on a lot of medications like you're talking about here; 4.5 per adult, and that's just the average. My question more is about, you know, what sort of cost are seniors having to pay monthly for their medications? I know if you have, you know, Medicare and then a Part D that does help, but I'm just kind of curious you know how many dollars are we talking about that the average senior is paying for their out-of-pocket for their medication every month?

ANNA DOROGHAZI: I think there's a lot of variations there, particularly with AARP's membership because our membership starts at age 50. We have a lot of variation between those folks who are age 50 and the folks who you know have reached the age of eligibility for Medicare Part D. Something that we have seen even among Medicare Part D enrollees, just a trend over the past year or so, is that -- the

graph kind of goes like this in terms of the number of people who are hitting catastrophic coverage with their Part D plan. So I think it was over a million Americans last year reached the point of catastrophic coverage. You know which means they are spending probably upwards of $6,000 dollars a year when it comes to their prescription medication. And that number is going nowhere but up.

REP. DATHAN (142ND): I mean you're on a fixed budget, you know you only have so much for retirement. You don't know how long you could live for. It's a frightening, you know, daunting issue.

So I'm very supportive of this, but anyway thank you very much for your presentation.

ANNA DOROGHAZI: Thank you.

REP. SCANLON (98TH): Any further questions? Seeing none, thank you Anna. I appreciate it.

Jill Zorn, followed by Leslie Wood.

Good afternoon.

JILL ZORN: Good afternoon Senator Lesser and Members of the Committee. My name is Jill Zorn, and I work at Universal Healthcare Foundation of Connecticut and we're here today to support House Bill 5366.

At the foundation, we've been working on the cost of prescription drugs for quite a few years now and there really seems to be two ways that states are addressing them, and I'm glad to see this bill is trying to deal with both. So on the one hand you have to look at insurance designs, particularly high-deductible health plans, and that's why we're

really glad to see the cap, out-of-pocket cap, put into this bill and that's an issue.

I've been looking at other states' bills, and I'm happy to answer any questions you might have about that. There are a lot of different ways to do it and I think the ultimate goal is to help people access their medication and also maybe to try to do it in a way that doesn't cause everyone's premiums to go up while you are saving on out-of-pocket and how to find that balance.

Another part of the bill, Section 11, is about formularies, no mid-year formulary changes which we definitely support. That's a contract that people have made, really they've chosen a health plan based on looking at the formulary very often and then to have that changed at the last minute or in the middle of their plan when they have no recourse. It's really not fair, and this bill did pass the House last year so I would love to see this piece make it all the way through this year.

And then a provision that you just spoke about, about the Critical Drug Shortage Review Board, we were really glad to see that in this bill. I'm aware of Louisiana was the place where maybe this idea first happened and they were trying to forward their Hepatitis C medication, but in light of the Coronavirus and ongoing -- you know whatever the next public health emergency is going to be, it's great to see that provision in this bill.

So I'm happy to answer any questions you might have, but thank you very much for introducing this bill.

SENATOR LESSER (9TH): Thank you so much Jill. You know there's a lot of different parts of this bill

as you've noted in your testimony, obviously each with its own issues. We did get some testimony that might be characterized as -- I would characterize it as snarky from some corners saying, "well clearly not all of it is going to pass". I don't know that that's true, but if we were to focus on things that are going to be most impactful and most achievable for Connecticut residents, what would you say you would think we should focus on?

JILL ZORN: Well on the insurance side, definitely the out-of-pocket caps. You just spoke earlier before this public hearing about capping those costs for people with diabetes and there seems to be huge support for that which is really wonderful, but there are a lot of other people with a lot of other illnesses who face the same problem. And so if we can figure out a way to start to deal with that and roll back the pernicious impact of high-deductible health plans, I think that's so, so important. And it's not revolutionary, other states have done it.

And I definitely think the mid-year formulary -- no mid-year formulary changes negative ones are also really important. I did really like the -- as I said that the part about the public health emergency, I think it's really, really crucial. And I -- let's see -- pretty much the one -- oh pay-for-delay is a really, really important issue and because the feds continue to not deal with it even though there's supposedly a bipartisan agreement.

The states once again are kind of stepping into the breach, and I know California passed pay-for-delay legislation. So I would love to see Connecticut follow in their footsteps.

SENATOR LESSER (9TH): Terrific. Thank you so much Jill. Are there other comments or questions from Members of the Committee? Going once. Going twice. Okay, thank you so much for your testimony.

Next up we have Leslie Wood from PhRMA.

Good afternoon.

LESLIE WOOD: Good afternoon Senator Lesser and members of the Committee. My name is Leslie Wood and I'm with PhRMA.

First, thank you so much for having us today. We do respectfully oppose House Bill 5366 and I think that you might be surprised that we do have areas of common agreement with some of the other testifiers that have gone before me. We really do believe that it is very important to have these discussions about affordability, especially since six of our companies do operate here in the state of Connecticut. We worked with this legislature in 2018 to come up with a bill that looks at the entire prescription drug supply chain and we're also talking with stakeholders now about the healthcare benchmarking legislation underway this year.

Given this, so we do have some problems with -- and concerns with the bill. We think that there could unintended consequences of limiting access to prescription drugs. We do think that the importation can jeopardize patient safety, and we do believe there are some serious legal issues here.

First of all, price controls that's laid out in Section 2, we think that that does not understand the deficit in insurance design that we are seeing here. And we agree, patients need to have predictable costs for their prescription drugs.

And we are very supportive of copayment-only plans because we see now that whereas before ACA there was no deductible for prescription drugs, now patients are having that surprise deducible at the beginning of the year for the drugs and whereas on the medical side where they would be paying the negotiated rate for their medical services during the deductible. With respect to our prescription medicines, they are paying the full list price.

There was a study that came out just in January from the Berkley Research Group that said that with regard to branded spending, only 56% is retained by our companies and -- excuse me 54% retained by our companies and then 46% is going elsewhere in the supply chain. We think the bill that we passed several years ago can look at that and we are very supportive of the $166 billion dollars that our companies paid in 2018 in rebates and discounts getting that to patients. We want that to go to patients and we are very supportive of policies that do so.

As you know, we do have safety concerns with respect to Canada transshipment. We don't believe that that's a secure chain and I'm happy to answer questions on that.

And then again with respect to the patent settlement section, Section 9, with insurance benefit design penalty there. We feel like there's a misunderstanding of these agreements. Hatch-Waxman in 1984 had a pathway in place in order for us to settle patent disputes. Without that, innovators generally do win patent challenges. And so this is a way really that generics are getting to market faster and even the CEO of the Association of

Accessible Medicines last year testified federally that these agreements do speed generics to the market, which we think -- we do think it's very good for patients.

And then lastly, Section 10, the Critical Drug Shortage Review Board; we think that there's also a misunderstanding of this policy. It's really aimed at drug shortages. For example, in the past looking at Cipro and Tamiflu, and it does not allow the government to infringe on patents. And it actually has not even been used in modern times. I would be happy to answer some questions there.

But with that, I'm happy to take your questions.

REP. SCANLON (98TH): Thank you. Questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Yes, first off I thank you Mr. Chairman. First off, I do want to make sure I'm looking at your written testimony. Did you have a chance to submit it to the?

LESLIE WOOD: Yes, I believe we did.

SENATOR LESSER (9TH): Oh, yes, yes. I think I found it.

We don't seem to have a copy of it, so if you could just maybe --

LESLIE WOOD: -- yes, we will definitely enter that into the records, no problem. Sorry about that.

SENATOR LESSER (9TH): Terrific, thank you so much.

So I just want to go through -- I guess want to start with the pay-for-delay piece. You had testified just a minute ago that without pay-for-delay agreements that the original developer of the

drug would likely prevail in those cases and that this is beneficial for the generics. Is that what I understood you to say?

LESLIE WOOD: The patent settlements is a very complex format and there's very -- there's a lot of different components of these agreements and so when you talk about this reverse payment situation, with respect to how the Connecticut legislation is laid out, it's actually laid out in a way that was rejected by the Supreme Court in an activist case in 2013 which gives FTC a lot more oversight over these agreements. All of the patent settlement agreements have to go to the FTC for review. And then the FTC is able to use the Rule of Reason in order to determine whether or not they are seeing anti-competitiveness, but the FTC themselves say that these agreements have declined since the activist case in 2013.

So what we are seeing is without having a patent settlement in place, yes the innovator is able to prevail their patents, that's for sure. There's more of a compromise allowing -- it gives both sides certainty so we understand when the generic is coming onto the market, when the brand is going off the market and that does speed generics to the market for patients.

SENATOR LESSER (9TH): But if the innovator is likely to prevail, wouldn't it be in your interest to do away with these agreements?

LESLIE WOOD: We believe no. We believe that these agreements do put certainty for our companies into play. We know when the generic is going to come onto the market and it puts a lot of certainty in

play for patients, and then we also know when the generic is coming on and when our time is done.

SENATOR LESSER (9TH): All right, and would you concede though that states like California and Connecticut do have the ability under our antitrust laws to determine when and where our companies are allowed --

LESLIE WOOD: -- Well I think that's being determined by the courts right now. The California piece is being litigated right now by the Generics Association, not by our association, by the generics.

SENATOR LESSER (9TH): In terms of -- and I heard in your testimony some of the comments we've heard from every other market player in healthcare where there's a lot of finger pointing and insurers blame hospitals, hospitals blame drug companies, drug companies blame PBM's, everybody blames each other for health and cost inflation. What are -- what's the average return that a member of PhRMA has in a given year in terms of return on investment?

LESLIE WOOD: Well if you look at the Fortune 500, our companies are well below the PBM's and insurers on that list. I think Johnson & Johnson is the highest there, but our members actually are farther down. But I, you know, do agree. We have put forward several solutions, you know working with the legislature because we don’t want to be pointing fingers. That's when patients lose. We think that there are some misaligned incentives and we want to work together to get that because we don't think that a patient who is sick should be subsidizing the rest of insurance, we think that insurers are supposed to subsidize the sick.

SENATOR LESSER (9TH): But your testimony, you do sort of point fingers at PBM's and to rebates, aren't you? Isn't that what you're trying to do?

LESLIE WOOD: We do believe there's misaligned incentives. I mean PBM's should not be making money off the value of their drugs, instead a fee-based solution could be more fair for patients.

And then also the fact that drugs are still 10%-14% of the entire healthcare spending if we can get these rebates down to patients thinking there's a benefit. Milliman has said that premiums would increase less than 1% of the dollars flow down to the patients, helping many patients save money every year.

SENATOR LESSER (9TH): With regard to Sections 3 through 8 of the bill, which are the re-importation sections, where are drug manufacturers today?

LESLIE WOOD: Most of the research and development happens here. Now the thing that happens with going to other countries is first of all the approval is different, dosage can be different and the United States population is much more significant than Canadians. So we're not taking the Canadian medicine, we're actually having a process where it just passes through the country as and still signed here.

SENATOR LESSER (9TH): Where are your drugs manufactured?

LESLIE WOOD: I believe there are many different sites, some are in Europe, some is here in the U.S.

SENATOR LESSER (9TH): Are there drugs that are manufactured in India?

LESLIE WOOD: Well my understanding is more of the generics side are more of the India and the Chinese markets.

SENATOR LESSER (9TH): Right, but the Sections 3 through 8 apply to the entire --

LESLIE WOOD: -- That's correct and I see you are talking about the branded industry.

SENATOR LESSER (9TH): That's fair, but you would concede that if you go into any Walgreen's, CVS, or Rite Aid in Connecticut and you were to search through the drugs that are for sale in Connecticut the vast majority of them are manufactured in foreign countries. Does that seem like a fair statement?

LESLIE WOOD: If I go into Walgreen's, I am certain that our government, the Food and Drug Administration, has approved the methodology and the pathway to get to the patient, which we believe is safe and is a closed system; and that you don't have that certainty from medicines generated elsewhere. And also you are creating an incentive for adulterated drugs to get into the system when you're stepping aside from our Food and Drug Administration.

SENATOR LESSER (9TH): Does the bill as you read it -- my understanding is that it requires approval by the Department of Health and Human Services for any re-importation agreement. Is that something that is comforting to you and to your clients?

LESLIE WOOD: So with respect to the approval, no HHS has been able to do it. Now there are talks underway. We do believe that there are going to be incentives for adulterated market and also the

system that's being created by the FDA now is going to be very costly for the states to implement and Vermont has been on the record acknowledging that.

SENATOR LESSER (9TH): So if it's expensive to implement and it is being regulated by the FDA, then I'm not sure what you're members' concerns are because if it's too expensive then there won't be any savings and then people will just continue to buy drugs the way they have been. If it is regulated by the FDA, then it seems like -- and the drugs that are currently available are from overseas in any event, then I'm not sure you know if this is gonna be incorporated into the track and trace system that's currently available for patient safety, then I'm not sure what the parade of horribles is right? The drugs are -- we already are importing drugs overseas, we're just creating an additional pathway to do so and to do so safely. And if the cost is not competitive then people won't do it because there won't be any obvious savings.

LESLIE WOOD: Well we do believe the latter is true, that we've seen these programs fail in the past when tried in other areas of the country. So we do agree with that. We respectfully just agree with the assessment on safety and we believe that it's better to work within our current system for ways to better get patients' savings on prescription medicines and healthcare.

SENATOR LESSER (9TH): And if tomorrow one of your members were to come out with a treatment for COVID-19, which we all hope happens you know maybe it will be on the news today, obviously I don't think that's how the drug development process works so I'm not expecting that, but if that happened what powers or

what would you suggest -- how should we think about the pricing of that miracle drug? Is that something that a member of your good discharge, any price for? How do you sort of determine at a time when the world is concerned about the possibility of a pandemic that could have potentially dramatic consequences to populations around the world. How should we think about that pricing question in understanding that we need to balance innovation and you know important public health crises?

LESLIE WOOD: Sure, absolutely. So our members are working with the government right now hopefully to find a vaccine to this. Many of our treatments are being used now to manage the symptoms that are unfortunately part of this epidemic. We are opening up our libraries in order -- right now the government has access to the patients and also access to specimens, so we are working with them to open up our compound libraries hopefully to see if something does work. You know there is precedent for working with the government in partnerships like this and they rely on a lot of our advanced technology in this space.

SENATOR LESSER (9TH): The question I'm sort of asking is about price, which is -- you know we are concerned about price gouging. We've seen reported practices by some of your member companies where they are accused of evergreening patients. There are folks who buy up drugs and then raise prices even though the drug has been on the market for many years. We are talking about a public health crisis and in the event of a crisis, you know it's our interest to get drugs to patients just as quickly as possible and I certainly don’t begrudge any company for trying to make a buck that's what people go into

business to do, but at a time when people are really interested in this issue and are concerned about potential barriers to people getting the care they need you know.

There have been stories on the news about how the cost of test kits, and I know that that may not be your industry, but the cost of test kits is a major public health crisis in this country that differentiates us from South Korea and other places that are trying to address this pandemic. What tools are in our toolkit to ensure that one of your members does not gouge the public by charging unaffordable prices if there is a drug that is so critical?

LESLIE WOOD: Well, I believe that the example that you talked about before about old medicines being increased; that was a generic issue and off-patent issue, and isn't our issue. We do work very hard to responsibly price our drugs. As we've been talking about, 46% of the list price of our medicine is going elsewhere in the supply chain, and we want to work you know to make sure that is getting to patients. We want to work for ways to make sure that patients have a reliable -- when they go to the pharmacy counter, they're not paying off of a co-insurance but they're paying off of a co-payment. Regardless of whether it's per flu vaccine, or a COVID; hopefully a COVID vaccine, or whether it's medicine to maintain their chronic illness.

SENATOR LESSER (9TH): All right, with respect I heard earlier comments from Representative Vail, who is out and he's not in the room right now, but he had expressed concerns on the insulin bill where there are some of your member companies that are

manufacturers of name-brand drugs and they had raised prices, maybe not as much in the last year since there's been a lot of public scrutiny, but previously they have dramatically increased prices for name-brand insulins. And I would sort of dispute that this is -- the issue of raising prices on products that have been on the market for a while is limited solely to generics. I think it's something that seems to exist across the industry.

LESLIE WOOD: So as I was talking about the misaligned incentive within the market, we do believe insulin is definitely an example of this where there is significant rebating going on that's not getting to the patients, and also all of our insulin companies are offering patient-assistance programs to help patients with this. And we agree that there needs to be predictability in what a patient is experiencing when they get to the pharmacy counter.

Again, one of the policies we support of passing through those rebates to the patients is not happened and we think that that were to happen that there would be extremely -- a definite benefit for insulin patients who use insulin.

SENATOR LESSER (9TH): Okay. That's all I have for right now, but I will turn it back to Chairman Scanlon.

REP. SCANLON (98TH): Thank you Senator. Just some basic 30,000-foot questions for you here. Nearly every day somebody in my district, especially because I Chair this committee and happen to work on this issue all the time, asked me why are drugs so expensive. I will ask you the same question.

