

CHAIRPERSON: Senator Matt Lesser

SENATORS: Hartley, Kelly, Anwar,
Bizzaro

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

REP. SCANLON (98TH): It actually just became good
afternoon, everybody, so I apologize for that. We
are going to go ahead and get started with the
public hearing and we are going to start with our
state comptroller, Kevin Lembo.

KEVIN LEMBO: Someone behind me just said oh, oh. I
don't know whether to take that personally or not.
It's good to see you and thank you for this
opportunity Senator Lesser, Representative Scanlon,
ranking members and members of the committee. I am
Kevin Lembo, the state comptroller, and I thank you
again for this opportunity to testify in support of
Senate Bill 347, establishing the Connecticut Plan.
I'm here today because all of you and I and every
other state elected official in Connecticut,
including our governor, has access to a plan and we
have something in common. No matter our political
leanings or anything else that sets us apart, we
share that thing. We have access to the highest
quality and most efficient healthcare in the state
of Connecticut, possibly the nation.

While this may be our community, it sets us apart
from many of the people we represent, including many

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of those sitting behind me, and most of Connecticut residents who frankly can't be here today, real people doing real work that doesn't allow them to flip the sign on the door and come to Hartford at noon on a Thursday. There are people who don't have and may never have that luxury of stepping foot into this building or the ability to hire high-paid lobbyists to defend their interests, but they are counting on us and I always, in my years in this building, have tried not to draw the us versus them because that's not what this is about, but we have to balance the interests of those people, as silent as they are today in many ways, with those who are going to darken your doors over the next couple of months and urge you, beg you, cajole you, threaten you to vote now on this bill.

This is not the first time we've had this conversation and I'll sit here again as many times as I need to until we finally make things right and establish the Connecticut Plan. It is time to share our care and remember, we're not talking about free healthcare or a government takeover of industry, even if that's what the high dollar advertising campaigns will surely allege. We are simply talking about allowing others to buy, purchase, and pay for access to our plan. The Connecticut Plan would allow small businesses, nonprofits, and Taft-Hartley plans run by unions and individuals in a separate track with no workplace insurance access to buy into a variety of plan options offered by the state.

These plans would range from the most affordable quality-focused plans to full benefits of the state employee plan. It would be up to the employee or the individual to determine what plan meets their budgetary and benefit needs, no matter which they

choose. Plans will be efficient and will not have high deductibles. We sometimes see here it here in the building. We have 90 percent something insured people in the state of Connecticut and that may be true, but ask them what kind of coverage they actually have and ask them if they ever get access to the benefit that underlies that coverage. In many cases the answer to that is no. The technical term, and I'm afraid to do this in an official hearing, is crappy coverage. Big plans -- I'm sorry, the legislature would allow the state to leverage its heft in the marketplace working in collaboration with our corporate partners, many of them headquartered in Connecticut, to provide quality employers the best quality and most efficient healthcare choices possible, allow small businesses and nonprofits to retain their best employees and attract new talent by competing with big corporation benefits, keep costs predictable year over year. No more double digit or erratic premium increases and give all people in Connecticut the chance to access a health plan, not just that insurance plan.

I see this as an economic develop activity. We spend a lot of money in economic development in the state of Connecticut. Often those dollars lead to borrowed hard hats and giant pairs of scissors and ribbons to be cut, but under it all is a winners and losers strategy that really leaves very few winners. The analysis that has been done over the years, by the auditors for example, will show you what the benefit has been or has not been. We clamor to funds, Small Business Express and Jet, they all have very interesting names, but think about redeploying those dollars to the balance sheet, the bottom line,

of every small business, the economic engines of our economy. If you ask anyone who works in this building, the nonprofits that do the work that the state would otherwise have to do and frankly, have been begging the legislature and governors of both parties over the years for additional funding to keep doing their core work, what happens if they go out of business? What happens if we do something to make a difference for them, especially at a time when you're told you can't add more money into the budget to support them? So I thank you for your attention. My written testimony is in the record and I'm happy to take any questions and I hope we can all get to yes at the end of the day, so thank you.

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

SEN. LESSER (9TH): Thank you, Comptroller Lembo, for your advocacy on this issue and for your work as the leader, thought leader, on healthcare. I want to talk about what this bill does and how you see it working. So it's different from previous proposals that were considered by this committee. Can you just touch on a few of those differences?

KEVIN LEMBO: Sure. The basic construction of the plan, and I think if you look at the language of bill as it came out and for your review, I think we all acknowledge it needs work, but the idea is to use the state employee plan, including those pre-65 retirees, the contracts I negotiate for them, including Pharma, where we save millions of dollars every year, the RFP we just did for healthcare. The big initiatives we're doing to bend the cost curve in healthcare and to make those available to others,

we would do that by using that platform and those reimbursements for, and I'm looking at some of my hospital colleagues to make sure that they understand what I'm saying, use those reimbursements to make opportunity available.

The state employee retiree silo, it's a bad word in management, would sit on that platform, the partnership plan would sit on that silo, and the new plan that we're discussing today would also sit there. We should have a discussion about what risk-sharing looks like in this relationship because each of those groups is underwritten in that we are using actuaries to figure out what premiums should be to make it sustainable, but there may be a point at the very top where we want to create a risk corridor that redeploys those dollars that we've talked about for economic development to make them available to help with that or not, depending on the will of the legislature. There are different ways that we can approach this, but that's the basic construct. I would go out to bid for all of it at once, including, I would hope, for the individual fully insured product that is also mentioned in this bill.

SEN. LESSER (9TH): So a coalition of business interests that are opposed to this proposal have put up a website and on that website they've made a few different claims. One, at the very top, it says don't force Connecticut families into a state government option.

KEVIN LEMBO: It's a choice.

SEN. LESSER (9TH): Does it -- So I was going to ask, does this bill force anybody to do anything?

KEVIN LEMBO: It does not, absolutely not.

SEN. LESSER (9TH): Okay. Second, it says there's some claims about or certain questions about the partnership 2.0 plan. Can you give us an update because I think we made some changes to the partnerships of the 2.0 plan? Can you just talk about the history of that and where we are right now?

KEVIN LEMBO: Sure. As some of you may recall, I think we discussed here a number of years ago and anyone who actually sits on a post will remember, we talked about it definitely there in the last two years. When the partnership plan was stood up, the benefit plan was limited to the state employee benefit design and it was a single premium for anyone who came in. We projected at that point that you could have some weirdness in who participates and a lot of discussion has taken place about what the experience last year was for that plan. So 2.0 adds in some geographic underwriting in that high-cost counties are going to see a small increase compared to others. Actually, there's at least one county, and I'm blanking on who is it, but it's not Fairfield County, sorry, is going to see a small decrease because they are a negative compared to the average, and it allows us to impose that in the premium setting which brings everything more into line.

The balance today for the partnership plan sits at positive \$20 million dollars, for emphasis, positive \$20 million dollars, and that has sort of washed its way through as new entrants into the plan have come in and we were, at one point as recorded, above 100 percent on our MLR. I think it was 107 and that was a strict look at premiums from X number of groups coming in versus cost per X number of groups that

came in, but this is not a static thing. This is a dynamic movement. Claims come in, premiums come in, and as more and more groups enter, more and more dollars were available and so ultimately again we end with a -- presently have a \$20 million dollar surplus in that account. Please don't try to grab it.

SEN. LESSER (9TH): We will -- Nobody on this committee is going to try to raid your --

KEVIN LEMBO: Yeah, there's some cross-walking between this committee and others, so.

SEN. LESSER (9TH): Well, I'm on all the committees I feel like sometimes, so I'll pass that on to my friends at Appropriations please do not. You know, I know this week was Super Tuesday and Representative Scanlon and I have different horses in that race and it is what it is, but one of the things that I note was that the big winner of that Super Tuesday primary that's across the country was Vice-President Biden. Vice-President Biden has indicated that he supports a public option and the day after he won across the country, if you looked at the stock prices of all of the major insurers, including all of the folks I think we're going to hear from today, they all went up through the roof. Anthem went up 13.2 percent, Cigna went up 10.6 percent.

I go down to other -- There are other insurers as well, but if -- Humana soared, as well, and this is the day after a presidential candidate proposing a public option won primaries across the country, so to those folks who say that this is an attack on our friends in the insurance industry, I would ask them to talk on their friends on Wall Street. And with

that, I think that's all the questions I have for right now, but I'm sure there will be some more discussion about this proposal.

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

REP. DATHAN (142ND): Thank you, Mr. Chairman, and welcome. We're so glad to have you.

KEVIN LEMBO: It's good to be here.

REP. DATHAN (142ND): I really wanted to talk about the opportunities for small businesses here. I come out of entrepreneurial background in my history, working for startup companies for many, many years, and I know one of the things that have inhibited people to start their own businesses, particularly in this economic climate, is the cost of individual health plans. My question to you is who would these plans benefit outside of maybe the sort of single shingle, if you will, to larger or smaller companies?

KEVIN LEMBO: Thank you, Representative Dathan, and you make a really important point. In addition to the engine of our economy being small business, there are plenty of folks who are locked in cubicles in offices in big corporations all over this state with big ideas and they feel, as you pointed out, that they are unable to take that risk and go out because they would run the risk of losing. If we can unleash that economic opportunity, if we can unleash the dollars that would flow from that, it's a huge deal and I would have trouble figuring out on its face how to calculate what that might look like, but it is real, given the centers of innovation we have all around Connecticut.

So there are two places, single shingle, I love that line, you know, small business is defined as between one and 50, so a small business of one is eligible for that plan. On the individual side, it is really any individual that doesn't have access to plan, so we would go out for that fully insured contract. I would use our negotiating power to get the best possible premium prices and tiers for that population, and we would negotiate that simultaneously, so while they would not share in a common risk pool, for example, they would enjoy the benefit of the negotiation because of that larger group in the group market.

REP. DATHAN (142ND): And just thinking about administrative costs, because I know it's -- how would this plan look in terms of administrative costs compared to maybe a traditional insurance plan?

KEVIN LEMBO: Yeah, so some recent debate about that. I think I got a letter from Senator Kelly and his leader about what sort of the administrative cost is of the plan, I think including electricity costs or something. There was a lot of stuff put into there. We run an admin of between 1 and 3 percent, usually 1 or 2, in the plan. That doesn't take into account, and I think it's reasonable to point out, that there are actual state employees helping to run the plan, but that's their charge anyway, so any incremental costs because of this additional program would be borne by the program, that would get embedded into the rate setting every year when that -- new rates are set. So if it's 1 and 2 in the state employee plan, I don't want to commit, but, you know, we're talking about low single digits because there would be a point or so

that would need to be added for the bodies necessary to make it go.

We rely heavily on our private sector partners, and I tried to say to folks in the industry last year, the CEO of the insurance company who figures out where the puck's going to be, that old Gretzky thing, and realizes that this is the way things are moving and changes the way they're thinking and gets away from that ring the cash register, bear the risk, and that's how we make our money, is going to really have the opportunity for a lot more business and a lot more covered lives in this state. We are successfully -- or we are negotiating contracts right now for the underlying health plan. As you know, we sole sourced that to Anthem Blue Cross and Blue Shield. If those negotiations are successful, they will be the sole carrier in that plan and it allows us to really partner, share data, and innovate together. That is a private/public partnership by any definition.

REP. DATHAN (142ND): So just to confirm, you're saying that this cost of this insurance plan, public option is not born on behalf of the taxpayers, but the people who actually use it?

KEVIN LEMBO: That's correct, Representative.

REP. DATHAN (142ND): So a user fee?

KEVIN LEMBO: Yeah, administrative costs are built into rate setting no matter if I'm setting the rates or some of our colleagues in the private sector are setting the rates.

REP. DATHAN (142ND): I was looking earlier at the opposition to this and trying to kind of get my hands around this to really figure it out and one of

the oppositions was a group that manages small businesses and looks at small businesses and works on their behalf and they have a competing type product. Would our product, not our product, but the state public option, would that product -- would obviously be in competition, but there would be no way that a small business could say well, you know, I have to use the state plan versus the other opportunity. Somebody -- It's a free market. Somebody would be able to choose if the rate in one plan were better than another plan, so if the example the small business consortium said oh, actually, we have, you know, much better rates, a small business said oh, actually you do have smaller rates, I'm going to go with you --

KEVIN LEMBO: Great.

REP. DATHAN (142ND): -- is that, you know --

KEVIN LEMBO: It's about competition and other options. It's not about replacing one for one. And if it drives down costs, if it leads to greater innovation in how we actually provide and develop care with high quality in this state, if those things come as a result of this, this will be good for not just the people who are in the plan, but others as well, so there's wanting a free market because there's wanting competition except when it involves you and your book of business and so I understand the concern, but that just means they're going to have to work harder to keep the business.

REP. DATHAN (142ND): So taking any way -- any monopoly that there might be in this. Okay. Thank you so much, Comptroller.

KEVIN LEMBO: Thank you, Representative. I appreciate it.

REP. DATHAN (142ND): Thank you.

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

REP. O'NEILL (69TH): This is really quite preliminary in terms of my questions to you.

KEVIN LEMBO: Sure.

REP. O'NEILL (69TH): First of all, I'd like to offer a competing analysis to the Super Tuesday stock market effect insofar as I'm not exactly sure how one would characterize Senator Sanders' option, but my guess is that most people looking at it compared with whatever Vice-President Biden had in mind breathed a huge sigh of relief, so that's what you may be seeing in the stock market more than an endorsement of public option is a -- just dodging a bullet, so to speak, with respect to Senator Sanders, but that's just my take and I'd be curious as to how much money was being bet on each horse that the two of you had in that particular race, seeing as how we haven't yet legalized sports betting in Connecticut.