LESLIE WOOD: Again, as I was talking about the misaligned incentives, we are 10%-14% of the healthcare dollar and we are an area where we can really bring down the costs in other areas. For example on the medical side, we believe we really need to work together to make sure that we have equity on the Insurance Benefit Design. As I mentioned before, patients are paying full price for their medicines at the counter during the deductible period and we are very concerned with that. Whereas if you go to see your physician, you are paying off of the negotiated rate with insurance when you go in.

REP. SCANLON (98TH): And why, again another question that I get very often, why are drugs so expensive in the United States?

LESLIE WOOD: The United States has a much different system than we see abroad. The system is highly subsidized and you do not have the full array of treatments that we have here in the United States where we research and develop the medicines. And it's a little bit of an apples and oranges situation; the prices we're hearing about internationally are negotiated where here in the United States we are talking about the list price.

And then also our medicines, with respect to generics, are very -- you see that patent cliff happen here where we have a great affordability with generics coming onto the market. That's not the same thing that we see abroad and generics are on the market forever. The patients abroad are paying more for their generic medicines abroad.

REP. SCANLON (98TH): Got it, and so you talked a little bit about safety and your concerns with

safety; what is the percentage of drugs that you sell in the American market that you sell in the Canadian market?

LESLIE WOOD: I'm sorry. I don't have the numbers comparing our market versus the formulary that's available in Canada, but we do have a rate of about 90% of the products are available here in the U.S. where it does drop off significantly when you go abroad.

REP. SCANLON (98TH): But some of the most common drugs that are on the market that are treating people, like Humira for example which is a very, very common drug but also very, very expensive drug, I'm assuming that you offer that drug in Canada right?

LESLIE WOOD: Well Humira is a different story. That could not be trans-shipped because it is a biologic medicine. It has very -- a lot of sensitivities with the transferred patient and that's not something that your importation proposal would address.

REP. SCANLON (98TH): No, I know, but I'm saying there are a lot of common drugs that people do take that would be, Humira is a bad example, but there are a lot that would be also being offered in Canada; would there not?

LESLIE WOOD: The thing about the proposal that you have is not pulling down drugs available in Canada, it's just shipping medicines through Canada. In the United States we have a vast population compared to Canada. If we took all of -- we would essentially take all of their medicines if we're drawing down

from the Canadian program. That's not how the program is designed.

REP. SCANLON (98TH): Yes, I've met with the Canadian government. They are concerned about our proposal. But yet, they pay 35%-55% less on their drugs.

LESLIE WOOD: On the medicines that they do have available there are some things that are less, just like there are some things that are less here. For example our generic medicines which are 90% of the prescription medicines utilized in this country.

REP. SCANLON (98TH): Okay, and then last question, and again I know this is a little bit of an unfair question, but in a perfect world because you do oppose this bill I'm sure if I said to you, "Ms. Wood we'll get rid of this bill but what's the best solution that you're gonna give me to replace the bill that I have here to help offset the ridiculous costs that my constituents are paying every day for drugs and having a hard time affording them?" What would your answer be?

LESLIE WOOD: As I mentioned, we do have a policy that we're hoping, and maybe you can be our sponsor sir we would love to work with you on that, that can get the rebates down to patients at the pharmacy counter. And I'd be happy to work with you on that.

REP. SCANLON (98TH): So I think you alluded to this a couple of years ago. I did sponsor legislation to finally bring some transparency with regard to rebates and where they are flowing and we're gonna finally this year get some answers on that, but that can't be the only solution to this problem. Transparency is great, and I think it's really

important, but that's not going to deliver the kind of immediate results that I think my constituents are looking for. And so I'm hoping that you have other suggestions that we can also take a look at too.

LESLIE WOOD: And I totally agree with you. I think that that bill was a great start. I'm looking forward to see how that plays out so we can look at the entire system, but as I mentioned we do have several policies and we would love to sit down with you about that.

REP. SCANLON (98TH): Great. Thank you so much. Any further questions today? Representative Nolan, yeah.

REP. NOLAN (39TH): Thank you and through you. Hi. Could you explain why it takes a rebate to get medicine cheaper?

LESLIE WOOD: I think that's a really good question. I do think that this is how the system has been working for several years, and we are concerned as I have been mentioning that it's not working correctly especially with respect to patients. Last year, the federal government did look at the rebate rule which unfortunately failed at the federal level, but we need to keep looking at innovative ways in order to align the system better for patients.

So I agree with your concern.

REP. NOLAN (39TH): So, could you explain what we could do to eliminate the rebate and make medicine cheaper?

LESLIE WOOD: Right now that's how things are structured, but we are definitely open to talking

about that. Another thing that has -- an idea that's been coming on, I don't think Connecticut has been working too much in this phase but is paying for value. And it's having manufacturers work with insurance companies to make sure their payments are associated with the value of the product and the outcomes for the patient.

I think that's something that we'll see coming more online. There are a few federal hurdles there that everyone is working through, but I think that's another way for example that a rebate for example might not be in play.

REP. NOLAN (39TH): What type of reason do you give for giving rebates?

LESLIE WOOD: That's just the way the system has developed over time. And so, like I said, we do think that is a bit outdated and we are looking at different options. For example, some companies are looking at -- have you heard of a Netflix model?

REP. NOLAN (39TH): I don't know a lot about it.

LESLIE WOOD: Okay, so basically paying like a per-member per month for the medicine and then no matter how much medicine is utilized by the Pharmacy Benefit Manager or the insurer the costs are stable and that’s not based on our rebate model.

REP. NOLAN (39TH): Okay. And could you explain what medicines that you have going overseas that are cheaper than here in the States?

LESLIE WOOD: What do you mean?

REP. NOLAN (39TH): Like is there any medicines that we have that come via through you that goes overseas

that we pay more for than overseas? And could you explain why?

LESLIE WOOD: Definitely. So as I was explaining before that for example there are much less medicines available overseas than are available here in America. And then when we're talking about prices between America and other countries, we are talking about the list price here in America and then the negotiated price that is available to the subsidized insurance markets that are much different than the U.S. In the U.S. we have about 90% of all treatments available to patients here and much less are available overseas. And we do believe that there are -- there is unfairness there with respect to trade agreements and the recognition of patents in other countries that we've been trying to work through with the federal government.

REP. NOLAN (39TH): And earlier you said that because of things being done for so long that that's just how it has been.

LESLIE WOOD: I think it's evolved. I don't think it's you know just how it's been done. I think that healthcare changes very slowly here in the United States. We did see the ACA common line and was the first significant legislation other than Part D which happened in 2003 since the Nixon era. So I think that healthcare has evolved very slowly here in the U.S., but we are willing to work with the federal government and have been trying to, especially with our support of the rebate role last year to come up with new, innovative ways to address healthcare.

REP. NOLAN (39TH): Are there innovative ways that you have now that are going to change the cost of healthcare?

LESLIE WOOD: So we do believe that, as I was mentioning, our proposals first let's make sure that these rebates are going to the patients. While we are working at other solutions, let's make sure that these rebates are going to patients. We can do that right now.

Then we also believe that there could be more predictability in insurance design. And then I think we need to look more at how our systems work together. For example, hospitals, insurers, PBM's, our industry and I think that'll take time but I think there definitely is -- and for this coming online with the employer community. And we're willing to be at the table for that.

REP. NOLAN (39TH): Okay. Thank you.

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

SENATOR LESSER (9TH): You represent members of PhRMA, there are a bunch of them, they seem to have a pretty broad stretch of the pharmaceutical industry not all of it on the name brand side, but about what percentage of your members are based in the United States?

LESLIE WOOD: As far as the entire? I can't tell you. I don't know off-hand how many are actually -- all of them are operating in the United States. I don't know how many are actually -- that the parent company is based in the U.S. I can get back to you on that.

SENATOR LESSER (9TH): Sure, but obviously Bayer is a member of yours but their parent company is not located in the United States.

LESLIE WOOD: Correct.

SENATOR LESSER (9TH): You know, I obviously know -- some of the questions I heard earlier, the U.S. pays the highest prescription drug costs in the world. We also have a lot of drug pharmaceutical innovation in the United States that saves lives and we should be proud of and certainly support it. Some of that takes place in Connecticut and that's also commendable and I think that is great.

But plenty of countries do have, in fact all countries have lower drug prices than we do, and many of those countries also have significant amounts of pharmaceutical innovation. I would say France, for example, has a system that provides support for pharmaceutical innovation and I don't know if Sanofi for example is a member of PhRMA or not, but in France they have found ways to incent innovation in this space and yet they also have vastly lower prices for pharmaceutical prices and I didn't know if you had any thoughts about how we could reform the system to more closely reflect countries that do reward innovation and bioscience but don't have unaffordable prices that result in consumers not being able to afford the care that they need.

LESLIE WOOD: Well we say that we still have much more research and development in Europe and in the E.U. or even I guess before the E.U. even existed; however, with the price controls coming online they are all of -- a good deal of the research and development actually came over here to the United

States where we have been investing billions of dollars here. Two out of every five research and development dollars in the entire United States across all industries come from our industry.

So I would say that our innovation here greatly dwarfs what we're seeing in the European Union.

SENATOR LESSER (9TH): So you would say that even though many of your member companies are based in the European Union?

LESLIE WOOD: That's right, and they would acknowledge that, yes. Sanofi also has facilities here in Connecticut, I believe.

SENATOR LESSER (9TH): I'm sure many of your members have facilities all over the world.

LESLIE WOOD: Their R&D is happening in the United States and like yes I think we are definitely seeing askew but we also have many, many more jobs here in the U.S. than we see abroad with respect to research and development of these medicines.

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

REP. SCANLON (98TH): Thank you very much. Christina Adams.

CHRISTINA ADAMS: Mr. Chairman, Members of the Committee, thank you for receiving my testimony today. My name is Christina Adams, and I'm from Canada. I serve as the Chief Pharmacy Officer of the Canadian Society of Hospital Pharmacists, a non-profit organization. CSHP represents pharmacy professionals working in hospitals to improve patient care by safe and effective medication use. I am also a practicing pharmacist.

As Canadians, we deeply value our relationship with our American neighbors, friends and allies. We work closely with the American Society of Health System Pharmacists and are sympathetic to the challenges that American patients face in accessing affordable medications. But like our sister organization, I'm here today to oppose HB 5366 to allow for Canadian drug imports.

Quite simply, Canada lacks sufficient drug supply for the U.S. population. Our nation of 38 million people does not have the pharmaceutical supply for your 329 million citizens. We're already experiencing drug shortages and currently there are as many as 2,000 medications in short supply in Canada.

In hospitals, drug shortages directly and negatively affect patient outcomes. Instead of doing clinical work with patients, pharmacists spend too much time sourcing scarce drugs from other hospitals or suppliers, finding appropriate therapeutic substitutes, repackaging for correct dosages, and communicating with other healthcare professionals about these shortages.

What you may also not be aware of is that in Canada, we do not have a track-and-trace system for our medicines. We can tell Canadians what farm the turkey on their sandwiches was born on, more easily than we can tell them the provenance of their medications. Thus, any track-and-trace system applied to medications imported from Canada to the U.S. would only lead back to Canada, and not throughout the Canadian supply chain.

This rule is an unworkable solution to a complex global system. It will result in more drug

shortages in Canada and unintended consequences on patient health in both our countries. Instead, we encourage our American neighbors to find solutions that address the root causes of drug pricing in the U.S. to make medicines more affordable for your citizens.

Thank you.

REP. SCANLON (98TH): Thank you very much and thanks for making the trip down here.

Not that I can expect that you've seen this article, but the first Google result of an article I found Googling the names of Trudeau, Trump and drug importation is a global news Canada article from August 2019 in which the Prime Minister promised in the face of escalating worry about the Trump Administration decision to allow prescription drug imports, "that there is a steady and solid supply of medications for Canada regardless of external or international pressures". How did that jive with what you just testified?

CHRISTINA ADAMS: Absolutely, so the contracts that our distributors have with pharmaceutical companies are to supply the Canadian market. The Canadian market is 2% of the global market, whereas the American is about 44%. So what happens is that our distributors sign contracts with the manufacturers to say, "we're going to -- we're selecting this amount of drugs, we're going to buy this amount of drugs for our -- for Canadians" and they're not permitted to redistribute those medications elsewhere to other countries for example. And what can happen is that if they try to start buying more drugs just from these companies, companies can

simply refuse to sell to them. And certainly that is a potential possibility.

REP. SCANLON (98TH): And yes, while they technically could do that, don't you think that they would from a business decision know that there would be an influx of American therefore buying those drugs and therefore, from a supple perspective and a demand perspective, that they would make more money by therefore giving you more drugs that then you would give to us?

CHRISTINA ADAMS: I really don't think -- I think that's a bit dis-ingenuous to be honest. I think that with a 2% global market share in Canada, that's pennies on the dollars to them. They are not gonna be interested in selling more drugs through Canada and the reality is that with 2,000 drug shortages in Canada as it is there's no way that we're gonna be able to ensure that there won't be further drug shortages.

And just to give you a little bit of perspective, asking Canada to supply medicines to the U.S. is like asking Connecticut to supply medicines to Canada? That's the same difference in population that we're talking about. So if you can imagine your state supplying -- all of the medications in your state also supplying an entirely other country, that's basically what you're asking Canada to do.

REP. SCANLON (98TH): I will correct you there and say that's actually not what I'm asking them to do. I'm asking them to supply them for the 3.5 million people who live in Connecticut, not the 330 million who live in the United States. I could care less what happens in Wyoming. I care about Connecticut.

And so I'm asking you to supply Connecticut, not the United States.

CHRISTINA ADAMS: I can appreciate that, but I'm not a distributor for one and I'm not a pharmaceutical company as well. I'm a hospital pharmacist and so I see the shortages in my hospital as it is and I only see this being exacerbated by all of this legislation, it's not happening solely in this state. And I can appreciate that you are responsible and you know to your constituents. I can appreciate that, but we're not -- we're being asked by many states to be able to allow this importation to happen and what I see is that my patients are suffering already from drug shortages and so I don't see this being any improvement to their lives if this were allowed to pass.

REP. SCANLON (98TH): All right, thank you again for being here today. Senator Lesser.

SENATOR LESSER (9TH): Thank you and thank you for your testimony. Just out of curiosity, you're a hospital pharmacist, what hospital are you at?

CHRISTINA ADAMS: So I am currently with the Canadian Society of Hospital Pharmacists. So that's my full-time job. Previously, I was the pharmacy manager of the Cornwall Community Hospital in Cornwall, Ontario, and I also provide relief services to Renfrew Victoria Hospital in Renfrew, Ontario, and on-call services for a number of hospitals in Ontario.

SENATOR LESSER (9TH): Welcome and hope you won't -- I'd love to do a taste comparison between maple syrup in Connecticut and Ontario, maybe you can get that offline.

Just a question though just about -- I think the argument you're making, you did mention sort of in passing that you raised concerns about the lack of a track-and-trace system in Canada. When you were a hospital pharmacist, were the drugs that you prescribed to your -- or dispensed to your patients; were they safe?

CHRISTINA ADAMS: They were safe, absolutely. That's not in question.

SENATOR LESSER (9TH): How do you know that?

CHRISTINA ADAMS: How do I know that? Because we are purchasing from manufacturing facilities. We are purchasing from the pharmaceutical companies and so what we can say is -- what I'm saying is not that our supply is not safe. It is safe. I give it to my patients. I've gotten it myself. But what I'm saying is, we don't have enough to supply to Americans.

SENATOR LESSER (9TH): Were the drugs that you prescribed, go down a list of commonly prescribed medications, is it your understanding that the drugs that Merck or Pfizer or another -- you know pick a drug company that sells to you and are they largely similar or identical to the drugs that are sold in the United States? My sense is that there's a substantial amount of regulatory harmony between the United States and Canada. Is that something that?

CHRISTINA ADAMS: So I'm not an expert on sort of the provenance of medications in terms of the manufacturing facilities. What I can say is that I imagine that they are probably very similar. We do very, very little manufacturing of drugs in Canada. In fact, I have the number here; 68%-70% of our

finished prescription drug supply is imported and 90% of the components for drugs that we do manufacture come from abroad.

So I would expect that given the limited number of manufacturing facilities in the world that the manufacturing facility you could manufacture for more than one country.

SENATOR LESSER (9TH): And I understand that there's a province of Canada or a couple actually that have French as an official language, but a lot of people in Canada such as yourself speak English and so I imagine that the labeling of drugs in Canada is probably broadly similar to the labeling in the United States. Is that likely to be the case?

CHRISTINA ADAMS: No, so that's actually not correct. All labeling in Canada is bilingual, English and French. There was a period last year when we had the significant drug shortage of potassium chloride in Canada and we had to import the U.S. labeled product and that actually created a number of -- a lot of confusion because the labeling is different.