REP. SCANLON (98TH): I would just say, Representative, my candidate is still running and his is no longer running, so. Oh, you're still here.

KEVIN LEMBO: Representative, I'm a 12 o'clock lunch guy, so if we could -- No. My blood sugar starts to drop around 12:20, so you may get things from me you're not expecting.

REP. O'NEILL (69TH): Okay. I'll hurry it up. It's basically a really basic observation about the whole

approach here because this is sort of like a -- I think when I was on Appropriations, there were different iterations of some version of this kind of thing over the last several years. What's most intriguing about what you're saying right now is what I would characterize as inspirational statements suggesting that we can perhaps achieve a significant economic competitive advantage for going forward with economic development by crashing the cost of healthcare or at least significantly improving the quality for the same cost, things like that, so that businesses might be attracted to Connecticut or choose to expand here and so I get that.

The problem -- The one question I have or I'll start with the problem. It sort of reminds me of something that Mario Cuomo used to say, which is we campaign in poetry, we govern in prose and I would take it a step further; we campaign in poetry, but we frequently end up governing in arithmetic, that's that what we have to deal with, as you so well know because that's what you deal with. And I'm just wondering, have we achieved the kind of innovative changes to our -- the healthcare delivery for the people who are already in the state plan? I mean, are we getting surgeries being done differently or medications being administered in some way differently? Are we saving lots of money? I understand the negotiations with Big Pharma because we have market buying power to kind of negotiate from, but in terms of the -- what sounded like technological type of innovations or changing the way healthcare is actually delivered, it seems to me that's got to be a big -- if we're going to save

money, that's got to be a big piece of the savings, so are we achieving those kinds of savings?

KEVIN LEMBO: I have a team in the office, Representative O'Neill, that works on this every day and in so many ways it's hard to list them all, but I will get you a list of what has already been achieved and what we are presently working on that is baked into the second year of the biennium budget changes that are before this legislature this year. So to highlight, not just negotiating with Pharma or with our PBN to get better pricing, but getting to the point of full transparency in auditing and clawing back where we need to was a really important use of that. Getting to the point where a physician at the point of prescription can see on his or her screen this is what you're prescribing, this is the cost to the plan, here are the clinical alternatives, do you still want to go forward, not in any way stopping them from doing what they want to do, but that simple information that -- talk to any physician or prescriber of any kind and they'll tell you they have no idea not only what something costs or even from plan to plan what it costs, that actually helps a lot.

The direct negotiation with the hospitals is not only new for us, it's sort of new for public entities in the country. There are a couple of us, a handful, that are doing these things, stepping out from behind the curtain where we always assume that we would hire a third party administrator, often in the entity of an insurance company, and they would not only pay claims, but manage the network and do prior authorization and utilization management and all of those things, but by virtue of their size, we were always going to enjoy the benefit of the best

possible pricing in the market. That's not true and employers, large employers, public and private around the country, are realizing that right now. When hospital CEOs came to me more than a year ago now and said we should negotiate directly for bundles of care around hip replacements, about identifying centers of excellence, that took a conversation and actually put it into action that was passed in the budget last year.

So there was talk in the building at that point of let's control costs by just setting a reference point price for Medicare, right. Let's say we're going to pay 175, 125, 225 percent of Medicare, achieve the savings, and move on. I think we were persuasive enough to get people to realize that just reinforces the existing model, it reinforces lower quality, it doesn't highlight the high quality performers, so we're going hospital by hospital, system by system, to achieve those savings. You know, I've got to find another \$90 million dollars in that plan, I think the number is, for next year and I'm responsible to do that. And we achieved something like slightly under \$50 million dollars in savings this past fiscal year or the one that's about to end. So there's a lot going on around that and more every day and again, that's just sort of off the top of my head, Representative, but there's way more I'm happy to share with you.

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

REP. SCANLON (98TH): Any further questions of the comptroller? Senator Kelly.

SENATOR KELLY (21ST): Thank you very much, Mr. Chairman. Thank you very much, Comptroller, for

being with us this afternoon. Good to see you, haven't seen you in a while.

KEVIN LEMBO: It's been a while.

SENATOR KELLY (21ST): It has.

KEVIN LEMBO: Happy days, we're back in the building.

SENATOR KELLY (21ST): Exactly.

KEVIN LEMBO: Can I confess? I hate this. I love you all, hate this. Love you most.

SENATOR KELLY (21ST): We'll try not to make it any worse than you already feel. You know, I do appreciate your comments to begin with because I believe if there's one issue that's really at the top of mine for all voters is healthcare and you delineated why, we hear the same thing, and, you know, we're committed to the same result. As you heard from Senator Lesser and Representative O'Neill that two individuals can see the exact same thing, but there's still different results and many times, it's not getting to the final destination, but it's the road to get there. So I know that we've had conversations on this subject over the past couple sessions and we all want to get to that good result. So I am going to keep an open mind, but what I want to do is along the way is to get some -- a little bit more detail on that.

Just from a personal perspective, you know, as a Republican, I have, I guess, an innate sense of contempt for government. That's just kind of baked into us, but as an individual cautious, but on the other hand, I have the same dose for corporate America. My dad was a brake shoe salesman for

asbestos brake shoes. We know what their history has been, not only to the environment, but also to its employees and after giving a life to that company, he was cut short and just let go, so that's not fair either. We've got to be mindful of what and how people are treated and I think that's our job to endeavor to do that. So I want to look at this bill and I have a couple of questions, a series of questions. I know you were just talking before I came in about negotiating with hospitals and I had heard that on the public hearing, or not the public hearing, your press conference that you were now negotiating directly with hospitals. Who negotiated with the hospitals before your involvement?

KEVIN LEMBO: The insurance did.

SENATOR KELLY (21ST): The insurance companies?

KEVIN LEMBO: That's right.

SENATOR KELLY (21ST): Okay. And did they put contracts in place?

KEVIN LEMBO: Did the insurers put contracts in place with the hospitals? Yes, of course.

SENATOR KELLY (21ST): And are those contracts still in place?

KEVIN LEMBO: They are in place until their expiration and they're different from facility to facility or system to system.

SENATOR KELLY (21ST): So now you're negotiating with these hospitals. Have you been successful in negotiating a lower price than the insurance carriers?

KEVIN LEMBO: So at this point, Senator, the track of the negotiation looks something like this. I do the introductory meetings, meet with the CEO and their management team, explain to them what we're doing, why we're trying to get there. To a CEO, the response has been thank you for engaging us, thank you for not doing something to us without talking to us, and we're happy to talk with you about ways to get this done. They're committed to the same things we're committed to. Step two, a lot of data gets generated around the cost of care for that particular facility where there may be quality outliers or quality highlights that need to be identified, and then a system by system negotiation is underway as we speak that looks at or looks at reinforcing of statements of the facility around -- in response to what are you good at.