SENATOR LESSER (9TH): No but I understand a francophone resident of Quebec might have trouble reading an English-language label, but if the drugs that are for sale in Canada are written in English that would not necessarily present the same problems to an English-speaking resident in the United States if we were to import Canadian pharmaceuticals.

CHRISTINA ADAMS: Yeah, I mean it's -- they are labeled in English and French. They have both the information. And certainly I know English is the primary language here in the States.

SENATOR LESSER (9TH): Now I understand that the Department of Health and Human Services in this country, which is grating waivers to states to -- is really focused on Canadian importation obviously there are other countries in the world some of whom have, like Canada, a large amount of regulatory harmony with the United States. I'm thinking of Australia and other countries that also speak English that also have similar drug regulation schemes.

Would you feel less uncomfortable with this proposal if we weren't singling out Canada, but we were looking at a more broad ability of countries around the world to, with regulatory oversight, allow more free shipment of pharmaceuticals across national borders?

CHRISTINA ADAMS: It's not my area of expertise, so I'm not really going to comment on it, but I what I will say is that a country like Australia is very similar in size to Canada and I can't support importing from Australia or another small country like that on the global market, but it's truly about quantity and we don't have a say in what the manufacturers will sell to us in terms of quantity.

SENATOR LESSER (9TH): So you're really -- I mean you raised -- you sort of raised the drug safety issue but then you mentioned that you know your drugs are safe and that the labels distributing it are intelligible, but the real issue to you it sounds like is you're worried that drug companies are going to punish Canada by cutting off their drug supply.

And so what I'm sort of raising as a potential way around that if that is a concern, obviously nobody

on this committee wants to deny Ontarians access to vital, life-saving drugs. That's not what we're trying to do here today. But if we were to say, "hey look we don't need to limit it to Canada, we could list you know five countries that have broadly similar designs"; if we were to go down that route, is that something that would leave you less worried that we were going to just have that supply impact on the Canadian pharmaceutical supply?

CHRISTINA ADAMS: So I didn't mention anything about the safety of the drugs nor the labeling, that's actually questions that you asked me in terms of concerns. So I just wanted to clarify that part.

My concern is about the fact that we cannot -- you know we cannot imply manufacturers to sell drugs to us. I'm concerned about the supply to my constituents, my citizens of my country. What I see here is a larger problem with regard to price control, which is not something that can be addressed by just buying drugs from other countries. And so that is something that has to be looked at internally within your country to see what can be -- 'cause that really at the end of the day is the root cause of a lot of these issues and so I think that what your country should consider instead of looking to buy our drugs is to look at why our pricing control works and look at how can you kind of use that type of scenario to bring prices more in line here in the U.S.

I think you would have a lot more success and a lot more support if you looked up that kind of legislation rather than just look to buy drugs somewhere else.

SENATOR LESSER (9TH): Okay, so let me just sort ask that last question in sort of a more direct way. Are you concerned that if we pass bill drug companies are going to cut off Canadian pharmaceutical supplies? Are you worried about retaliation?

CHRISTINA ADAMS: I'm not worried about retaliation, but I don't have a say in what the manufacturers will do. But what I am worried about is the amount -- they may not cut off the supply, but say even 10% of the U.S. population started importing drugs from Canada, within six months our entire supply would be depleted. So whether or not they cut us off, if they just continue to supply us the amount that they are already supplying us, we're gonna run out.

SENATOR LESSER (9TH): And you don't think you can buy more?

CHRISTINA ADAMS: They -- ramping up production of a pharmaceutical product is not a simple task. It's extremely complex with regard to acquiring the active pharmaceutical ingredients with regard to having the lines, all of that. It's not just about, we can't just tell them make more because we need more. A lot of the drug shortages we're seeing now is because there's not the ability to just kind of on a dime say, "we're gonna start these production lines to supply the Canadian market". So production lines that supply different countries run at different times, and so there's you know say ten lines for Americans and one line for Canadians. They can't -- the manufacturing companies can't just say, "okay, we're gonna ramp up production for the Canadian supply because now they're going through

that". It's just not gonna happen. It's not realistic.

SENATOR LESSER (9TH): And this is sort of a tongue and cheek question, but you're sort of encouraging us not to buy Canadian drugs. Should we encourage you not to buy American drugs?

CHRISTINA ADAMS: We don't.

SENATOR LESSER (9TH): No, but you do. You said most of your drugs, almost all, you said very little of your drugs are manufactured in Canada that you buy almost all of your drugs from abroad.

CHRISTINA ADAMS: Yeah, but the vast majority are coming from other -- I mean whether they come from the U.S. or not -- I'm not sure to be perfectly frank. I don't know where we buy them from, I just know they are not manufactured in Canada. It's for you to say if whether or not your supply is safe or not, but I'm confident in the medications that we buy. So it is what it is.

SENATOR LESSER (9TH): I'm sure all of the drugs developed in the state of Connecticut are safe and you should by all means continue to purchase them and I would never discourage you from doing that.

So thank you very much Mr. Chairman for the time.

REP. SCANLON (98TH): Representative Delnicki.

REP. DELNICKI (14TH): Yeah, thank you Mr. Chair, and thank you for your testimony. And I'm gonna ask a question that I don't know whether you will be able to answer or not, but I have to ask it anyway. You're talking about a significant concern of a shortfall of drug availability in Canada if we were to institute this policy or law; would Canada in

turn shut off the ability to export drugs from Canada to the U.S. if the scenario you talked about pertaining to shortfalls of drugs in Canada for Canadian citizens?

CHRISTINA ADAMS: That's a great question, and so the ability to export products from Canada is controlled at the federal level and I'm not part of the federal government, I can't speak for our government, but what I can say is that it is within their power to prevent -- to pass legislation to prevent export of drugs from Canada to the U.S. It is within their power to do so. I can't speak as to whether they would or they wouldn't, but certainly I would say that many Canadians are -- if this were to come to pass would encourage that type of legislation.

REP. DELNICKI (14TH): Thank you for that answer. Is Canada exporting drugs currently to any other country?

CHRISTINA ADAMS: I'm not sure. I can't really say, but I would say my guess would be no. We don't export -- I mean we manufacture very few medications, so I don't think we export, but I really I can't say for sure.

REP. DELNICKI (14TH): Okay, well thank you for your answers then. Thank you Chairs.

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

REP. PAVALOCK-D'AMATO (77TH): Thank you Mr. Chair. Just one question. How did you hear about this hearing?

CHRISTINA ADAMS: Yeah. That's a great question. So our organization is part of the Alliance for Safe Online Pharmacies. We are a member organization of this organization, the Canadian chapter. And so we're always kept up to date on all of these potential bills that affect the Canadian market and the Canadian -- I wouldn't say market actually, Canadian drug supply. And so we hear about this, we are kept up to date and so that's how we heard about these hearings in these different states that are occurring with regard to drug importation from Canada to the U.S.

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

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

REP. NOLAN (39TH): How are you doing? Could you tell me -- do you have in your drug shortage that you're talking about, is your shortage with more than five drugs or less than five drugs?

CHRISTINA ADAMS: Currently? In Canada?

REP. NOLAN (39TH): Yes.

CHRISTINA ADAMS: Two thousand.

REP. NOLAN (39TH): Two thousand. Could you name five of them and tell me where they come from?

CHRISTINA ADAMS: Yep. Heparin, pre-mixed Heparin is manufactured here in the United States. We have levetiracetam, which is Keppra, an epilepsy medication. I don't know where it's manufactured. We have erythromycin ointment for children that is currently on back-order on short supply. We have supply issues with Vancomycin and we also had supply issue with potassium chloride IV.

Those are all -- now I will say my personal experience is with medications that are used in hospitals, not so much medications that are used in community retail pharmacies. So just to provide a bit of clarification there.

REP. NOLAN (39TH): And these five are U.S. drugs?

CHRISTINA ADAMS: I can't say for sure other than the Heparin which I know is manufactured in the United States.

REP. NOLAN (39TH): Can you give me five of your 2,000 that are U.S. drugs?

CHRISTINA ADAMS: I can't do that right now. I'd have to look them up. Sorry.

REP. NOLAN (39TH): Okay. And what are you doing for your shortages right now?

CHRISTINA ADAMS: So it depends on the shortage, it depends on the medication and the type of shortage, how long it's going to be, if there's other therapeutic alternatives available, if there's other potential things that we can do about it. We have within Health Canada a Multi-Stakeholder Steering Committee on Drug Shortages that meets regularly to reexamine some of these issues. We also have -- there's a private project with Health Canada called the Tier Assignment Committee and so there are different Tiers of drug shortages. Tier I being the least impactful to Canadians; II or III being the most impactful, and there are different kind of doors that can be opened the higher Tier shortage of medication is called to be.

So for example, I sat as an ad hoc member on the Tier Assignment Committee when we looked at the

Heparin drug shortage and what that allowed -- what that does is it looks at you know are there other options available, therapeutic alternatives for Heparin, is there anything else that we can do, how long is the shortage going to last. And so we kind of review that and decide that Tier. And so once it's assigned Tier III, there are certain things like we can import drugs that are maybe not labeled for Canadian use as a temporary measure to alleviate a shortage that is considered medically necessary for a medically necessary drug where patients can be harmed by the lack of the medication being available.

REP. NOLAN (39TH): And the shortage amount between Tier I and Tier III?

CHRISTINA ADAMS: It's not necessarily about the amount sometimes. It's about if there's other options. So say like one generic brand of a medication is backordered but there are five other generic brands, for example, of the same strength then that would be a Tier I shortage because it has a low impact. There are a lot of other options available.

It could also be about the duration of the shortage. So say if it's meant to be short for a couple of weeks that might be less impactful, but if something that might be shorted for like six months or a year or two years for example.

So I can't -- the actual differences between the Tiers, I don't know necessarily what the cut-offs are. What I can tell you is that Tier III is a medically necessary medication that is not available for a period of time that has no therapeutic alternatives on the Canadian market. That would be

a Tier III shortage. We don't get those very often, but certainly we get a number of them per year.

REP. NOLAN (39TH): So out of your 2,000, how many are Tier III?

CHRISTINA ADAMS: At this time, I think that there are probably at the moment I know of two at least, but I can't say -- again I'd have to look it up. Like it's available online, it's just I don't the numbers with me right now.

REP. NOLAN (39TH): Do you know the two names of those two?

CHRISTINA ADAMS: Yeah, the Heparin and the levetiracetam, the Keppra IV, is a Tier III shortage as well. So that is used in treating epilepsy in children and so we are short of that medication in Canada, and so they're having to ration it's use for use in children only and try to find alternatives for adults.

REP. NOLAN (39TH): And how hard is it to find alternatives?

CHRSTINA ADAMS: It can be quite hard and so I think that the supply -- there's a different medication and again I'm not an expert in this treatment area in terms of epilepsy in children but certainly it's not easy always to find an alternative medication.

REP. NOLAN (39TH): So when you say shortage, out of the 2,000 there's various amounts that are urgently short, which you only named two, and then there's those that are just short because they're out but you have alternatives for them.

CHRISTINA ADAMS: So you're right, is that the ones that are very urgent at the top that I can name off

the top of my head right now, there are two, but what I'll say is that the ones that have alternatives, they're not always good alternatives. So we could be putting patients on a second or third-line treatment rather than the first-line treatment because the first-line treatment is not available. But it's an alternative potentially available that's just not elevated to the Tier III. Like the Tier III is like the most extreme you know where there's really a chance for patient harm, and so we don't want to go to Tier III unless we have to.

And so there are times when you know it could be bottles of an IV medication that we use to make for patients are not available and then we are having to rather than take ten 10-gram vials to make 100 bags of Vancomycin, we are potentially having to go into a hundred little 1-gram vials to get the same amount for patients. And the workloads involved with that and the potential for harm increases significantly. So although it's not a Tier III shortage, it still has a significant impact on patients.

REP. NOLAN (39TH): And for the top two that you just named as far as Tier III, what is the amount of time that there's been a shortage for those?

CHRISTINA ADAMS: So the Heparin has been at least, I would say, six months, and I don't know that the shortage has been alleviated yet. The other one is a newer drug shortage, and I think it's only been short for a couple of months, but again resupply is -- I don't know what the potential resupply date is at the moment and often we don't find out for a periods of time.

REP. NOLAN (39TH): So in ordering, when you make your -- I don't know you order them, but when you make your large orders you don't know when they're gonna come in?

CHRISTINA ADAMS: Nope. We have no idea because they can't supply the drugs. So we often will place orders for drugs and we won't get them, and then we have patients who will miss their pain medication because we can't get it from the manufacturer because it's short.

REP. NOLAN (39TH): What is the alternative of these two drugs? Do you know?

CHRISTINA ADAMS: No. So they were considered to not have any alternatives, which is why they are considered Tier III.

REP. NOLAN (39TH): Thank you.

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

Moving on to 5365, John Disette.

JOHN DISETTE: Good afternoon. There's been some pretty brainy intellectual discussions this morning. I'm gonna bring this down a little bit. [Background laughter] My name is John Disette. I am the President of A&R Employees Union. I represent the insurance examiners, the actuaries and the attorneys at the Department of Insurance.

I am submitting testimony in opposition to the removal of language from Subsection D of 38a-8, specifically lines 85-87. I was here earlier this morning when Commissioner Mais did mention that he was going to speak with me regarding my concerns with the removal of the language on lines 85-87. We

have spoken. We are going to discuss tomorrow; however, I do want to give you a brief synopsis. I have submitted a written testimony, so rather than read through that I'll just give you a brief synopsis of that.

Simply A&R does feel very strongly that the removal of the language as proposed would risk diminishing the state's ability to perform its regulatory obligations. The existing language maintains the independence and integrity of the state's regulatory functions. We have concerns that the impact of the removal of this language would harm the Connecticut policyholders -- excuse me, would harm the policyholders in the state of Connecticut.

With that, I said I'll keep it brief. I did submit written testimony and I am gonna meet with the Commissioner, but if you have any questions please feel free.

REP. SCANLON (98TH): Thank you Mr. Disette for being here today. Did you know of the department's intent to put forward this change prior to finding out about this public hearing? Is it something that's been discussed internally?

JOHN DISETTE: I found out about the removal of the language only within the last couple of days, at most it's been five days since I was made aware of what was happening. I don't believe necessarily that there's mal-intent with this, but nonetheless it does remove protections and certainly raises concerns about what the potential is.

REP. SCANLON (98TH): And I know you are the president, so maybe it took a while to get up to you, but did any of your members know about this and

talk to the department about this or their managers to try to express concern about it or is it sort of just you're all finding out about it now and trying to do the best you can.

JOHN DISETTE: Yeah, naturally I didn't flip through the bills you know, as many bills as you guys have, and stumble onto this. I was alerted to it. Whether the members have brought this up, I can't tell you for sure. Obviously, it is talk and scuttle but within the agency it's obviously very disconcerting to them.

REP. SCANLON (98TH): Sure. Okay. Well I look forward to keeping in contact with you and the department to hopefully see if you guys can figure this out internally and then hopefully come back to us with some information and we'll have to decide what to do.

JOHN DISETTE: Absolutely.

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

All right we breezed through that bill. Onto 5369, Allison Fuller followed by Dr. Katherine Tucker.

If you could just press the mic. Yeah, thank you.

ALLISON FULLER: Good afternoon. Representative Scanlon, congratulations on your new baby, and distinguished Members of the Insurance and Real Estate Committee. My name is Aly Fuller. I am here to emphatically support House Bill 5369, and ask the Committee to pass this legislation.

I am here on behalf of Prolacta Bioscience, a company dedicated to the advancement of the science of human milk. As you are all aware, doctors and

experts agree that a mother's milk is the best source of nutrition for her newborn baby. The American Academy of Pediatrics recommends that breast milk be the sole source of nutrition for all newborns from birth until at least six months of age. For a variety of reasons, however, not all mothers can provide milk to their babies in sufficient quantities, whether due to an inability to produce breastmilk, adoption, surrogacy or other complications. It is in these cases where donor human milk is needed.

For the tiniest preterm babies in the NICU, the need for human milk is the highest. During the last trimester in the womb, unborn babies receive sufficient nutrition through the umbilical cord to support the rapid development of critical systems that happen during this period. Very premature infants miss this critical nutrition, and their dietary needs are greater than what breast milk alone can supply. As you will hear today, it is for this reason that the American Academy of Pediatrics recommends that all babies weighing less than 1,500 grams receive fortified milk.

This is where Prolacta comes in. Prolacta makes a human milk based human milk fortifier. This is in contrast to the cow's milk based human milk fortifiers made by formula companies which were the standard of care prior to the introduction of Prolacta's fully human fortifiers and sadly in some places it still is. Without human milk based fortifier, a very low birthweight baby is at an increased risk of developing necrotizing enterocolitis, or NEC. This is a terrible, often fatal disease for which the only determining cause thus far is exposure to cow's milk proteins. Of all

extremely low birth weight babies, about ten percent of them will develop NEC, and about 50 percent of those will either die or require a devastating surgical intervention where a portion of the intestines is removed, setting this child up for a lifetime of health issues.

We have shown in rigorous clinical studies that by providing an exclusive human milk diet including human milk based human milk fortifier, along with mom's own milk or donor milk, we can reduce the incidence of this terrible disease by more than 75%. House Bill 3569 would provide coverage of donor milk and human milk based fortifier, saving both lives and money. In fact, our cost analysis shows the use of an exclusive human milk diet results in a cost avoidance of nearly $6 million dollars annually in the state of Connecticut.

But today you're not gonna hear a lot of opposition to the coverage of donor human milk and human milk based products. Instead, you will hear opposition to something else that has been recommended by the American Academy of Pediatrics and included in this bill: government regulation of donor milk banks. Other states including -- [muffled laughing].

REP. SCANLON (98TH): Will you just try to summarize the rest of your testimony?

ALLISON FULLER: Sure.

REP. SCANLON (98TH): Thank you.

ALLISON FULLER: You bet. Other states surrounding Connecticut, including New Jersey, New York, California, Maryland and soon Pennsylvania, already do this. We're not asking Connecticut to do

something that another state hasn't already done. I have a lot to summarize here.

Lastly, I'm just gonna leave you with this. I'd like to call your attention to something that is published on *Connecticut.gov*. This site reads, "Milk has a potential to stir up as a vehicle for disease and has in the past been associated with disease outbreaks of major proportions. In order to maintain regulatory oversight of milk industry, farms, companies and individuals engaged, the following are required to be inspected and licensed by the Department of Agriculture." And the remaining of the statute goes on to enumerate milk producers, companies offering milk for sale those testing milk and truck drivers hauling milk. "This testing is included to not just nutritional analysis for fat, protein and water, but also antibiotic and bacteria screening." This is talking about cow's milk that we buy, at the store, that we drink. Shouldn't our tiniest infants be provided the same level of safety and screening?

I'd be happy to answer any questions you have. I'm sorry for going over.

REP. SCANLON (98TH): That's okay. No, that's totally fine. So you answered one of my questions, which was do any states currently regulate this and it seems like a lot of our neighbors do. The second question though is, when is the last time -- I know in your testimony references there was a tragedy in Pennsylvania, but when is the last time that anything like this happened in Connecticut where somebody was exposed to a contaminated or a dangerous milk?

ALLISON FULLER: I can tell you that from Prolacta Bioscience the milk that we provide to Connecticut, it has not happened here. As far as other events, we're just not sure. The regulatory structure is set up that adverse reporting is not as stringent as it is for formula companies or even for produce, the turkeys, I think we heard about earlier, the turkeys in your field. So we simply don't know.

REP. SCANLON (98TH): Got it. And then for Prolacta, are you the only company right now that is marketing what you market or are there other competitors that you have?

ALLISON FULLER: We are the only company on the market that currently makes a human milk based human milk fortifier. Yes.

REP. SCANLON (98TH): Okay, and so to just ask you a very blunt question. Obviously if this bill in its current form were to pass, you would essentially -- and the donor banks would go out of business, you would potentially have a monopoly of this, correct?

ALLISON FULLER: Well that is not something that anybody wants to have happen. The use of our products requires having donor milk to mix into. We need non-profit human milk banks to supply human donor milk. That is not the business that we are in. We do make a human donor milk product. We don't sell very much of it, and certainly don't market it at all as our product. The tests that we are recommending through this legislation are commercially available tests. Any suggestion that they're proprietary to only Prolacta Bioscience is just false. Here's a copy of where we buy our tests. It's a Michigan-based company called

Neogene. Any company could institute these tests for as little as ten cents an ounce.

REP. SCANLON (98TH): Okay. Thank you very much. Any questions from the Committee? Seeing none, thank you so much for being here today.

ALLISON FULLER: Yes, you're welcome.

REP. SCANLON (98TH): So I understand there was a change, so we're gonna go to Dr. Katherine Tucker followed by Brett Citarella.

DR. KATHERINE TUCKER: Hi, good afternoon Representative Lesser and Members of the Committee. I do want to follow up today and speak to you a little bit about House Bill 5369.

My name is Dr. Katherine Tucker. I'm a resident of West Haven, Connecticut and I'm an Advanced Practice Registered Nurse. I sit here today wearing not just my nursing hat, but also in my role as a lifetime and proud board member of the National Black Nurses Association. The National Black Nurses Association represents the voices of about 300,000 nurses, 113 chapters represented across the U.S., including two chapters that here in Connecticut. I serve now as the immediate past President of the Southern Connecticut Chapter. Our mission is, “to advocate and implement strategies to ensure access to the highest quality of healthcare for persons of color.”

I am here on behalf of the NBNA to emphasize our emphatic support for House Bill 5369. This is legislation that will save lives. And not just any lives, but the lives of our state’s most vulnerable citizens, extremely premature infants. These babies are born between 24-36 weeks gestation, and weigh under 3 pounds. They are still developing their

intestines, hearts, lungs and brains. And the line between life and death to them is thin.

As many of you are likely aware, the United States has a shockingly high rate of maternal and neonatal mortality. Also in the United States, the rate of premature birth disproportionately affects African American women and their children. According to the March of Dimes, African American women are 60% more likely to have premature infants, and their infants suffer the highest rates of mortality in the nation. This is an issue that the NBNA takes extremely seriously. In fact, it is part of our public policy agenda. We consider it our obligation to give these mothers and babies what they deserve, which is every fighting chance that can be given.

One of, if not the most, critical parts of giving extremely preterm infants a fighting chance is ensuring that they receive a milk diet that provides these tiny babies with the safest most natural nutrients and calories that they need to catch up on the weeks and months they have missed in their mother's womb, allowing the growth their bodies and brains need to become stronger and healthy infants.

Last year, as you are aware, the state of Connecticut approved Medicare coverage for donor milk. We recommend the Members of the Legislature -- we thank you and commend the Members of the Legislature for doing this, but I am here today to call attention to the fact that that effort was just not enough. The NBNA supports equal and expanded access not only to pasteurized donor milk, but to human milk based fortifiers for those most fragile premature infants. Only by providing mother's own milk or donor milk plus an essential human milk

based fortifier can these infants grow and have a chance at optimal health outcomes.

The alternative, as you have heard, are cow's milk based fortifiers, which increase the chances of complications like necrotizing enterocolitis, or NEC as we call it, along with many other co-morbidities. The evidence demonstrates a direct correlation between the use of cow's milk based products and the development of this devastating and often terminal NEC by 77%. But we also decrease many other comorbidities such as sepsis, retinopathy, bronchopulmonary dysplasia and feeding intolerance. By preventing these adverse events, we are not only able to save lives, but we are also able to decrease the length of stay and overall cost by as many as nine NICU days. This saves lives and money.

The other issue that the state missed in its efforts last year was the regulation of donor human milk and donor human milk derived products. Many people are surprised to hear of the lack of regulatory oversight regarding human milk banks and the vulnerable populations that they serve. This means that Connecticut babies who are provided donor milk may be receiving milk that is currently not tested for viruses and bacteria, drugs, such as opioids, and other even nicotine with a profound impact on the baby's brain. Perhaps as concerning is that parents, and often health care providers, are unaware of this lack of basic safety oversight.

The National Black Nurses Association is highly concerned with the lack of minimum safety standardization and regulation of donor human milk banks which are currently collecting, processing, and selling or distributing donor milk in

Connecticut. We fear that this is putting highly vulnerable premature infants needlessly at risk. With insurance and Medicaid coverage of donor human milk and human milk derived products, and the subsequent expanded use of these life-saving medicines, it is even more important that the state ensures their safety.

It is for this reason that in 2017, the NBNA authored our Associations' Resolution entitled, "Creating a Culture of Safety with Human Milk Banks." Here we call for oversight of the collection, storage, and donation of human milk.

I will close by reiterating that the NBNA implores the Connecticut legislature to take prompt action to mandate coverage of human donor milk and human donor milk derived products and regulate milk banks. I thank you for your time today and for your attention to this critical matter, and also your willingness to lead the way on this issue. And I welcome any questions you may have.

REP. SCANLON (98TH): Thank you Doctor. Thank you for being here today. Any questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you Doctor for your testimony. And I wasn't there for the beginning part, but I did hear the last half and apologizes if you've answered any of these questions previously.

Are you aware of any conversations with the Department of Public Health as to whether or not they're equipped at this point to be able to regulate these breast milk banks?

DR. KATHERINE TUCKER: I have not had any conversations with the Department of Public Health, but I would imagine that there would be a concern about this additional responsibility that they may have with regard to regulations.

SENATOR LESSER (9TH): And do you believe that -- do you see value in your sort of expert passé, do you see value in human -- in the value of breast milk -- you see this as something that is a clear benefit for?

DR. KATHERINE TUCKER: I do. Yes, I do.

SENATOR LESSER (9TH): Could you tell me a little bit more; there's a word "products" listed in the bill right now, the bill I guess had passed last year -- the law that passed last year is limited to under the provision under Medicaid it covered breast milk. It didn't cover breast milk product. What is a breast milk product?

DR. KATHERINE TUCKER: Those are the fortifiers that the people who had testified previous to me have spoken of. The human breast milk fortifiers. I think that they could probably give you the intimate details about what that may include, but it's a product that supports the nutritional needs of these premature infants that would be added to human donor breast milk.

SENATOR LESSER (9TH): And what are the fortifiers that are currently used in hospitals today in Connecticut? Do you know?

DR. KATHERINE TUCKER: I can't speak to what hospitals currently use. I can't. [Background voices] Yes, please.

SENATOR LESSER (9TH): Yes, if you could please state your name again for the record.

ALLISON FULLER: Yeah, I'm Aly Fuller. In Connecticut, there's a mixture. Some hospitals like Danbury use human milk based human milk fortifier. There are other hospitals in Connecticut that still use cow's milk based fortifiers.

SENATOR LESSER (9TH): And what's the cost difference between the two?

ALLISON FULLER: I am not entirely certain what the cost of cow's milk based fortifiers is. The cost to use our human milk based fortifiers is estimated to be about $10 thousand dollars for the stay of the infant, but we can estimate the reduction as Dr. Tucker said that a decrease in nine days of NICU stays results in an estimated annual savings for the state of Connecticut of $6 million dollars.

SENATOR LESSER (9TH): Okay, thank you. We have a whole lot of testimony from some of our volunteer-run milk banks and obviously safety of the public is always something we care a lot about, but sort of in balancing the issues before us one of the questions is if we were to impose a regulatory screen that means that children no longer have access to breast milk banks. We've seen concerns that the regulatory approach might actually require these volunteer banks to shut down and that could result in diminished access to breast milk, not expanded access which of course is the intent of the bill.

And I'm just trying to sort of parse out that concern. Is Prolacta, to your knowledge, are they the only company that currently tests or provides this testing mechanism?

DR. KATHERINE TUCKER: I don't represent Prolacta. I represent the National Black Nurses Association, so I'm speaking from that vantage point. And it is my hope that we do not put other banks out of business because to the point that was made earlier, I think we need all of the human donor banks that are out there and that are available to support the needs of these infants, and that is what I'm here to kind of speak about.

SENATOR LESSER (9TH): Okay. Are you aware of any -- is there something that happens, obviously we want to make sure that everything that's available anywhere is safe and I certainly commend that; are you aware of any problems that have happened because of unsafe -- you know is somebody who has contaminated breast milk, has that been something that's resulted in any injuries to infants?

DR. KATHERINE TUCKER: None that I am aware of; however, I would imagine that any biologic products such as human milk would benefit from regulatory oversight. I don't think that we want to give -- I would personally not want to give a baby of mine milk that was donated and I was not sure about its safety.

SENATOR LESSER (9TH): And I just want to note, I'm puzzled by the absence -- I know that there's a you know global pandemic, but normally the Department of -- this is you know this is the Insurance Committee so we don't do a ton of Public Health bills, but normally when there's a proposal to expand the scope of the Department of Public Health they are generally pretty aggressive in asserting their authority over public health concerns and so I note their absence today. I don't know if they didn't

know about this or what, but it would be important to get their input before this can go forward.

DR. KATHERINE TUCKER: Absolutely, and I just would like to take a moment just to thank Represent DiMassa also for speaking on behalf of this legislation.

SENATOR LESSER (9TH): Thank you so much. I really appreciate it Doctor. Thank you for your testimony.

REP. SCANLON (98TH): Any further questions? [Background voices] Maybe offline you guys can chat, just, we've already broken the rules once to bring you back, so.

Okay, Brett Citarella followed by Naomi Bar-Yam, if I pronounced wrong I'm sorry.

BRETT CITARELLA: Good afternoon Senator Lesser, Representative Scanlon and the Distinguished Members of the Insurance and Real Estate Committee.

My name is Dr. Brett Citarella, and I am the Interim Director of Neonatology for Danbury and Norwalk hospitals, which are part of the Nuvance Healthcare System. We are affiliated with Connecticut Children's Medical Center and I am member of the Department of Neonatology at Connecticut Children's. Human milk is one of, if not the most important medication or therapy we can provide to the smallest, most premature infants. There is overwhelming evidence to support the benefits of a human milk based diet for all infants. This is even more pronounced for the most premature, from reduction of infection, decrease need for IV nutrition and improved long-term outcomes for our smallest patients.

Donor human milk has long been available for use in the care of extreme premature newborns. Whether this has been as a bridge until a woman is able to produce breast milk for her infant or the primary source of milk for some infants. However, breast milk or donor human milk alone is not enough to support the nutritional requirements for these babies. In other words, every extremely premature infant receives fortified milk, whether that milk has been pumped by their own mom or is donor milk. For years, it was necessary to supplement mom's own milk or donor milk with cow's milk based fortification. The advent of human milk based fortification has opened a path to provide the smallest most vulnerable infants a completely human milk based diet. Even for those mothers who provide adequate volume of breast milk for their infants, it is still necessary to supplement this milk with additional nutrition.

For almost three years now, we at Norwalk and Danbury hospitals have been able to provide an exclusively human milk based diet from mom's own milk or donor milk plus human milk derived fortifier to our tiniest patients. Since implementing this exclusive human milk diet at Danbury and Norwalk hospitals, we have seen life changing effects from this investment. I use the word investment because that's what it currently is for the Nuvance Healthcare System. The organization made the decision several years ago because they understood the dramatic benefit that a human milk based diet could have for our smallest patients.

But it comes at a cost to the organization and understandably, as you will hear in testimony today, not all health care systems can make that choice.

This legislation can dramatically reduce or eliminate that cost to health care organizations and thus make this available to all extremely premature infants throughout Connecticut.

I have worked in Connecticut as a neonatologist for the past 13 years. I have experience using donor human milk with cow's milk-based fortification. While this approach showed a benefit over formula for these babies, I have since had the opportunity to use an exclusive human milk based diet for the initial care of our most extremely premature infants. Since then, we at Danbury and Norwalk hospitals have seen firsthand the tremendous additional benefits that it provides. We have seen a decrease in the number of days required for an infant to reach adequate nutrition from milk. This reduces the need for IV nutrition and thus the need for IV catheters which pose significant risk to our infants.

In addition to an overall decrease in risk of infection, there is a dramatic decrease risk of gastrointestinal complications such as necrotizing enterocolitis which can be life threatening. This has also led to a noticeable decrease in length of stay. All these benefits can lead to an overall decrease in cost for our patients.

In my written comments, I intentionally did not --

REP. SCANLON (98TH): -- If you could just summarize? Thank you.

BRETT CITARELLA: Yeah, that's what I'm doing now. [Laughing] I intentionally did not mention or comment about the regulations outlined in this bill. I support the essence of outlining -- of an outline

providing safe practices for the use of human milk; however, I do not want these regulations to become too onerous to allow current non-profit donor banks to provide donor milk.

If the reimbursement matches the added costs or a balance be agreed upon between all of the companies that supply hospitals with donor milk, then this would be a tremendous benefit to all the babies in Connecticut. I absolutely do not want this bill to lead to a reduction in the access of donor milk throughout the state though. With this legislation, the Committee does have the chance to greatly improve availability of this critical therapy for all babies in Connecticut. I thank you for this opportunity and am willing to answer any questions.

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

Naomi Bar, followed by Monica Belyea and again when you get up here you can yell at me for mispronouncing all of your names. And please correct them for the record. [Laughing]

NAOMI BAR-YAM: Okay. So Senator Lesser, Representative Scanlon and other Members of the Committee for Insurance and Real Estate, I want to thank you for this opportunity to share some information and facts about Bill 5369.

My name is Naomi Bar-Yam. I'm the Executive Director of Mothers' Milk Bank Northeast. One of the network of 29 nonprofit milk banks. Similar to a blood bank in operation and protocols, a nonprofit milk bank provides donated, pasteurized milk to babies in fragile health. Mothers' Milk Bank

Northeast serves over 90 hospitals in 11 states throughout the Northeast and our milk bank also operates six human milk depots, drop-off locations, in this state.