We ask them like what are you really good at, where do you think your centers of excellence are, and then we bring the data and compare them to their peers and we identify those centers of excellence, so that's one piece of it. And the other is how many bundles, how many procedures do you feel ready to share a little bit of risk with us because your quality side and you're doing this efficiently, where can we look for savings with us and a potential upside for you. The net dollars and cents of this exercise is embedded in the savings number for year two, but what it will be on a facility by facility basis, I can't tell you now and even if I knew at this point, it would probably be a bad negotiating move for me to say out loud where we are.

SENATOR KELLY (21ST): Fair enough. Thank you. So I know on line 40 in this bill, it references insurance. How is this an insurance product?

KEVIN LEMBO: The only piece that I would call insurance is the individual piece that we go to the private market for because it's fully insured.

SENATOR KELLY (21ST): Okay, so --

KEVIN LEMBO: The rest of it is a health plan, not unlike the one we're covered under.

SENATOR KELLY (21ST): Okay. So it's not an insurance --

KEVIN LEMBO: It's a self-insured insurance plan. I think that's what we all call them. Is your insurance fully insured or self-insured is what we ask people, the question generic insurance or legal insurance?

SENATOR KELLY (21ST): So will it be regulated by the Department of Insurance?

KEVIN LEMBO: The individual piece certainly would be and I think it's fair, because I did hear a question raised about what do we do about giving confidence to those folks who are going to participate, if it is outside the reach of the Connecticut Insurance Department, I think the plan that we're talking about as an addition, the Connecticut Plan today, should be covered by ERISA and we should have to comply with that up to and including the point where it open up the state employee plan to ERISA as well. I think we should be open to that as an individual protection.

SENATOR KELLY (21ST): But ERISA is a federal --

KEVIN LEMBO: It is.

SENATOR KELLY (21ST): -- statutory --

KEVIN LEMBO: Which covers 60 something percent of the market is self-insured, more than 60 something percent, is covered by federal law and you have very little reach into what goes in those plans as state legislators.

SENATOR KELLY (21ST): But as a government entity, would you be opposed to being subject to the Department of Insurance and its regulators?

KEVIN LEMBO: Not on the individual market, certainly, because they're bearing risk, but beyond that, the precedent of putting a fully insured -- a self-insured plan under the regulation of CID I think is bad precedent and may open a can of worms for folks who also offer a plan who will wonder how long that slippery slope that often gets talked about leads to their door, so I think CID is not the right regulator for the self-insured part of this program. That said, the insurance department sits in on the Healthcare Cost Containment Committee. They are part of our RFP process. There is specific language in the statute that has me checking in with CID, you know, on our plans for bidding and innovation, so in that way, I would hope they would continue in that role, not as a regulator, but as a highly educated partner.

SENATOR KELLY (21ST): But don't you see the benefit of having the regulator at least look at your rates to make sure that you're not overcharging or undercharging, but right sizing the user fee that you're going to be charging?

KEVIN LEMBO: CID would see those at the Healthcare Containment Committee because I believe everything we do on this plan has to go back to them for approval before the rates are officially set, so that would be the moment where they would have input into what those rates should be. You know, you get ten actuaries in a room and you're going to get 12 opinions.

SENATOR KELLY (21ST): But here you're going to have and compete with, I'm going to say, insurers, carriers, who are subject to DOI regulations and rules, but you weren't be if I'm correct?

KEVIN LEMBO: Only for their fully insured business. The bulk of the business they do has nothing to do with CID, nothing to do with you guys, nothing to do with this building at all. You have no reach into those self-insured plans, limited reach, I should say.

SENATOR KELLY (21ST): I understand self-insured, but you're going after in the bill, if I'm not mistaken, small business, 50 and under, nonprofits who are generally not self-insured?

KEVIN LEMBO: Not so, Senator, I'm sorry. That's just not true. As a matter of fact --

SENATOR KELLY (21ST): Do you think small business and nonprofits are self-insured?

KEVIN LEMBO: Yes, the larger nonprofits certainly are and there's been a move in the market in the last number of years to sell what they're calling hybrid policies, which I'm sure you're aware of, to smaller and smaller businesses, both nonprofit and for, that have an insurance core with an excess loss wrap around it in an effort to get folks into that

self-insured market and I think it largely takes them outside of the reach of CID and I would argue that that's not a good thing because they are not equipped to be self-insured.

SENATOR KELLY (21ST): Okay. Where in the bill might I find the requirement for insurance actuarial expertise?

KEVIN LEMBO: We could certainly add it in, but the rate setting is done by actuaries that we contract with. Again, as I said earlier, I don't do this on my own. It's not like I sit and try to figure out what you should pay. The actuaries that we hire do that. If you want to add in language that says they must be approved by an actuary, that's happening anyway. I'm happy to see that.

SENATOR KELLY (21ST): Okay. If we were to look, for instance, at the Connecticut Health Trust Fund, in the account, if that experience is a surplus and user charges over claims, what happens to the surplus?

KEVIN LEMBO: Well, one good year does not a trend make and so the dollars in that account are non-lapsing and they would remain there. Premiums would be set accordingly and you go forward because while we may have had a good year this year and have \$20 million more dollars, next year may not look like that. There is no thought at this point to rebate back. That said, there should be some thought in premium setting of the surplus when premiums are set.

SENATOR KELLY (21ST): Okay. Now, with regards to the -- So as I understand it, there's a surplus, you keep the surplus?

KEVIN LEMBO: We don't keep the surplus. It stays in the account because it's there to serve the members who buy in.

SENATOR KELLY (21ST): The trust account --

KEVIN LEMBO: It remains in the trust account to pay claims that come in.

SENATOR KELLY (21ST): Okay, and if it's a deficit?

KEVIN LEMBO: Well, we have to figure out, together I hope, what the appropriate risk-sharing, if any, looks like and that's one of the pieces that is, you know, not there but needs to be discussed. Are we going to share risk at the top as we do with the partnership plan right now? Maybe that's right. Do we want to create a risk corridor there where we share in the risk corridor, but then they're responsible for the excess? We might have to look at there as well. I would say the partnership plan has been a huge success for those who are participating and stands to be a bigger success in the next year or two with the flexibility we've received and it has given teachers and firefighters and police officers access to great coverage through their employer and has brought property tax relief into those communities as well, or at least should have unless the money difference got spent on something else, which I can't control.

SENATOR KELLY (21ST): So when we look at the medical loss ratio, under the bill you're looking at 90 percent?

KEVIN LEMBO: Correct.