Mothers' Milk Bank Northeast favors insurance coverage for donor milk. However, this law, as written, would drive nonprofit milk banking out of Connecticut. The 10+ Connecticut hospitals that use donor milk from nonprofit milk banks would be forced to order from for-profit companies, at substantially higher costs. The six depots would close leaving mothers who wish to donate altruistically to nonprofits with no option other than selling milk to a for-profit company.

Bill 5369 requires milk to be tested for a series of drugs and medications. There is one test available to measure these drugs in milk, developed recently by a for-profit company in corroboration with another company as mentioned, Neogen. Its effectiveness, accuracy and efficacy have not yet been tested fully, just haven't been around long enough. Donor and milk screening procedures at Mothers' Milk Bank Northeast and other nonprofit milk banks follow the guidelines of the Human Milk Banking Association of North America. Those were first published in 1990. They are updated biannually by a panel of experts in the fields of neonatology, pharmacology, infectious disease, nursing, lactation and in conversation and compliance with FDA, CDC and Health Canada.

Our milk costs just under $4 dollars an ounce. Healthcare providers at hospitals we serve have shared with us their concern about the cost of milk from for-profit companies such as Prolacta

Bioscience, and neonatologists at major medical centers also stress the importance of physician choice in making feeding decisions for fragile premature infants. Many of them also have reservations about the quality and sources of research regarding human milk based human milk fortifiers.

Creating regulations that exclude nonprofit milk banks would drive up costs substantially and threaten fragile babies also by challenging the clinical judgment and expertise of the neonatologists who care for them.

The Connecticut legislature unanimously passed a law in 2019 mandating Medicaid coverage for donor milk. This is a good law and should be implemented rather than repealed.

Research, history, and clinical practice support the safety, efficacy, and cost-effectiveness of pasteurized donor human milk from the 29 nonprofit HMBANA milk banks. As a nonprofit organization, we share your commitment to serving the public. Our bottom line is the babies of Connecticut. We stand ready to help modify, adjust this bill to assure equitable access to safe donor milk for Connecticut's most vulnerable citizens.

REP. SCANLON (98TH): Thank you very much for being here today, and I'm sorry again that I mispronounced your name. So as has been alluded to you, I'm a new dad. I have a five-month old son at home, and I'm embarrassed to ask you the following questions but I want to make sure I understand everything that's going on here. So my wife is breastfeeding our child with the risk of TMI, but if she had excess

milk she would be the kind of person who would be donating to your bank correct?

NAOMI BAR-YAM: She could, yeah.

REP. SCANLON (98TH): And then you in turn give that donated milk to hospitals you're saying correct?

NAOMI BAR-YAM: Mostly hospitals, also outpatient babies, correct.

REP. SCANLON (98TH): Got it. Now, that process as we've heard a little bit about today seems to be completely unregulated, is that true?

NAOMI BAR-YAM: It's not completely unregulated. So within our organization, the Human Milk Banking Association of North America, we do what is essentially self-regulation except that it's also -- we also are registered with FDA as a food prep facility, so we are regulated by the FDA. And the FDA is involved on an ongoing basis in our conversations with -- I mean in our creating our guidelines and our clinical guidelines under which we operate. So we are -- and we have tissue banking licenses from the states that require it. Several states view it as a tissue and we do have tissue banking licenses. So there's additional oversight.

REP. SCANLON (98TH): Okay, and again in your testimony I see here that you have a facility called Acelleron in Guilford?

NAOMI BAR-YAM: Mmm-hmm, a depot.

REP. SCANLON (98TH): A depot, okay. So can you just walk me through how the process works? So if somebody goes to that depot, they drop off milk?

NAOMI BAR-YAM: Right. So the donors are screened by us at the Mother's Milk Bank Northeast.

REP. SCANLON (98TH): You can't just drop off any milk?

NAOMI BAR-YAM: You can't just drop it off. Yeah, yeah. We do the screening first and then they can drop it off there if that's the most convenient way to get us milk.

REP. SCANLON (98TH): Got it, okay. Then from the depot the milk would go to the hospital. Does any additional testing or screening happen there or they are trusting your certification?

NAOMI BAR-YAM: So the milk comes from the depot to our facility. We test the milk. We have already screened and tested the moms. We test the milk. We pasteurize the milk and we test the pasteurized milk to make sure that it is indeed safe and that it killed all the things it was supposed to kill. Then we can send it to the hospital.

REP. SCANLON (98TH): Got it, okay. And my last question I think would be that there was some testimony that was given to us earlier about the potential risks of people who might be infected with certain diseases and the milk therefore could potentially transmit those diseases. I had asked a previous witness whether that's ever happened in Connecticut. To your knowledge, have we ever had an incident such as that where somebody was given contaminated milk?

NAOMI BAR-YAM: No, and we test mom's for those diseases and then we pasteurize the milk as well.

REP. SCANLON (98TH): So as far as you're concerned, the system is working well? Mothers that are unable to lactate are supported by the donors that you facilitate and the system is working?

NAOMI BAR-YAM: And they get safe milk. Correct.

REP. SCANLON (98TH): Okay. Last question, I lied. Are there any recommendations that you would make to us -- now our Committee is not really the place that we should have this debate, it's more of a public health issue, but are there any additional regulations that you think would help fortify the public's confidence in the milk that you're producing. Obviously, the other side of this issue seems to question a little bit about the safety of that milk. Are there things that you would proactively suggest that we be looking at to help validate and protect the milk that you're passing on.

NAOMI BAR-YAM: So what some states have done is set up a licensure type of system for milk banks. For example, there are three states that require tissue banking licenses that is an additional layer of oversight. They have also been clear that the guidelines that are set by our, the Human Milk Banking Association of North America, are safe guidelines and any milk that comes in needs to abide by those guidelines.

REP. SCANLON (98TH): Okay, thank you very much. Any? Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you Mr. Chairman you stole a couple of my questions, but I'm okay with that. Just a -- you mentioned I think in your

opening or that your facility is licensed by the FDA as a production facility? Is that?

NAOMI BAR-YAM: A food prep facility.

SENATOR LESSER (9TH): As a food preparation facility, is that something that applies to all of the milk banks?

NAOMI BAR-YAM: Yes.

SENATOR LESSER (9TH): Okay, so they're all licensed by the --

NAOMI BAR-YAM: -- and the Canadian milk banks are certified by the Canadian equivalent, yes.

SENATOR LESSER (9TH): Well we've learned an awful lot about Canadian and American [all laughing] regulations today. So, okay great.

And then to be sure to zero in on the -- so there's three sections of the bill as I remember but there's a first section and it's about expanding insurance coverage. The second section is about regulating the milk banks and the supplies. And then there's a third section that's conforming. Going to the first section about expanding insurance coverage, I assume you have no issue with expanding insurance coverage to require coverage of donor breast milk?

NAOMI BAR-YAM: No, not at all. In fact, the bill that was passed last year was really just Medicaid and to expand it to insurance would be great.

SENATOR LESSER (9TH): And so then a portion of that, there's a second part of that first section that goes from breast milk to breast milk products. And just wanted to know if you could speak a little bit to the fortifiers that we just heard about. Is

that something that you have an opinion on one way or the other?

NAOMI BAR-YAM: I think if those could be covered, and the issues that always come up are costs even if insurance covers it somebody's gotta be paying for it, and assuring the efficacy of doing that I think that if insurance companies can cover the fortifiers, so much the better for the baby.

SENATOR LESSER (9TH): Okay, yeah our concern obviously right now is just simply about obviously I'd like insurance to cover absolutely everything, but there are severe restrictions that have been placed on us by the Affordable Care Act about our ability to do that and so you know we're certainly interested in getting more information from other speakers and from other folks who are recommending before the Committee on that question. But thank you for clarifying that, and I think that's all I have.

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

Monica Belyea followed by Marisa Merlo.

MONICA BELYEA: All right, Senator Lesser, Representative Scanlon, Members of the Insurance Committee, thank you for the opportunity to testify today on House Bill 5369.

I'm Monica Belyea. I'm the Chair of the Connecticut Breastfeeding Coalition. As you might expect, we are very much in favor of expanding insurance coverage for donor breast milk. We are concerned about the regulations outlined in Section 2, and we believe that the human milk products derived from

donor breast milk will drive up the cost. So we're concerned about that.

Breast milk, including donor milk is the standard of care for medically fragile infants. You've heard that today. In Connecticut, the cost of providing this milk is born by the hospitals and by the patients. Infants who require donor milk should have access to it regardless of their family's income and it should be covered by their insurance. We believe it would be very safe to remove all of Section 2, the language about DPH regulating donor milk because the department like others around the U.S. recognizes the evidence based standard set forth by the Human Milk Banking Association of North America (HMBANA). There are 29, as you heard, accredited non-profit milk banks. They screen their donors extensively prior to donation. They maintain strict protocol. And because of their high standards and the fact that donors are not compensated, they don't need to screen the milk. Research shows that the drugs detailed in this bill do not show up in the HMBANA-accredited non-profit milk banks' donor milk.

The milk banks have been providing their donor milk in Connecticut for many years without any issues or any concerns. And the requirement for drug screening of all donor milk in Connecticut addresses a problem that doesn't right now exist.

The for-profit milk provider Prolacta must screen their milk for drugs because they pay their donors for the milk. We don't have a problem with donors getting paid, it's not inherently wrong, but it does create an incentive to conceal drug exposure.

Two other concerns; the regs in Section 2 were worried they will exclude the non-profit milk banks and that would limit the supply and drive up the cost. Again, we're concerned about cost. We'd be left with only the private for-profit milk suppliers.

So we're not sure whether those companies have the capacity to fill the demand that we have and then the cost you've already heard the non-profit milk is about $4 dollars an ounce. We're told that the for-profit milk is about $14 an ounce, and adding the human milk fortifiers sends it up to about $80 dollars an ounce.

We are hoping that you will move forward with expanding the insurance coverage for all donor breast milk and amend the bill, especially to remove Section 2 and also potentially to take out human milk products derived from donor breast milk in Sections 1 and 3.

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

SENATOR LESSER (9TH): Thank you, and I guess I'd look to ask the question that Representative Scanlon asked earlier. Do you see any need right now if the -- it's not an industry because it's a volunteer-run boards -- is there a need for any state government regulation specifically? I know that there is -- you are arguing that there isn't a problem that needs to be fixed, but obviously we have to sort of think ahead rather than just look at our past experiences. Is there a benefit for state government oversight in this area?

MONICA BELYEA: So I've heard from other breastfeeding coalitions that they're using, adopting HMBANA's accreditation process as their regulations. So they are using that as their proxy for regulations.

So we could potentially do that.

SENATOR LESSER (9TH): And Representative Scanlon and I are sort of outside of our wheelhouse because although we are members of the Public Health Committee in another life, this Committee is mostly focused on insurance which is the subject of Section 1 of the bill. So thank you for that.

There's been some discussion of the bill that passed last year, the law regarding Medicaid coverage. Obviously this is about private insurance coverage. Has that law gone into effect? And if not what are the barriers?

MONICA BELYEA: So far we're told that Medicaid is not reimbursing yet for donor milk that's being provided to their member infants. So we would like to see that move forward. I haven't heard from BSS what the delay is, but we've heard from everyone here today that donor milk saves money because it's the medically the best choice for infants. So, I don't know. Sorry.

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

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

Marisa Merlo followed by Natalee Mertin, Martin, not my day. [All laughing]

MARISA MERLO: Good afternoon Senator Lesser and Members of the Committee. My name is Marisa Merlo

and I'm a registered nurse from Wethersfield, Connecticut. Professionally, I am the Certified Lactation Consultant at UCONN Health in Farmington with a background in neonatal nursing stemming back to 2003.

On a personal, and perhaps more important, level I am the proud mother to three beautifully breastfed children. My passion with breastmilk and donor human milk stems back to 2008 when I gave birth to my first child. I made the educated decision to breastfeed my children, knowing it was the best nutrition for my babies and was blessed with the ability, knowledge and supply to do so. My personal breastfeeding past led me to become a lactation consultant so that I could better assist and enhance other mothers' breastfeeding experiences.

Due to my background in neonatal nursing, I've had the good fortune of working with both mothers' own milk as well as donor human milk. And I've been witnessed to human milk improving health outcomes dozens and dozens of times. It's literally life-saving medicine. I've seen and appreciated the need for donor human milk when stressed NICU mothers are unable to produce and express enough milk for their fragile infants.

Because of this, along with Natalee Martin who we'll hear from next, I have worked tirelessly over the summer of 2018 to bring a Mother's Milk Bank Northeast milk depot to UCONN Health. Since it's opening during World Breastfeeding Month in August, I'm thrilled to share that I have collected and shipped over 13,000 ounces of breastmilk. This is equal to just shy of 40,000 life-saving units for premature infants. An incredible feat, one I am

incredibly proud of, and shows the clear need and interest in this area for donor milk. Collaborating with Mother's Milk Bank Northeast has been rewarding, gratifying and fulfilling.

I have had the fortunate opportunity to meet and assist countless local moms donate their surplus breast milk. These moms are donating out of the goodness of their heart for the pure purpose of paying it forward to help a fellow NICU mother and her precious, fragile infant. They are not paid for their milk. They expect nothing in return. They have no ill will toward anyone and have no other incentives.

HMBANA's screening methods for donor human milk have been proven to be effective. Testing of breastmilk from over 3,000 donors showed not one single sample positive for any illicit drugs. There's no need for further direct milk testing for HMBANA donors, the donors I encounter regularly from the Mother's Milk Bank Northeast milk depot at UCONN Health.

If this bill, as it's currently written, is passed non-profit corporations such as Mother's Milk Bank Northeast may cease to exist. My gracious donors would be forced to donate their liquid gold for for-profit corporations such as Prolacta. The local community outreach through our statewide HMBANA milk depots would disappear. On a person and professional level, this would greatly sadden me.

I was here last year to testify in support of Medicaid coverage of donor human milk. I still fully support insurance coverage for donor breast milk. I applaud the state of Connecticut for recognizing the importance of human breast milk; however, I cannot support Bill 5369 as it's

currently written. Language to support non-profit agencies that comply with the HMBANA is necessary before this bill is brought to a vote.

Hard-working donating mothers deserve the right to continue to donate to a local non-profit milk bank agency. Selling their milk to a for-profit corporation, quite frankly, leaves a bad taste in my mouth. Please allow these mothers the gift of donation, allow me the gift of supporting them and allow these wonderful HMBANA milk banks, including Mother's Milk Bank Northeast, to continue to serve our most fragile population, which is premature infants. Thank you so much for your time.

REP. SCANLON (98TH): Thank you for your testimony, and thank you for the important work that you do Great driving.

Senator Lesser.

SENATOR LESSER (9TH): Thank you so much for your testimony. I was just really impressed by the work that you've done at UCONN Health. That is a really great accomplishment. Certainly we wouldn't want to do anything to jeopardize the work that you do for new mothers in UCONN Health or other volunteers too across the state. So just want to express how impressed I am and look forward to working with you and other advocates to figure out how we can get this bill right.

REP. SCANLON (98TH): Any further questions. If not, thank you so much for being here today.

Natalee Martin followed by Stephanie DeMarco.

NATALEE MARTIN: Good afternoon Senator Lesser and Members of the Committee, and Representative Scanlon congratulations again on your new baby.

My name is Natalee Martin. I'm a resident of West Hartford, a mother of two beautiful breastfed daughters. I work for UCONN Health, and I'm here today as a member of the Board of Directors of the Mother's Milk Bank Northeast. I also proudly donated my extra milk almost seven years ago after the birth of my second daughter.

We are extremely fortunate to have a milk bank right here in New England to serve our hospitals across Connecticut, along with our six depots scattered around the state to make donating milk more easy for our moms. Unfortunately House Bill 5369, it its current form, threatens to take away this valuable resource for our state's families that critically need donated human milk. I also was here almost exactly a year ago testifying in favor of Medicaid coverage for donor human milk and was thrilled with the outcome and showing of support first importance by our state's government.

Being here today, however, seems like a giant step backwards from all of the progress that we made last year. Let me be clear, I'm not here to oppose the section of this bill regarding insurance coverage. However, should the bill pass as is, mothers in Connecticut with milk to donate would only be able to do so to for-profit banks like Prolacta located in California. And they wouldn't be donating, they would be selling their milk. If you ask any milk donor why we donate, why we take the time away from our babies to pump extra, store extra, ship extra milk you'll hear stories about wanting to give back,

wanting to share what we've been so fortunate enough to create, wanting to make a difference in the lives of sick infants and their families. We don't donate our milk to make money. We don't donate our milk to put money in the pockets of men in fancy suits and fancy offices. We donate our milk to save our community's babies.

If this bill passes as is, Prolacta would essentially monopolize donor milk in our state giving every mother only one way to donate and every hospital only one way to purchase milk for their NICU's. They want to take away our options; safe, more cost effective options that have been incredibly successful and do not necessarily need fixing.