SENATOR KELLY (21ST): That's higher than the Affordable Care Act?

KEVIN LEMBO: It is.

SENATOR KELLY (21ST): Okay. What happens under your plan if you don't attain that 90 percent aspirational goal?

KEVIN LEMBO: That's sort of what the statute demands we hit, so I'm not sure I understand your question.

SENATOR KELLY (21ST): Well, under the Affordable Care Act, depending on what you're --

KEVIN LEMBO: The claw back.

SENATOR KELLY (21ST): They're at 80 or 85 percent, if you don't make that number, there is a check cut back to the individual who was the insured. What happens in your case?

KEVIN LEMBO: I would certainly be open to that, but a world where we would have a better than 90 percent MLR is an interesting scenario, but I would be open to that same claw back provision.

SENATOR KELLY (21ST): Okay. And either one of my questions is going to how do we know that you make or don't make the 90 percent medical loss ratio? Where's the transparency to make sure that you did hit it, didn't hit it, and if there's a check going back, where's the catchment point?

KEVIN LEMBO: Senator, I hope there will ever be a question in this building whether I am in favor of transparency and encourage others to do the same. Everything we do must be transparent and it will be.

SENATOR KELLY (21ST): Okay, well --

KEVIN LEMBO: Do you want to codify that because one monkey doesn't stop the show and I could hit by a bus, absolutely, please do that.

SENATOR KELLY (21ST): That's really where I was driving at. I don't see it in the bill.

KEVIN LEMBO: But I want to own my bona fides around transparency.

SENATOR KELLY (21ST): Okay. Now, the offering, you've talked about it being on the same platform.

KEVIN LEMBO: Correct.

SENATOR KELLY (21ST): Okay. Would these individuals be in the same pool with the state employees?

KEVIN LEMBO: No.

SENATOR KELLY (21ST): No, so it's not the actual same plan?

KEVIN LEMBO: Same design, same platform, same reimbursements, same structure, same administrator, same TPA, same everything, but they would be in their own plan sitting on that platform.

SENATOR KELLY (21ST): But now as I read this bill, I see that you're looking at a geographic area versus partnership 2.0, I believe, was a geographic area by county and I saw that as a substantial difference. Am I missing something?

KEVIN LEMBO: No, we would use the same. Geographic, it means county, and we'd look at the cost of care in those counties.

SENATOR KELLY (21ST): Okay, but couldn't it, in this bill -- I know in 2.0, it was county?

KEVIN LEMBO: The same language would be sought in this bill and should be if it's not the same.

SENATOR KELLY (21ST): Okay, because right now it just says geographic area, which I could see as being drilling into a municipality --

KEVIN LEMBO: Exactly.

SENATOR KELLY (21ST): -- which is a little bit --

KEVIN LEMBO: Laser, you know, that whole thing, right, yeah, yeah.

SENATOR KELLY (21ST): Right, okay. So this requires somebody to be in the program for three years. Is there anything in the bill that would prohibit the user fee from increasing in that three year period or is that going to be a year to year, could go up, could go down?

KEVIN LEMBO: It should be able to float up and down as needed in the face of a surplus or, you know, a great MLR year or what like sort of whatever the experience of the group is. It should be able to float. I would love to report a negative premium increase.

SENATOR KELLY (21ST): And is there anything that would require you to always provide the same level of service or benefits?

KEVIN LEMBO: So the benefits are, you know, the requirements around the benefits live in two places. One is the one that sets the state employee and retiree design that we all enjoy and the other gives me the flexibility through the Healthcare Cost Containment Committee to design alternative benefit structures, including a narrow network that may be health systems sort of designed or geographically

designed. That would be lower cost, but you have to make a conscious decision before you get into one of those plans, whether it's a Yale Plan or a Hartford Plan or, you know, pick it, so those -- The mechanism for approving those or not goes through the Healthcare Cost Containment Committee. I don't know that I have ongoing opportunity to create more and more and more plans in the simplicity of -- the administrative burden of the plan demands that there be to a couple limited options and we not keep changing the game.

SENATOR KELLY (21ST): You reference a couple times now the Healthcare Containment Committee?

KEVIN LEMBO: Correct.

SENATOR KELLY (21ST): We're here in the -- what we like to call the insurance capital of the world where we have, I'm going to say, some of the best and the brightest when it comes to the insurance industry and being able to understand risk. How many individuals are on that committee from that experience or that profession?

KEVIN LEMBO: There is -- There are actuaries that come from the management and labor side, but nobody who represents an insurance company, for example, because again, not insurance, right, for starters and B, it's really a mechanism by which the collective bargaining agreement -- The reason it was set up in the first place was to monitor the collective bargaining agreement in reference to the health plan, to make sure we were complying. It's taken on greater responsibility in statute over the years, including partnership and some other things, but that's really its core mission, is the management/labor negotiator.

SENATOR KELLY (21ST): Okay, which is, you know, while I understand it's not insurance, we're still looking at risk because you're going to ask a user fee and based on that user fee, you're going to make claims and that's all based on risk and I would think you would to have --

KEVIN LEMBO: We do, Senator, I'm sorry. I didn't mean to sort of give you the wrong impression. So we go out for contract for actuarial services every couple of years. You know, we use Segal, we use others who have -- We have a number of consultants that work with us in the administration of this plan from actuaries to disease management specialists to folks who are helping us with the bundles that I described earlier and in every one of those, except for the disease management one, there are actuaries, many of whom have spun off of the insurance industry, right? So when we look at sort of what's happening in our economy and where the growth is occurring, it's not happening in the big mega businesses, right, it's happening in those small businesses that are going from two to four and expanding from there.

The job loss in the big size has been significant over the years without any threat to business -- their business model. It's just the natural cycle of what's going on, so many of those highly trained actuaries you talk about and others, insurance executives, are part -- and go off and start these other small companies that we contract with. So -- And I think you'll see more of that, not because Connecticut is considering the Connecticut Plan, but because that's the evolution and the life cycle of their business model.

SENATOR KELLY (21ST): The other aspect is, you know, not looking at user fees, but benefit levels. While you talk about this as high quality and offering it to everyone, one of the concerns we often see in -- was mentioned earlier that we legislate by numbers. In things like, you know, a bill that's kicking around again this year, the prescription drug formulary bill, and many times you'll see the initiative that's designed to give consumers a greater protection against pharmaceutical companies moving drugs between tiers in any calendar year is often exempt from the state employee plan, so the state employee plan doesn't have protections that I'm going to say a fully insured individual would have.

KEVIN LEMBO: A third of the insurance written in the state, but yes, you're right.

SENATOR KELLY (21ST): Right, but still, they get -- So there are examples of where the state employee plan doesn't have all the protections and benefits of a the fully insured market.