We want to make sure that every safe option is still made available. We want to make sure our milk depots in Danbury, Guilford, New London, Norwich, UCONN Health and our newest in Glastonbury are all able to stay open and continue to collect milk from Connecticut moms. We want to make sure our Connecticut hospitals can continue to partner with Mother's Milk Bank Northeast and other non-profit banks to continue to provide safe human milk to our sickest babies. That's why I donated. That's why everyone donates, and that's why I cannot support this bill as it is currently written. Thank you.

REP. SCANLON (98TH): Thank you for being here today. Any further questions? If not, thanks again for the baby congratulations. I appreciate that.

All right, last on this bill is Stephanie DeMarco.

STEPHANIE DEMARCO: Good afternoon Senator Lesser and Members of the Committee.

My name is Stephanie DeMarco and I am testifying in response to House Bill 5369. I am a resident of New Britain, a mother to two beautiful children and a milk donor. This is my daughter, Wilhelmina. She was born three years ago at only 24 weeks gestation weighing 1 pound, 12 ounces. I was incredible fortunate that my breastmilk came in right away, which is not common for moms of micro-preemies. I pumped religiously every two hours and brought progressively larger containers of milk with me to the NICU and I was so proud.

Sadly, Mina's lungs were not strong enough to survive the infection that she developed and we made the devastating decision to remove her from life support at 12 days old. Now, my story could end here. I could have asked the NICU to dispose of all of that milk and worked to let my milk dry up. I almost did. I woke up in the middle of the night after my daughter had passed away covered in tears and milk. I pumped a little bit just to relieve some pressure. And then I poured that milk down the drain. And then I sat on my kitchen floor and sobbed. It felt like I had just poured the only thing I had been able to do correctly for my daughter down the drain. It felt like I poured our connection down the drain. It felt like I poured my motherhood down the drain. But the next morning I saw a little hope. When you leave the hospital for the final time without a baby, you get a tiny box of memories and a folder with some pamphlets on grieving, not a great turnaround. In that folder was a card for Mothers' Milk Bank Northeast. I spoke to the milk bank and I chose to donate not only the gallons of frozen milk that I already had, but to continue pumping through my daughter's due

date. For another 16 weeks, I faithfully pumped. I got up multiple times a night making milk for babies I'll never meet. It was an incredibly large part of my family's grieving process.

I firmly believe that every premature and medically fragile baby has the right to the medicine that is breast milk. If their mom isn't able to provide it for them, there is an army of moms right behind them, supporting them, and selflessly donating their breast milk so that those tiny fighters have the best chance of survival.

That being said, I have serious concerns with House Bill 5369 as it is written. By forcing milk banks to test individual donations for drug use, you will be putting an undue burden on non-profit organizations, effectively allowing a for-profit company to monopolize milk donation. I did not donate my milk to make money, nor did I receive any. I donated because I don't want another mother to walk in my shoes.

Between my two children, I have spent over 700 hours of my life attached to a breast pump so that another set of parents doesn't have to decide if whether their child should be buried or cremated. The idea that moms, like me, are going through the multiple steps to become a milk donor, including blood screening, sitting around pumping for hours and hours, sterilizing pump parts, carefully storing, labeling, freezing, rotating stock, managing their own freezer supply, contacting the bank, and shipping milk, often while caring for a child young enough to still be nursing, for free, and also doing drugs, is, quite frankly, laughable. And I'm also

not a dairy cow, so I kind of resent the implication of the tie to my hygiene and whatever.

Now if the only way to donate milk in our state were through a for-profit bank, I would not have had the ability to donate over 1,000 ounces in an act of love and compassion in memory of my daughter. I would have been selling the milk that was only here because she was and, quite frankly, I wouldn't have done it. Between my two children, I have now donated almost 11 gallons of breast milk to help babies in the region.

Therefore, I ask you to thoroughly consider the language contained in this bill, ensure that coverage of donor milk exists for all babies that need it and that restrictions aren't put in place that essentially make hospitals required to utilize more expensive milk fortifier products from for-profit companies. Thank you.

REP. SCANLON (98TH): Well Stephanie, I'm not really sure what to say and that story is incredibly powerful and beautiful in so many different ways, and there's nothing really to say other than it's incredible to hear you take something so tragic and turn it into something pretty powerful. And I appreciate you sharing this story with us today.

Anybody have any questions? Senator Bizzaro.

SENATOR BIZZARO (6TH): Thank you Mr. Chairman. I don't have any questions. I just want to echo the comments made by Representative Scanlon. I can't imagine the courage it takes to be up here and tell that story, and just a remarkable, remarkable end to that story, and I just want to thank you for coming

up here and commend you for your courage. Thank you for your testimony today.

STEPHANIE DEMARCO: Thank you so much. That's really what donating moms are about. We are giving back to other moms, no matter what our story is and how we got there. Thank you so much.

REP. SCANLON (98TH): Before you go, a couple of other questions here.

STEPHANIE DEMARCO: Sorry, I didn't expect it.

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): I'm overwhelmed. Thank you so much for everything. I mean this is wonderful. I have three children and breastfeeding was one of the best experiences of my early life with them and it made such a difference to me as a mother to have that bond and I can't imagine the pain that you experienced. I remember being depressed when I had to throw away milk. I'd pump milk and then throw it away because I hadn't eat something that I felt was appropriate for my baby, and throwing the milk down the drain would crush me. But I just have to tell you I have a friend who had a baby at 24 weeks and the baby was less than a pound and less than 12 inches, and she wasn't able to produce milk and like you were saying sometimes that early on it just didn't work.

STEPHANIE DEMARCO: Right, it's not common for micro-preemie moms to be able to lactate right away or at all.

REP. DATHAN (142ND): And one of the things she was able to get donor breast milk and the -- after a few months of having this the doctor said that this gift

that someone gave her would help her child in so many ways with allergies with the ability to get these essential proteins that just the synthetic milk products don't provide. And you know she says now looking back, and her son now is 16 same age as my son, they would have been born 24 hours apart if you wouldn't adjusted the date but he ended up being born three months earlier. And I remember her at the time and his name is Max and she says now when -- he's had a lot of problems in school, but all of the doctors have said that these issues have been minimized because he had so much donor breast milk and the learning issues, and you know she is just so grateful because what could have been a real long lifetime of strong issues you know have been helped. And we don't know for sure what would be different, but everyone has said to her this donation has just made her child have a strong success in life when they really were worried as you were.

So thank you so much, and I just wanted to share that story because there are so many mothers out there that can't say thank you directly, but my friend was one of those mothers, so thank you so much for your testimony.

STEPHANIE DEMARCO: Thank you.

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

STEPANIE DEMARCO: Sorry for hitting you with that twice Representative Hughes, I remember you from last year. [Laughing] Sorry. I saw you come back in. I was like, oh man. [Laughing]

REP. SCANLON (98TH): If not, thank you again.

All right, moving on to HB 5360, John Fielding.

You just press the microphone button. Thank you sir.

JOHN FIELDING: Thanks very much. Good afternoon Mr. Chairman and Members of the Committee. I appreciate the ability to speak this afternoon.

My name is John Fielding and I represent the U.S. Travel Insurance Association. UStiA members include travel insurers, third-party administrators, travel retailers and related businesses involved in the development of administration marketing of travel insurance and travel-assistance products.

We really appreciate your considering this legislation which is important for consumers, regulators and the industry. Travel insurance is a little different from other lines of insurance, like homeowner's, auto or health insurance. It's a limited line of insurance that protects against certain kinds of loses that occur while traveling. So you are covered if you lose your luggage or your trip gets cancelled or you get sick while traveling. It's generally offered with non-insurance services like translation services, lost passport assistance, that sort of thing.

The legislation is important because it creates a framework specifically for the regulation of travel insurance. Travel insurance has been regulated forever, it's subject to the insurance code and regulations just like other lines of coverage. But what this bill does is clarify the law and create travel-specific provisions where needed. You actually started this process a few years ago here in Connecticut when you enacted changes to the way you license and register travel insurance agents and travel retailers. This bill, the new bill, builds

on that and addresses other areas of regulation. By way of background, the legislations based on substantially identical Model Acts adopted by the National Conference of Insurance Legislators (NCOIL) and the National Association of Insurance Commissions (NAIC).

And many of the issues addressed in legislation like bundling products, filing travel insurance as an inland marine line of authority, that sort of thing, are practices that have been widely accepted by regulators for years. The legislation codifies those practices, specifically clarifying them for travel insurance so that regulators and industry are on the same page going forward. The hope is that going forward, there will be no confusion as to what is permitted and what is required in the travel insurance industry under the law.

In addition to bundling and form filing, the legislation addresses other issues, such as Premium tax allocation. Now, the industry has always paid premium taxes, what the bill simply does is it clarifies who is required to pay those taxes. It does not address premium tax rates or anything like that, but who is required to pay. The bill also deals with travel administrators responsibilities through the intermediary level. And it deals with market practices like prohibiting opt out sales and instituting a 10 to 15-day “lookback” period for cancellation of policies, that sort of thing. And it includes numerous consumer disclosures that are in the law currently.

So there's two concerns that the UStiA has with the bill. There's a couple of issues where we're hoping that you might consider putting in some of the

Model-Act language that has not been included. The first thing is that the legislation does not clarify that in the event of a perceived conflict between this bill's provisions and other provisions that are in current law regarding the sale and marketing of travel insurance, the new law's provisions will control. So if there's any confusion there that the new law controls and supersedes what might be in place currently, or clarifies what might be in place currently. And the second issue is that the legislation doesn't define what it means to deliver the fulfillment materials. The disclosures are included in the fulfillment materials. That information is required to be delivered to the policyholder and the Model Act includes specifically what does it mean to be "delivered". So those two areas are areas that we would ask for further clarification in some of the inserts on the Model Act language.

But in closing, we think the legislation is an important step to clarify and reform the way travel insurance is regulated here in Connecticut. It has been thoroughly vetted both nationally and here in Connecticut. It provides legislators and regulators with what you guys need to effectively govern for good governance that updates the regulatory requirements and processes that reflect the way the marketplace operates today, and most importantly it protects consumers.

So, we urge you to move forward with it. And thank you very much. I would be happy to answer questions.

REP. SCANLON (98TH): Thank you. So I just want to clarify. The two changes that you're requesting are

in the Model Act but they somehow did not make it into our draft? Is that what you're saying?

JOHN FIELDING: Correct. That's correct.

REP. SCANLON (98TH): Interesting. All right, we'll take a look at that and appreciate you flagging that for us.

JOHN FIELDING: I could forward that language if it would be helpful?

REP. SCANLON (98TH): That would be great. Thank you so much. Any further questions from the Committee? Seeing none, thank you so much.

All right moving onto SB 0330. Dan Toner, followed by Drew Bloom.

DAN TONER: Good afternoon Chairman Scanlon, Members of this Committee. First of all, I'd like to thank you for the time and attention here.

My name is Dan Toner. I'm the President of 3-D Bail Bonds, Vice President of the Bail Association of Connecticut, I'm a member of the Professional Bondsman of the United States, as well as the American Bail Agent Coalition. I have been in the bail bond business for nearly 25 years. That's a quarter of a century. It's hard to believe how quickly it's gone by. But we've effectively provided the release and guaranteed court appearances for literally tens of thousands of Connecticut citizens that have been arrested.

Myself, in my company, we returned over 11,000 bail absconders (people that have missed court and are actively running from their court cases). I know bail. I've been in the business for like I say for a quarter of a century, not only in Connecticut but

throughout this country. And the one thing that we do is provide this service to the citizens of Connecticut, all at no cost to the taxpayers.

Bail is the only form of pre-trial release that guarantees defendant's appearance in court, thereby giving victims their day in court. And again, we do this at no cost to the taxpayer. I'm proud to say that Connecticut, because I've been a resident here for so long, has some of the best pre-trial outcomes in the country.

SB 0330 is looking to provide a task force to review the regulatory body for the industry. I don't think that's necessary at this time. I fully support oversight of our industry, so much so that I've personally authored -- or assisted in the authoring of legislation in that vain. It's a tough industry we're in. We're doing a tough job. We're licensed and have been regulated by the Insurance Department, which is where I believe our regulations should stay.

I love this state and believe we've provide a very good service to our citizens. Thank you for your time and attention. And I'd be happy to answer any questions you may have.

REP. SCANLON (98TH): Thank you Mr. Toner. So I'm not sure if you were in the room earlier when the Commissioner joked that he would be very happy to jettison oversight of the [laughing] Bail Bonds Agency. Are you -- is there anything in your industry that you think has prompted this because it's my understanding that a colleague of ours was approached by one of the bail bondsman in her district and asked them to introduce this bill. So

is that sort of a split thing in your industry or do you think most want to stay with insuring?

DAN TONER: I didn't think it was as a result of a bail bondsman, I thought it was an issue that they had with one particular bail agent and like I saw the tens of thousands of people that are brought back from -- that are bail absconders that are running. And I think there was one isolated incident that was an issue for one of her constituents.

REP. SCANLON (98TH): You're right. That's right. So, you are right. Okay. So you think that almost all if not all of the industry is happy where they are in insurance?

DAN TONER: I couldn't say 100% happy, but certainly I think it's an insurance product. It should be regulated by the Department of Insurance.

REP. SCANLON (98TH): Okay. And I hate to even ask this question but since you're here, this I think is the fourth year that I've been in charge of this committee and it's the fourth year the department is trying to do their bail bonds changes in their tech bills. Do you have any thoughts that you wanna weight on that, even though that's not up for a hearing today?

DAN TONER: Yeah, that’s not at the hearing today, but with that said we certainly would welcome an opportunity to speak to you know to the department and work toward coming to a mutual agreement, so.

REP. SCANLON (98TH): Okay, thank you very much. Any further questions? Representative Nolan.

REP. NOLAN (39TH): Hello sir, how are you?

DAN TONER: I'm well thank you, how are you?

REP. NOLAN (39TH): Through you, Chair, how would this hurt you if it went through?

DAN TONER: I'm not sure it would hurt. As an industry, it just makes sense that this is the insurance capital of the world. We are an insurance product. We should be regulated by the Insurance Department. So, we're licensed by them so I would think that should be the regulatory body.

REP. NOLAN (39TH): So there's nothing that would hurt your business and/or any other businesses if this was the path?

DAN TONER: Well I don't, you know, I don't know that it would if there's anything specific that I can think of sitting here that would specifically hurt our industry, but like I say it is an insurance product I think it should be regulated by the DOI.

REP. NOLAN (39TH): And is there a reason why you prefer the insurance?

DAN TONER: No. I don't, you know, I just think obviously we are kind of accustomed to what we know. We're a highly regulated industry. There's all kinds of audits that we go through and all kinds of regulation that we have to maintain, and it's well-suited with the DOI I would think.

REP. NOLAN (39TH): Okay. Thank you.

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

REP. DELNICKI (14TH): Thank you Mr. Chair, and thank you for coming forward on this issue. And I have to apologize, I had to step out of the room for

a few moments and if the question has already been asked, feel free to tell me that. What is the crux to the issue here? What is the crux to the matter? Why are we even looking at this and if it's working and working well, why do we want to touch it and change it?

DAN TONER: Representative Delnicki, I've asked myself that question so many times in this building I can't even tell you. [Laughing] But with that said, I believe there was an isolated incident with one agent that may or may not be a rogue agent that had an issue and I think that has been -- we are certainly trying to resolve it at this point, so.

REP. DELNICKI (14TH): And how many bail agents in the state of Connecticut are there?

DAN TONER: Roughly 300.

REP. DELNICKI (14TH): Three hundred?

DAN TONER: Three hundred bail agents, yes.

REP. DELNICKI (14TH): Three hundred and you may have had an issue with one agent?

DAN TONER: I'm sure there's been other issues, but I believe that this was a one-off issue with this, Representative.

REP. DELNICKI (14TH): Well I'm just making the comparison from the standpoint that in typical employment, and no matter what industry you're in typically, there will be somebody that is a problem.

DAN TONER: Correct.

REP. DELNICKI (14TH): And if you're looking at 300 thereabouts people that are actually out there doing

that work, one out of 300 is -- but it's a-third of a percent.

DAN TONER: Right, if that. If that high. And I, as a company, in 20 almost 25 years have probably bailed out roughly 40,000 to 50,000 people and so never had an issue and so. It's quite frankly a -- I don't think it's a huge issue that can't be resolved. And certainly should be overseen by the Insurance Department.

REP. DELNICKI (14TH): Yeah, I was gonna say with all of the things that we study it should be something that really is a glaring issue, and to me unless I missed something here and I would invite someone to correct me, it doesn't sound like this is an issue -- actually it does sound like an issue in search of a problem. There really doesn't seem to be a problem there. Is that a fair comment?

DAN TONER: Well, you know, obviously if it's the person that has that issue it's a big issue, but I think this is certainly an isolated situation that I don't think needs to have regulatory body change.

REP. DELNICKI (14TH): Well I thank you for coming forward and I'm looking forward to hear what anyone else comes forward with in the way of some kind of testimony on this.

Thank you Mr. Chair.

REP. SCANLON (98TH): Thank you. Any further questions? Seeing none, thank you so much Mr. Toner.

Drew Bloom.

ANDREW BLOOM: Good afternoon Senator Bizzaro, Representative Dathan, Representative Hughes and

Representative Nolan. I lost my Chairman, but that's okay. [Laughing] My name is Andrew Bloom -- and any other Members of the Real Estate and Insurance Committee.

My name is Andrew Bloom. I'm here to testify in opposition of Senate Bill 0330, AN ACT ESTABLISHING A TASK FORCE TO STUDY THE REGULATION OF SURETY BAIL BONDS AGENTS IN THE STATE. I have been licensed as a surety bail bondsman for 24 years, a bail enforcement agent, and am one of the owners of 3-D Bail Bonds with offices in Hartford and New Britain. I am a longtime member of The Professional Bail Agents of The United States, and a founding member board member and Immediate Past President of the Bail Association of Connecticut.

In 2015-2016, I proudly served on the Judicial Committee's Task Force to examine the methods to reduce the costs of extradition. In my career as a Bail Enforcement Agent and as president of the Fugitive Recovery Agency, I personally have nearly 1,500 arrests while supervising over 11,000 defendants arrested. Bail Bonds is the only form of pretrial release to self-monitor and self-enforce non-compliance. When a principal fails to appear or fails, no other form of pretrial release is held to the same standard as bail bonds, nor does any hold the accused accountable for their appearance, giving the victim their day in court.

While I support the monitoring and enforcement of surety bail bonds regulations, I feel the proper authority is, and must stay with, the Connecticut Department of Insurance. Surety bail bonds are an insurance product. We insure appearance of the defendant and that department understands and

regulates insurance. Surety bail agents are licensed insurance producers. The Department of Insurance has the expertise and experience to regulate surety bail bond agents.

In 2011 the Connecticut General Assembly enacted Public Act 11-45, AN ACT CONCERNING SURETY BAIL BOND AGENTS AND PROFESSIONAL BAIL BONDSMEN. This is comprehensive legislation that was accumulative of several years' efforts including input from all interested parties. Studies were conducted and data was collected. It resulted in many robust changes to the regulations and enforcement of statutes and regulations. Since 2011, the DOI has successfully regulated and enforced surety bail bond agents in Connecticut, and migrating this regulatory authority is unwarranted.

In the future, if there is a need to study the regulation of surety bail bonds, we respectfully ask that the industry be included in the conversations beforehand and included in any working groups. I and other Connecticut surety bond agents would be available and happy and proud to serve and assist with members of this committee.

Again, I respectfully oppose Senate Bill 0330 as written and ask that you reject it at this time. Thank you, again, for time and attention.

REP. SCANLON (98TH): Thank you very much. Any questions from the Committee? Seeing none, thank you so much.

Moving onto HB 5357, Paul Grabowski.

PAUL GRABOWSKI: Good afternoon Chairman Scanlon and Members of the Committee. Thank you for the opportunity to provide this testimony.

My name is Paul Grabowski. I'm an attorney at the Center for Medicare Advocacy. The center is a non-profit, non-partisan law organization that works to advance access to Medicare and quality healthcare for older people and people with disabilities.

We believe that HB 5357 should be amended to address the recently diminished Medicare supplemental insurance, also known as Medigap, options for Connecticut Medicare beneficiaries who are under age 65 and qualify for Medicare based upon disability.

As of January 1, 2020, newly eligible Connecticut Medicare beneficiaries with disabilities under the age of 65 no longer have access to Medigap Plan C. They only have access to Medigap Plans A and B, which do not cover the hospital deductible which is $1,408 dollars, skilled nursing facility co-insurance which is $176 dollars for days 21 through 100 or foreign travel emergency coverage which usually for other Medigap plans is around $50,000 dollars of travel emergency coverage.

Under Connecticut general statutes, companies selling Medigap plans are required to offer A, B or C to individuals eligible for Medicare by reason of disability, but due to a recent change in federal law under the Medicare Access and CHIP Reauthorization Act of 2015, Medigap Plan C can no longer be sold to people who become eligible for Medicare after January 1, 2020. So this limits the options for Connecticut's disabled population to just Plan A or Plan B.

In order to address this, we do believe that there needs to be a change in the Connecticut general statues to ensure that under Connecticut law companies are required to offer Medigap Plan D to

individuals who qualify for Medicare by reason of disability. Now there have been changes to the insurance regulations in Connecticut as a result of MACRA that do address this, but the statute has not been changed to add an option Plan D for these disabled individuals.

So simply what we're asking the committee to do and what urge the committee to do is to amend the general statute which is in Title 38a, Chapter 700c, Sections 38a-495c to add "Plan D" to the available options for disabled individuals. This will simply hold harmless people who have become eligible after January 1, 2020 giving them as similar as possible options as beneficiaries who became eligible prior to January 1, 2020.

So I am happy to answer any questions you may have about this. I know it's a little complicated. I'm covering for a colleague today myself, so I'm coming up to speed on the technicalities here, but I'm happy to try to answer any questions you have.

REP. SCANLON (98TH): Thank you. The only question I have is, any ballpark of how many people are impacted by this in the state of Connecticut?

PAUL GRABOWSKI: So, I tried to look to see what I could find on the C plan and the utilization. I can tell you some general numbers about the disabled population that's on Medicare. So that is roughly 13% of Connecticut Medicare beneficiaries are on because of disability, which is 88,000 individuals. So that's the proportions there that are looking for these plans, but I can't give you specifics. They are just now limited in their options of what they can select.

REP. SCANLON (98TH): And again the only people this would affect are people with disabilities under the age of 65, correct?

PAUL GRABOWSKI: That's correct.

REP. SCANLON (98TH): Okay. Any further questions from the committee? Seeing none, thank you so much.

Moving right along. We are now on 5361, Kathy Flaherty.

KATHY FLAHERTY: Good afternoon Representative Scanlon and Members of the Insurance and Real Estate Committee.

My name is Kathy Flaherty. I'm the Executive Director of Connecticut Legal Rights Project. I'm the Co-Chair of the Keep the Promise Committee, and as a member of the Steering Committee of the Cross Disability Lifespan Alliance. I want to be here to testify about HB 5361, but also add my support for 5366 which is AN ACT CONCERNING THE COST OF PRESCRIPTION DRUGS.

I have a story of having my insurance company change the formulary or change the requirements in mid-year and going to the pharmacy to pick up my prescription and being told that it costs a lot more than I expected it to cost. I'm lucky. I have a credit card. I was able to buy my medication, take it home and write a rather scathing letter to my insurance company, sign it with ESQ after my name, and they sent me a check reimbursing me for money they shouldn't have charged me and I didn’t have a problem again.

Most people are not fortunate enough to be able to have that. If they go to the pharmacy expecting to

pay one price for a medication and then are told they cannot have it unless they pay substantially more, people will choose to go without the care they need. We can do better. This bill has been before you before. I urge you to pass it. That's it.

REP. SCANLON (98TH): Thank you. All of that is true. That has been before us before and we certainly are thinking about the story that you just told when we talk about people we know this is impacting. Any questions for, yup, Representative Delnicki.

REP. DELNICKI (14TH): Thank you Mr. Chair, and thank you for coming forward with that testimony. Do we have any idea of how many people have been affected in that same type manner that you were affected?

KATHY FLAHERTY: I can't give you that answer today, but I can reach out to some of my colleagues who may have some statistics on that. I think the thing that's a little bit hard is people are going without care, and so really you are collecting people's stories. So whether there's data, if there is I can track down some folks who may have it. I don't have it.

REP. DELNICKI (14TH): Yeah I'm wondering from the standpoint because obviously one person having the problem is a big issue. I'm not taking anything away from that, but if it's one of those endemic type of situations that happens quite often then it becomes a, you know, a huge issue. And that's the reason why I asked that question. Not to take away the gravity of the situation for you.

KATHY FLAHERTY: Understood, and that's how I took your question. I mean I think it's absolutely true that this shouldn't happen to anyone. I was here when Ann Pratt testified. We need to do more in terms of healthcare and coverage in essence generally, but bills like this are a good start. And so like I said, I will follow up with you and try to get that information.

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

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): Thank you Chair, and thank you for your testimony. I hear it all the time as a social worker in the field, and it's -- I don't have statistics. It's just unconscionable to me how this is allowable because it seems to be price fixing. It's just, you know, it was allowed and then, "well we can get more if we you know kick it out of the formulary" or get this new drug in, you know, that is coming from the manufacturer that's just been approved. You know, we need stability just like with our state budget. We need to be able to know that what we're gonna be paying and that our insurance is either gonna cover it or not cover it and work that out with our doctor before we come to the pharmacy to fill the prescription. It's way too late then. Way too late. So.

KATHY FLAHERTY: I mean I just want to add is this is not saying they can never change it, it's just saying during the plan year. So I mean basically you sign a contract and you make your choices about which insurance coverage you want because you have taken the time, 'cause a lot people do, look at what the formulary is before they choose which plan. So

for the company to be able to change it in the middle of the year is --

REP. HUGHES (135TH): -- It's a breach of contract. Absolutely.

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

All right moving onto 5364. I don't see Susan, but I see Michelle.

MICHELLE RAKEBRAND: Good afternoon to Members of the Committee.

My name is Michelle Rakebrand. I'm Assistant Council for CBIA, and I'm here to testify in support to the concept of HB 5364. As this committee is well aware, the cost of health insurance is really becoming an issue for individuals and small businesses alike and a big contributor to that is the mandates. And so we're really happy to see a bill that suggests a cost benefit analysis being done prior to mandates happening out of the committee.

However, we do have some concerns about the language. One being that the review will only be conducted on one to five mandates per session and that this review will only be done by a majority vote of the committee. Under current law, there is this cost benefit analysis already in statute and the review is done currently at the discretion of the committee and the report hasn't been done since 2014. So mandates have been passed and signed, and those numbers are a little old for us to use as any sort of baseline for how much they really cost nowadays.

So again we really appreciate the intent behind this bill, but we're not sure that it will offer the full transparency that we think this bill is trying to offer. And I'm happy to answer any questions.

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

Moving onto 5375. David Gallitto from the Realtors.

All right. Anyone on 5372?

All right. Last bill today, 0325. Phil Pappas.

PHIL PAPPAS: Good afternoon Senator Lesser, House Chair Scanlon, Senator Ranking Member Kelly, House Ranking Member Pavalock-D'Amato and Distinguished Members of the Insurance and Real Estate Committee.

My name is Phil Pappas. I'm the Executive Director of the Connecticut Craft Brewers Guild that represents over 112 Connecticut-based breweries that has produced over 800 full-time jobs and $1 billion dollars in economic impact on the state of Connecticut. I'm here in support of SB 0325. As you may remember, last year we supported a bill raised by the committee that would have permitted our state's breweries to form an exempted plan that would not be covered by the small employer rating laws. After the committee voted 16-3 to pass a bill, we tried working with the administration and the Department on Insurance on alternative ideas that would allow approximately 1,000 covered recipients with their dependents to form a health plan that met all required mandated health coverage laws and would not be a captive insurance plan that would be outside Connecticut regulatory oversight.

We understand that association health plans are not the best package for every trade group in the state when considering the risk and stop-loss ratio numbers that need to be met to achieve savings. What hasn't been disputed by anyone in the past year is that our unique makeup of insured recipients would be the best population of workers to benefit from one of these plans.

I constantly have members citing how important this bill and this issue is for them. And every brewery we represent has expressed their desire in hiring more younger and healthier employees, and having a reasonable insurance plan would assist them in hiring this much-needed workforce.

To be brief our guild gained 56 legislative cosponsors for the bill last year and the fiscal note issued by the Office of Fiscal Analysis cited that the proposal would have no fiscal impact. If there's one way you can support our guild it's by supporting us to form a special health plan. Thank you for considering this testimony on behalf of the person who could fill up your growler but can't find affordable health insurance. Thank you.

REP. SCANLON (98TH): Thank you Phil for being here today. At the risk of putting you on the spot, 'cause I don't want to do that. There is another bill that's floating through this committee that we're gonna hear on Thursday which is essentially to come up with the public option for health insurance where individuals and small businesses can purchase their insurance through there. That bill was also around last year and did not make it forward, and these two bills I understand are two possible avenues for you to get insurance. Can you speak a

little bit about why it's so hard for your members to find affordable health insurance?

PHIL PAPPAS: Yeah, and so even though we are one of the most collaborative and you know cohesive industries in the state and growing at the rapid growth rate that we have, we have a lot of businesses that are two, three, four, five is medium employees with maybe a dependent or two on there. So for the insurance for them to have and provide that for another employee is significant. And we're losing a lot. And since we are manufacturers, we're losing a lot of these potential manufacturing employees to larger manufacturing who have thousands and tens of thousands of employees where the insurance costs and the benefits they have.

This is -- now we've entered into being legitimate businesses and legitimate careers. We have a program in the state of Connecticut with Sacred Heart launching this summer brewing science programs. So these are now potential full-on careers for younger college students to enter the workforce. And when they don't have affordable health insurance in front of them it makes it very difficult to offer that person that job. But with more leverage in buying power, you would get better -- [crosstalk] -- Yeah we have 112 going on 130 breweries with about 6,000 total people, like I said about 1,000 people that would be on this group plan together and that obviously would lower the risk and spread that -- and the average age for our group is significantly lower than the average employer so the risk is extremely low when you're looking at a group plan like this.

REP. SCANLON (98TH): And I'm glad you brought that up though 'cause that's the one sort of con that we hear and even myself as somebody who certainly does sympathize with what you're saying and represents quite a few breweries in Branford that are pretty awesome. But the whole idea that from the critics of this bill would say that you're taking what's mostly a group of dudes in their 20's and 30's that are relatively healthy out of that other market. Your argument is just that it's just impossible for them to find something affordable in that market, right?

PHIL PAPPAS: Correct, exactly. And we represent, even if we did take those 800 to 1,000 people off that plan that's less than half a percent. And as we continue to grow in the state of Connecticut, those would be pretty replaceable employees.

REP. SCANLON (98TH): Sure. Okay. Thank you. Any questions from the committee? Seeing none, thank you for being here today.

I'm just gonna return very quickly to 5375. David Gallitto.

[Background talking]

DAVID GALLITTO: [mic not on] -- president with the Connecticut Realtors. On behalf of the entire Real Estate community across the state, I'd like to thank you for the opportunity for testifying in front of this committee on House Bill 5375, AN ACT CONCERNING LICENSING REQUIREMENTS FOR REAL ESTATE BROKERS.

As presented in our written testimony, this bill proposes modifications to the preconditions for issuing real estate brokers' licenses across the state. The bill changes the time a person has been

actively engaged as a real estate sales person from two years to three years and requires that sales person to have actively worked under the supervision of a licensed real estate broker in the state of Connecticut for at least 1,500 hours during that immediately preceding three years. It also requires the perspective broker to have represented a buyer, a seller, a lessor or a lessee in at least four real estate transactions that have closed during the three years immediately preceding the broker application license date.

Currently an individual can obtain a broker's license without any knowledge of transactions and by simply holding a real estate sales person's license without spending an hour practicing or learning real estate in that time period. Connecticut Realtors is concerned from a consumer's standpoint that the consumer cannot be properly and professionally served on what is their largest financial investment in their lifetime when the involvement or oversight includes zero experience. Connecticut Realtors believes adding experience requirements will ensure the consumer in a real estate transaction has an appropriately educated and experience broker safeguarding their very important financial transaction. With regard to the necessary submission of information noting the achieved requirements, the Department of Consumer Protection could establish the necessary form for submittal of information.

In addition, Connecticut Realtors also respectfully requests this to submit additional substitute language to House Bill 5375 related to an issue that has come before this committee in the past. This language is related to the disclosure of real estate

broker relationships and we look forward to revisiting this language and the proposal in accordance with your committee at a later date.

To conclude, Connecticut Realtors asks for your support of House Bill 5375 and I thank you very much for your time in indulging me for being late. If there's any questions, I'd be more than happy to answer them for you.

REP. SCANLON (98TH): Thank you. Any questions? Senator Bizzaro.

SENATOR BIZZARO (6TH): Thank you Mr. Chairman. Thank you very much for your testimony and for being here today. So you said right now under the laws that exist there is no requirement for a mandatory minimum number of hours prior to obtaining a broker's license?

DAVID GALLITTO: We're increasing those hours from two to three years and increasing the hours of working as a salesperson. To put it simply Senator, we're trying to bring more professionalism to our business. And to actually have a situation where a salesperson can obtain their broker's license and not conduct any transaction is just simply a place that we don't want to go, and we feel that the consumer deserves a more experienced and professional broker to handle this transaction. And as you're aware, there's the salesperson's license and a broker's license that includes more education. You take one and then you take the next step to the broker's license not really conducting yourself as a salesperson and being involved with transactions and being able to work with consumers as buyers or lesser or sellers or what have you and then move

onto a broker's license just does not make any sense in our humble opinion.