KEVIN LEMBO: I cannot think in my ten years in this job and my experience with the comptroller's office over a long time now where the Healthcare Cost Containment Committee has not adopted a mandate that the Insurance Committee and the legislature have passed through. I can't think of a time that happened and that's not good will, that's the power of negotiation and that sort of labor management. You can be sure that labor brings that to the table and they want it to be added in and management tries to probably get something else from them in order to put it in.

SENATOR KELLY (21ST): Now, regarding Partnership 2.0, do you know how many premiums were received and total claims paid in Calendar 2019?

KEVIN LEMBO: Off the top of my head, I don't, Senator, but we will get you a breakdown of sort of the in and out if you would like to see that.

SENATOR KELLY (21ST): In 2018, there was a loss. It ran at 107 percent of --

KEVIN LEMBO: Correct.

SENATOR KELLY (21ST): -- of user fees. Do you know where the money came from to pay that overrun?

KEVIN LEMBO: So there was a truing up, I believe, with the state plan at that point because we were running a little behind our claims, but I will double check and make sure you have that information as well.

SENATOR KELLY (21ST): When you say the state plan, you're talking about --

KEVIN LEMBO: The state employee plan.

SENATOR KELLY (21ST): The state employee plan?

KEVIN LEMBO: Correct.

SENATOR KELLY (21ST): So in that case, the state employee plan may have absorbed the cost of the partnership?

KEVIN LEMBO: Use of it certainly. An expected piece, as I think I've already articulated, I think we all knew that was coming. The question was what was it going to look like given the selection of people who came in and where they were coming from and the cost of care in those places. Pulling back

from that a second, Senator, I'll just say we all make sort of risk/reward decisions every day with pieces of legislation that move through this building and some of them do put the state at risk and some of them put the taxpayer dollars at risk, but you think it's the right thing to do in some cases and so it gets done. So whether we have an insurable interest or the same sort of goals as municipalities and we can help them to control their healthcare costs, I can't think of a better thing for us to be doing, given their need for other resources to make municipalities run.

The idea that, again, cops and firefighters and teachers would have access to a good plan because you decided to allow that to happen and to have some level of risk-sharing at the top is a very high-minded and appropriate thing that happened through this legislature and when I compare that, for example, to other ideas that kick around the building, around, for example, the high-risk pool idea, well, yes, we may be able to seek a waiver or yes, we may be able to get state taxpayer dollars to fund a risk pool. That's putting state dollars at risk as well and creating a dynamic where big corporate insurers are able to wash through -- high claims through there and we'd better be darn sure that we're protecting the state's interest as well.

So I just make that point, Senator, to say this isn't unique and if we're really committed to putting our money where our mouth is and to saying we're here to support municipalities and we want to make things better and we're here to support nonprofits and small businesses, these are ways that we can do that. We can bear risk, not open risk, please don't misunderstand me, but we are a big

purchaser, we are the state of Connecticut, within reasonable corridors, we can bear some risk if it leads to greater value downstream to those municipalities and others because the alternatives are the small business has to bear the risk, the municipality has to bear the risk. What happens when a single municipality has a bad year? Well, then their numbers are all sort of out of whack and then they're coming to you anyway to seek additional support or you have to pay the insurance carriers to bear risk. That comes at a very high cost and I think we see now that the cost of getting the carriers to bear that risk has reached the point where it's unreachable for the majority of folks in the state of Connecticut.

SENATOR KELLY (21ST): Yeah, I don't necessarily disagree with trying to help, you know, but I think there's more to it than just local government, small businesses. There's people, middle class Connecticut who are looking for help, but at the same time, it's not just healthcare help. There's a real weight on what I call kitchen table economics, where the middle class in Connecticut we hear all the time that over the past 15 years, the cost of healthcare has increased by 77 percent, but the mean income in Connecticut has only been 21 percent, okay? The Connecticut economy has failed to perform for the middle class and they're struggling, they're struggling paying their healthcare costs, they're struggling paying their taxes, so while we want to do the aspirational goal to bring better quality healthcare to Connecticut families so that they get the promises that have not been delivered on the Affordable Care Act, which was lower insurance, higher quality, greater access, that has not been

the experience. The experience has been in Connecticut the two largest tax increases and the Connecticut middle class is crying, screaming uncle. So while we want to do this, the question that I have is how do we mitigate that risk, how do we provide the healthcare that they deserve, but not the big tax bill and to that extent, would you be open to stop-loss insurance or some other tool that would --

KEVIN LEMBO: I would be open to some tool. I absolutely -- Senator, I think, and I appreciate you getting this on the record, but I hope at this point, the concerns you just articulated are concerns that we share in common and I know you that and when I look at the national job picture, it's not just Connecticut jobs. When you look at -- I would encourage you to look at the letter of the first I put out every month, I know some of you read it from cover to cover, but there is a new entry into that report that talks about quality -- the quality jobs index and it is startling nationally what is happening. Yes, unemployment at whatever it's at, but what are the quality -- what's the quality of those jobs and they're horrible, they're horrible, so yes, kitchen table economics. What's actually happening in the paychecks of the people in the state of Connecticut has to be concern number one for us always, but I would argue that these investments, and that's what I see them as, whether it is sharing some level of risk or developing something, or anything else you do, these investments in municipalities, small businesses, nonprofits do two things.

One is you make it easier for them potentially to hire more people, to hire more qualified people.

You make it easier for a mill rate not to go up. You make it easier for a nonprofit not to potentially go out of business. Coming back at you as the legislature and governors saying we serve 150 developmentally developed people and we're out, right? That's our responsibility as a state. They're doing this as our proxy, right, they're coming back to us, so here's an opportunity to for us to make an offer to them that makes their balance sheet a little bit better and allows them to do the work that they need to do. So yes, I would be open, of course, to figuring out ways to mitigate big exposure to the state. A stop-loss private sector policy, we would have to debate that and see what the terms look like.

SENATOR KELLY (21ST): Thank you. I'm going to get to the part of the bill that I really have trouble wrapping my head around.

KEVIN LEMBO: So we're going up, we're not going down?

SENATOR KELLY (21ST): I don't know. I think we're just going across the board. It's the whole concept of buying into Medicaid, which is a welfare program, and how does somebody buy into welfare?

KEVIN LEMBO: So Senator, I will, at the risk of looking like I'm sidestepping your question, not the part of the bill that I'm most intimately involved with and you do not want me talking about Medicaid because I'll get 90 percent of it wrong.

SENATOR KELLY (21ST): That's fair enough. I won't excoriate you with Medicaid questions. That would be totally unfair.

KEVIN LEMBO: I appreciate that.

SENATOR KELLY (21ST): So I guess just one -- If you do this and offer this, your department is then going to have to deal with a lot of claims and customer service issues. Is that going to require additional staff, bureaucracy, or can you do that on your current I'm going to say footprint platform?

KEVIN LEMBO: Yeah, so most of what you've described, Senator, is performed by the private sector partners that we contract with to do that work. That said, it's not unusual for folks to bypass the carrier and get to well, frankly, my desk, right, because they're having a problem with the plan. I think to be frank, there would be some additional bodies that would be necessary on my staff, mostly to manage the additional sort of workload, but we're talking about a relatively small, incremental -- and I actually can't put a number out on it for you today, but I'd be happy to do that in the not too distant future. It takes bodies to make something like this run. The cost of those, not unlike partnership, however, get wrapped into the administrative load on the rate, so when we do partnership, yes, I have a couple more bodies on my staff that are performing my work, but the cost of them being there gets wrapped into the partnership rates in the next year.

SENATOR KELLY (21ST): And you're looking at putting most of this like on your third party administrator?

KEVIN LEMBO: Yeah, I don't process claims among networks and I don't know if you should get your knee replacement or not and you don't want me making that decision, exactly.

SENATOR KELLY (21ST): Well, I appreciate your candor and your time that you've spent here answering the questions. Thank you very much.

KEVIN LEMBO: Senator, thank you. I always appreciate the back and forth and I always hope we can get to yes and if we can't get to yes, I think the fundamental question is if not this, then what because door-knocking time is coming and as you said, our constituents have been clear, they're suffering under the cost of this and so, to say I'll do a little tinker over here, look what I did, is not going to be enough for them, I think.

SENATOR KELLY (21ST): Thank you.

REP. SCANLON (98TH): Thank you, Senator. Any further questions of the comptroller before he gets to lunch? Anyone else? Seeing none, thank you for being with us this morning.

KEVIN LEMBO: It was great to see you all. I look forward to the continued conversation.

REP. SCANLON (98TH): All right. I saw Senator Looney, but now I don't, and I have not seen Senator Fasano yet, which means that we're upon Vicki Veltri.

VICKI VELTRI: Good afternoon, Representative Scanlon and Senator Lesser, Senator Kelly, Representative Pavalock-D'Amato. I'm Vicki Veltri. I'm executive director of the Office of Health Strategy. I have a couple of guests here with me today. On my left is David Seltz, who is the executive director of the Massachusetts Health Policy Commission, and on my right is Rachel Block, who is program officer with Milbank Memorial Fund and they are both here today to assist in the discussion around House Bill 5018, which is the governor's bill, and includes several provisions. I have my colleagues from other state agencies who are

going to testify on other provisions, but I am here today to support the healthcare cost growth benchmarks provisions of House Bill 5018.

As you all know, and we have written testimony so I won't repeat it, we have been working for a long time together on this bill and the Governor's Executive Order No. 5, which was issued on January 22nd of this year. That executive order and this bill both require OHS to develop annual healthcare cost growth benchmarks beginning calendar year 21 by December of this year to set targets for increased primary care spending to reach 10 percent of total healthcare spending by 2025, to develop quality benchmarks beginning in calendar year 2022, to monitor and report annually on healthcare spending both across all public and private payers, and to monitor the development of accountable care organizations, or ACOs, because everything in healthcare has an acronym, and the adoption of alternative payment models.

In short, Senator Kelly brought up a point that we reference a lot in our office, which is that through some of the work we've done to try to develop an affordability standard for the state, we did an analysis of data that showed that healthcare costs increased by 77 percent, while median rate of income growth was at 21 percent. That's just an untenable situation for our consumers and what we're seeing in healthcare cost growth is related to price increases and that's been substantiated in multiple peer-reviewed literature articles that you can see any -- that we can provide to this legislature, but recently the Healthcare Cost Institute just came out with its annual report which showed in Connecticut, prices have increased almost 15 percent over the

last four years, while utilization is only increased by 2.5 percent overall.

That just can't keep happening without us doing something about it. What we like about the healthcare cost growth benchmark is it's a proposal and an executive order. It brings people around the table to strategize around these issues and try to do something about these increased costs that we're seeing in the state of Connecticut. It is not price setting, it is not reference pricing as was just discussed previously. It is an effort to try to decrease the rate of cost growth over time and tie it more realistically to the rate of growth of other things that we see growing in the state of Connecticut, a reasonable economic measure of the rate of growth.

We think that that's the route to go is to bring those parties around the table and just recently, we announced the establishment of both a technical team and an advisory -- stakeholder advisory board to help us with this process and I think if you look at the list of people on both of those groups, you'll see it's highly representative of the healthcare industry in the state of Connecticut, our employer sector large and small, consumers, the plans, health plans, in the state of Connecticut, our providers, and state government.

And we think that's the route we would like to take. I won't take a lot of time describing it. You know, we've had lots of discussions about this issue over the last year and we've had the benefit of that last year to get I think the kind of support we need to move forward. You know, we're happy to continue to discuss ways to make the goal better, but we feel

very confident that we've gotten a lot of partnership on this proposal and think it's the route we need to go to put the attention where it needs to be on the rate of growth of cost in the state. So with that, I'll let both David and Rachel make some comments to provide the Committee with some additional information.

DAVID SELTZ: Great. Good afternoon, distinguished members of this committee. It is really an honor to be able to testify here today on the healthcare cost growth benchmark. I'm David Seltz. I am the executive director of the Massachusetts Health Policy Commission and I just first want to commend the governor here and this committee and this legislature for really your attention and focus to this critical issue of the high and unsustainably growing cost of healthcare. Senator Kelly and Senator Lesser, as you both mentioned earlier, this is a nonpartisan issue. When we look across the country, 80 percent of Americans say that taking steps to reduce healthcare costs is extremely or very important and we know this because the affordability challenges of residents, small businesses, and governments are facing are really real.

In Massachusetts, we have a very high performing healthcare system. We have are home, like Connecticut, to some of the best health plans and hospitals in the country, but we are also a very high cost healthcare state and so in 2012, the entire healthcare community and our governments, policy makers, consumer advocates, business leaders all came together around a new reform idea, this idea of setting up a target for more sustainable cost growth and so what we've called this is our

healthcare cost growth benchmark and it's set in law and it's tied to the overall longtime rate of growth of the state's economy or 3.6 percent. And this is an ambitious goal for Massachusetts because prior to the passage of this law, we were seeing in some cases double digit annual year over year cost growth.

The target is just that. It is a goal. It is not a cap. It is something that every part of the healthcare system begins to work towards that we can track and monitor our progress, that we can use data to understand what it would take to hit this target and this goal, and it is really something that over time, we can really start to save a lot of money in healthcare. And so we do that not by price setting, but through collaboration and communication and partnership with all the different component pieces of the healthcare industry. The law also established the Massachusetts Health Policy Commission. We're an independent state agency that is solely focused on this mission and this goal and in working with all the pieces to identify those opportunities.