SENATOR BIZZARO (6TH): No, I understand that and I appreciate that. I think that makes a lot of sense as a practitioner in the field, I know that you know one of the things that we often struggle with in this industry is people who want to dabble and you know work part time without getting the necessary training that's required. As we know, it's becoming ever more complex to do real estate transactions and it's really not something that ought to be a hobby. So I think this is you know very commendable on your part, and I look forward to voting on this. Thank you very much.

DAVID GALLITTO: Well thank you Senator. I mean we take very seriously the idea that on a daily basis we are involved with consumers in the state that are looking to buy or sell, and to be involved in a transaction as I mentioned that may be the largest transaction, financial transaction, of their lifetime is very important to us. So we appreciate the support for this bill, and look forward to it moving along. Thank you.

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

I see you've been joined by Susan Halpin. Does she want to testimony? Okay.

SUSAN HALPIN: Good afternoon Mr. Chairman, Representative Dathan, Members of the Committee. For the record, my name is Susan Halpin and I'm here today on behalf of the Connecticut Association of Health Plans.

With your indulgence, I just wanna talk on a couple of bills. I do want to support the bill that you're on currently which is 5364, which is a mandated benefit review process. I think you guys see your fair share of mandates every year, some may have a cost benefit analysis, some may not. But I think it makes a lot of sense as some of the other states so. I don't have a list, I apologize, in front of me to give them a little bit of research and consideration before voting on them because they do often have significant costs associated with them. And I think it's always prudent to make sure that you're getting the benefit that you intend.

I'd like to spend a few minutes on some of the pharmacy bills that are before you. I've been up here many, many years talking about formularies in particular and how important they are to push back on the cost of pharmaceutical drugs. There's an article I had hoped to copy and distribute to you today that ran yesterday in one of the major news outlets that talked about delayed-release drugs and how you can get significant savings in pharmaceutical pricing if you just took two pills a day instead of the delayed-release pill. Substantial savings. Same drug, but just different time table. Doesn't work for everybody, of course, but those are the things that our companies consider when they put together formularies.

And like I said I've been before you for many, many years talking about the ability of carriers to use their formularies to negotiate against those price hikes that are put in place by the pharmaceutical companies. If we lose that ability, if we are required to keep the formularies basically static or you know the same throughout the year then we don't

have those abilities to bring on cheaper drugs as they become available and basically incent folks to go to that cheaper drug but moving it to a different tier.

And those are the things that I think when we all look at global healthcare policy and we look at trying to keep the costs, in particular pharmaceuticals, lower for consumers those are the things that we should be doing as we look at these. And that's our concern, predominantly with 5366, Mr. Chairman respectfully.

And we do applaud a lot of the components in that bill that seek to address the wholesale cost of drugs, but as we've seen again over time in this building often times some of those proposals don't make it to the end, but the insurance proposal pieces seem to be the last thing standing and that does remain a big concern for us.

I also just wanted to comment -- and that same argument goes for 5361 as well. One of the other pieces I just wanted to talk briefly about, and you'll see this in a number of pieces of my testimony this session. There are a lot of placeholder bills or study bills and task force bills. And just for the record, I've just kind of tried to flag those because I know oftentimes more substantive language can be added to those at a later date. And in the past we haven't had [laughing] comment on the record and some people say, "well you didn't comment on it". I say, "well, 'cause it was a task force bill". So, you know we did put a couple of those notes in the record just to flag going forward.

So I thank you for your indulgence on that. And if I can answer any questions for you, I'd be happy to.

REP. SCANLON (98TH): Thank you. I can assure you they're all mandates. [All laughing] Just so you know. Just kidding. Any questions from the committee? Senator Lesser.

SENATOR LESSER (9TH): Thank you Susan for your testimony. I'm somewhat saddened to think that -- I guess I'm frustrated a little bit on the prescription drug bills because the refrain that I've heard from folks across the insurance industry over the last few years has been that we're really focused only on one of the cost drivers across the healthcare system, right, that insurance certainly and the cost and so are providers and so are pharmaceutical companies and you know. I don't whether or not we lump PBM's in with insurers now or not, or we keep them separate, but you know obviously there's a lot of players in the healthcare system and we focus, on this committee, inordinately maybe because of the name of the committee, on insurers when they're really trying to contain costs in many cases and they are certainly may not be the worst doctors by any stretch of the imagination in the healthcare system. And we've heard that frustration from insurers that really we should spend more time focused on other parts of the healthcare system. And you know the bill before us I think attempts to do that. And I think your testimony speaks to that. Right, that there's a lot in there about containing costs of prescription drugs that we heard earlier from our friends in PhRMA that are not particular fans of.

On Thursday I think we are going to hear about efforts to control provider costs as well. I think we are sincerely interested in working with all aspects of the healthcare ecosystem to control costs and make healthcare more affordable for everyone in Connecticut. But I don't know that you believe us. I think you think we are focused on just insurance, and I don't know how we sort of get past that because I think we are moving a good pace to try to control costs and you know whether it's through looking at re-importation of Canadian prescription drugs or find other things to get at that. And yet you just told us a minute ago that you think that all we are out to do is beat up on insurance companies. At least that's what I -- I'm paraphrasing what you said it's not obviously in your exact remarks, but I just wanted to know like how to do suggest that we show and demonstrate good faith that we really are looking at the overall cost of healthcare?

SUSAN HALPIN: Yeah. First, I don't think that was the intent of my comments if that's the way that it came across. I think what my concern is, is whether the state has the authority to do some of the things that are prescribed in the bill. And that's been a frustration frankly of many of us, myself included, around pharmaceutical pricing in particular. And you know I think a lot of that authority lies at the federal level. And I think sometimes what happens is the frustration around not being able to get at those core costs ends up, you know, I've been saying it a lot this session but it ends up being an insurance solution to a pricing problem. And I understand, you know, the frustration the policymakers have around that, but our concern is

that you don't remove tools from our toolbox to control those costs. And this committee in fact and this legislature has taken a number of actions to make sure that there are consumer protections in place. There are override provisions for drugs that are medically necessary. There are provisions to continue on a drug with doctor outreach if you've been on a drug for a chronic condition. We were the first state to enact, you know, the appeals process. We have the Office of the Healthcare Advocate who is very engaged with our carriers when consumers outreach to his office and his people.

So I feel like we have a number of provisions in place. My fear was not that I don't trust you, it's just that with the frustration at the end of the day or the you know the understanding that perhaps certain things couldn't be carried out under state's authority that we end up with the insurance section still in place and then we lose more tools in the toolbox to actually manage the benefit.

SENATOR LESSER (9TH): I guess I hear that, but I think that there probably are tools that you can do to help control costs and certainly one of the things is in helping insurers negotiate lower pharmaceutical prices. I understand that there are barriers right now to you know the most effective negotiating tactics. I'm sure any trust laws are part of that. There are other things -- but I can't help but think that the state can be a partner in trying to lower pharmaceutical costs. I don't see -- I would love to see a greater willingness from your industry to engage with us in how to achieve that because I think that that could be beneficial potentially for everybody in the state. But, you know, my hope is that we can get there.

With regard to one specific section of the prescription drug bill that has the global cap on out-of-pocket costs; is that something that could actually increase the leverage of carriers in negotiating down prices? Is that something that would give you an additional tool potentially? I mean obviously, your testimony reads it the other way, but I was wondering if that's something that you think might actually give you an additional tool to say, "listen we are capped at our PhRMA's spend, so we can't possibly go with any further"?

SUSAN HALPIN: I think you're gonna hear another bill coming up on Thursday that talks about the healthcare, the Health Cost Council Benchmark Bill. Thank you. And I think that that is the important first step in those kinds of processes. You know in Connecticut, and this isn't a criticism, it's just we always want to tackle everything rather than take smaller steps. Massachusettes put into effect the Health Cost Council a few years back. It has shown promise in keeping costs down and I think that's the direction that we would like to see taken first. I think if we felt the way that you suggest that it would actually help us negotiate prices, I think we would probably be the first to support it, but I don't think we view it in that context.

So I hear what you're saying in part. The volume of the bill doesn't always afford for the most in-depth testimony that we would perhaps like to give, and just the press of the process, but I understand what you're saying. And I think it's important that we drill down on costs and that we focus on things. And I think our position on the bills in front of you may not be the position on some of those other bills that you'll see on your agenda in the future.

SENATOR LESSER (9TH): Okay. I think that's all I have.

REP. SCANLON (98TH): Representative Hughes.

REP. HUGHES (135TH): Thank you Chair. A couple of comments about the formulary, especially I think you just heard in the testimony, what we you know in the social work sector but in a lot of sectors, are most concerned with this impact. You're right there are other ways to override, but you're talking about you know often we are talking about trying to minimize the barriers to people getting care, often life-saving care, and these people are often sick. So to say, "well you know you could appeal that, you can go to the Office of Healthcare Advocate", you know that is way too late when you're showing up at the pharmacy counter and denied because you know the formulary's been changed.

And I do believe that the actors with most resources have a responsibility to plan out ahead of time and not hold back on planning out what would be the most cost-effective thing for that contract for the year because people's lives depend on it. So I feel like that actors have way more resources to plan that out than the patients who need the prescriptions.

And I'm dealing mostly with elderly that have no capacity to do the, you know, the next tier resource navigation; no capacity to even know where to call or what to do. So, yeah. So I believe that that toolbox needs to be tightened way up so that it's not impacting adversely the patients, first and foremost. That's my belief. So.

SUSAN HALPIN: If I could respond?

REP. HUGHES (135TH): Sure.

SUSAN HALPIN: I think your example actually drives home one of our main points, which is any legislation that gets passed in this assembly only applies to a small segment of the market. So it's not going to apply to Medicare, for instance. It's not going to apply for the self-insured market. It's only to go apply to about 35% of the market. And that 35% of the market is the most price sensitive part of the market. So they feel more acutely any increases in premium that might be a result of various policies that are enacted. And they're also the ones frankly that are subject and already have all the protections afforded under the law. So no one should show up at the pharmacy and be told at the pharmacy that something is off the formulary because at the Department of Insurance, we have regulations on the books that require us to give 60 days' notice if there's a change in formularies.

I have gone through this process myself. I have had my children go through this process. We have you know a very quick turnaround for acute redeterminations of care if you will, three days. So I have gone through this process, but I've also seen as a high-deductible health plan owner myself I have also seen the benefits of these things when I was on a drug that costs $500 dollars per 30 days' supply and my insurance company informed me that a generic came on the market. And there was actually by the way another substitute I could have taken, but I had to take that three times a day, and by the time I did that I was too tired so I appealed and got it approved for the $500 dollar-a-day one. But now I am very thrilled to say that I'm only paying

$10 dollars you know for the new drug that's on the market.

I'm not sure that I might've you know made some of those changes if I wasn't given all the information from my insurance company. So I understand your point and it's a struggle, you know, but I think the protections are in place currently in statute to address you know those concerns currently.

REP. HUGHES (135TH): I guess my macro view is that we have shifted the administrative burden on going through those hoops to the patient and normalize that. Like you're right, maybe it wasn't that hard for you to do that with the 60-day notice and quick you know like figure out which one is due and try, you know, but again that administrative burden we've normalized in this country to be just taken on by the patient who is already paying for their insurance and it's like there's something really upside down around that, especially given that people need these prescriptions to be healthy. So there's already -- it's just one more barrier and I think it should be taken on more by the insurance companies than by the patients. And that's why I'm thinking that that tool is you know needs to be tightened up between the pharmaceutical and the insurance industry. Work it out, but don't put it onto the patient to have to now manage in addition to the illness or the treatment. That's my view.

SUSAN HALPIN: And I think that we are all struggling with the same issues. We may come at it from different ways, but we're all struggling with you know how to provide sustainable, affordable coverage right and we're looking at it in different ways and there are different things that the you

know the health plans have rolled out in terms of policies. Some get changes from year to year. I mean this is not a stagnant process. But I appreciate your comments.

REP. HUGHES (135TH): Thanks.

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

Next up Tim Phelan, followed by I guess Michelle Rakebrand.

TIM PHELAN: Good afternoon Senator. Am I the last person between you and adjournment of this?

SENATOR LESSER (9TH): You are not. No. You are most certainly not.

TIM PHELAN: All right, I thought last bill, last person to testify, thought I might do that.

SENATOR LESSER (9TH): Absolutely not. No, we'll listen and will wrap the tension beyond your testimony.

TIM PHELAN: Is it all right then if I expand my remarks? No, I will keep them brief. Thank you. Representative Scanlon is not here, but Senator Lesser and other Members of the Insurance Committee, I'm Tim Phelan.

I'm the President of the Connecticut Retail Merchants Association. CRMA is a statewide trade association representing some of the world's largest retailers in the states' main street merchants. I'm here today to testify in favor of Senate Bill 0325, AN ACT CONCERNING ASSOCIATION HEALTH PLANS. I've

submitted written testimony for you to review, so I'll just summarize that testimony.

There is no doubt that the highest business cost at a main street retailer faces in Connecticut today is healthcare. And for our members, those costs can be crippling. Senate Bill 0325 gives them a chance to lower their costs by joining forces together with other retailers to use the power of group purchasing to negotiate better rates.

Our members are in a bind with insurance. Many of them are caught in between. So not to be able to take advantage of the exchange, so they are left at the mercy of the private marketplace, which for small employers would cost extremely high rates. The formation of association health care plan is in our opinion a private sector solution to the question, the creative of creative ways to lower healthcare costs.

It's an approach that is taking place in Massachusetts with our colleagues in the Retailers Association there. They formed an association healthcare plan that lowers members' insurance by some 10% through the association's healthcare cooperative plan.

We could take the same approach here with this bill and give our members some relief. In closing, as you know the retail industry especially main street retailers that populate all of your towns that are operating in a hypercompetitive world. They are committed to Connecticut. They work here. They live here. They raise their families here. It's often said they are the fabric of the communities in which their stores are located. But they are struggling, not just from the new digital economy

but from some public policy decisions that this legislature has made. So now they are looking for some relief. They've taken on increased costs in almost all parts of their business and often ask me, "when will the legislature do something to help me stay in business, where's my relief?"

We believe Senate Bill 0325 can be your response to that question. Together, we can work on a healthcare bill that helps them and gives them the relief that they desperately are seeking. So I thank you for your time and I'd be happy to try to answer any questions you might have.

SENATOR LESSER (9TH): Thank you very much. Are there comments or questions from the committee? If not, you're -- Godspeed.

Next up Michelle Rakebrand from CBIA. I think only half of your name is on the sign-up sheet.

MICHELLE RAKEBRAND: I'm sorry. It kind of trailed off at the end.

SENATOR LESSER (9TH): No problem, figured it out.

MICHELLE RAKEBRAND: All right. Good afternoon everyone.

My name is Michelle Rakebrand. I'm Assistant Counsel for CBIA, and I'm here to testify in support of Senate Bill 0325 which would authorize the insurance department to approve associate health plans. As this Committee knows the cost of health insurance is hard for businesses to afford but we often do hear that larger sized businesses do have an easier time.

What this bill would essentially do is give smaller business the buying power and the leverage to

essentially purchase health insurance as if they were a large business. AHP's do often get criticized though for being skimpy plans, but we would like to remind the committee that under federal law they are acquired to cover the essential benefits that are enumerated in the Affordable Care Act. They are also regulated by ERISA and would be regulated by our state Department of Insurance.

The business community would also like thank this committee for taking a broad-based approach to this bill. In the past, we've seen bills that are very industry-specific to AHP's, but small businesses of all sectors really have a hard time affording healthcare so broadening the language is something that would be appreciated across all industries.

And that is all I have. I'm happy to answer any questions.

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

REP. DATHAN (142ND): Thank you Michelle for your testimony. I know that the CBIA offers plans to small employers. Does the CBIA, do you think that they would be able to take advantage of these plans and offer better benefits for their member companies?

MICHELLE RAKEBRAND: At CBIA, yeah we really take a broad approach to healthcare. So Association Health Plans are not the best alternative for everyone, so for our members if this is something they would be interested in we'd certainly offer them, but we would continue to offer plans that are compliant with ACA and in the self-insured market.

REP. DATHAN (142ND): Just as a side, can you remind me exactly what size companies that the CBIA, the members have number of employees? What's the sort of range generally?

MICHELLE RAKEBRAND: So most of our companies are small businesses, 95% are, and we consider small businesses for our purposes under 100 employees.

REP. DATHAN (142ND): Okay, so some of these plans might be beneficial for those small entities I'm guessing?

MICHELLE RAKEBRAND: Yes.

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

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

That includes the list of people signed up to testify. Are there other members of the public who wish to testify at this time? If not, that will conclude our public hearing. We will have another public hearing at, I believe, at 11:00 on Thursday in this room.

And with that, I would like to adjourn the public hearing of the Insurance and Real Estate Committee.