Since this law has been passed, we have made considerable progress in reducing the healthcare cost growth in Massachusetts. Every year since this law has passed, our healthcare cost growth has been below comparable U.S. averages and every year since this law has been passed on the commercial or kind of the employer part of the business, again our rates have been below U.S. averages and if you add up the difference between our growth rates and the U.S. growth rates and what we would have spent, it would have been \$7.2 billion dollars more over these last couple of years. That's \$7.2 billion dollars

that otherwise would have been put onto the backs of employees and employers in the form of higher premiums, copays, and deductibles.

We think the benchmark is a great tool to have kind of this central organizing principle to bring all the pieces together and we, today, still have the support of our hospital society, our medical society, all of our major health plans, all of the big organizations that are a big part of our healthcare are supportive of the HPC, supportive of the healthcare cost growth benchmark and see it as a way that we can all work together to achieve our shared goals. In closing, I would just say as Connecticut is beginning this journey, I want to extend my hand in partnership and in collaboration. If there are any resources that I can provide to you about our experience in Massachusetts, I'd be happy to do so. I'm a huge believer in states as laboratories to test, to innovate, to learn, to share successes and failures and I think there's a great opportunity for our states to do that, especially as our states are beginning to have a more regionalized healthcare system, certainly New England, so extend that offer of assistance and commend your work on this issue.

VICKI VELTRI: So thank you, David. David's already been, as you know, a partner to us for the last -- even before we started this legislative process even a year ago, he's been partnering with us on it, and I just want to bring up a couple points before I hand it off to Rachel. One is we put this bill in in part because we wanted to codify the executive order. There are a couple things additionally in this bill that were not explicit in the executive order and one is around the performance improvement

plans. I don't want to suggest that they're not in there, but Massachusetts, we've included provisions around a performance improvement plan should someone exceed the rate of growth that we set for the target. We think that's a process. We can talk to people, we can target initiatives that bring that cost growth under control if the cost growth exceeds, you know, the benchmark for a particular year.

There are also provisions in this bill that would protect certain data, confidential data, from being disclosed that would otherwise possibly be disclosed. The other thing that we think is important is not be redundant in data collection. OHS is the host of All-Payer Claims Database and many other sources of data that can be used as tools in this process and we are very cognizant of not wanting to overburden any of the partners that we have in this process with additional data requests. So that's a very key point I want to make here that, you know, if there's something we need to adjust on that we will to make sure that that's the case.

But importantly, and something I didn't mention earlier, is the governor's executive order and this bill also really focuses on primary care, that's important. We've been spending a lot of time over the last four or five years in our office trying to help providers, with our health plan partners, to try to redesign healthcare delivery around primary care, to really emphasize it. We're not going to increase the rate of cost growth without emphasizing the importance of primary care and increasing our share of spending on it. Right now Connecticut, depending on the reports you look at, is either the worst overall or near the bottom of primary care

spending as a share of overall expenditures with the exception of our Medicaid program. We have to do something about that. We can be much better and other states that have done that have seen a correlation between their primary care spending increases and emergency department utilization visits dropping. That's absolutely critical for us moving forward. That's why we put the primary care target in there and quality is equally important and that's why quality benchmarks are in there, but, you know, it's very hard to tackle all of those things at once, so that's why quality is out one year. so with that, I'll ask Rachel if she can make a couple comments.

RACHEL BLOCK: Thank you very much, Vicki, for inviting me. I'll really build on some of the points that David made. The Milbank Memorial Fund is an operating foundation dedicated to informing state policy makers with evidence and experience on strategies to improve population health. Our job is to connect state leaders across executive and legislative state and party lines with each and with experts who help them craft strategic and practical solutions to address complex healthcare issues. As a foundation, we take no position on legislation in general and we will not speak so much to the merits of this specific bill, but the letter that we have submitted for your consideration to the Committee provides some context that we hope is helpful. I'd like to summarize a few of these points.

It is hard to find a more complex problem than rising healthcare costs, as has already been discussed by several people you've heard from today, but across the country more and more state leaders are joining with the private sector to untangle this

big knot, starting with increased transparency of information on healthcare spending. We know that a focus on healthcare cost growth can work. Several states have capped the annual rate of increase in growth in their Medicaid programs and a few, including your neighbors in this region, are expanding this focus to look at healthcare spending across the entire system. As you know, Massachusetts, and David can represent more detail here, has the most experience and to date, the results are encouraging, but this has actually become almost a national phenomenon now. Oregon recently passed legislation and is moving forward with efforts to set a benchmark very similar in process to what mass has done.

As you know, Connecticut here, the executive order and legislation has been introduced and we are currently working with several other states that either have legislation pending or are considering taking this action just this year. There's actually a parallel here to a certain extent. Vicki mentioned increased primary care spending. This is another topic, a priority topic, for the foundation. We've been working with the state to share information about legislation, how to measure primary care spending, how to increase primary care spending, and what we found that a couple of states took the lead and then shortly thereafter wanted some experience sustained to see that this was an effective strategy to increase primary care spending. We had nine states take action, both legislative and regulatory, to move in that direction last year. We're expecting a similar phenomenon to happen this year.

So I'm simply suggesting that one of our roles is to help identify these key practices that are successful and share those with other states and we've been pleased to serve as an advisor to Vicki and her team and we also benefit from learning from Massachusetts at the same time. Why focus on total health system costs? Well, this broader focus is important because otherwise, as you probably often hear, costs may be shifted from one payer segment to another or resources may be increased in some provider segments shortchanging the others. If the increased cost is concentrated on higher cost services, that cost growth impact is multiplied and investments in more cost effective services, like primary care, can get squeezed out. So it is important not only to see where the dollars are going today, but to plan for how we would like to shift those resources to areas like primary care that can save money and save lives.

So I'm here today to note that the mobilization of public and private leadership developing a total healthcare spending strategy, as proposed by this legislation and the executive order, is consistent with leading practices across the country. The combined effort proposed in this bill, public measurement, review, and target setting is an essential combination. The Office of Health Strategy already has a broad view and many existing policy levers that can be focused on dealing with issues relating to healthcare spending growth. Similarly, the Connecticut Health Compact, which my boss, Chris Culler, has participated in and spoken with, has a broad scope of membership and galvanized stakeholder participation and action on these issues. It will take time, it will take leadership,

and it will take persistence, but these forces combined with a clear legislative direction will help to untie that knot of total healthcare spending and provide information that empowers every sector to create effective solutions. Thank you.

VICKI VELTRI: So thank you to the Committee and obviously we'll entertain any questions you might have.

REP. SCANLON (98TH): Thank you all three for being here. I know Senator Lesser has some questions and I'm sure other folks do too, but David, if I can start with you, the number I've heard is that since 2013, you have saved \$5 billion dollars for the taxpayers of Massachusetts with this. Is that correct?

DAVID SELTZ: The updated number is now \$7.2. We got one more year of data.

REP. SCANLON (98TH): Just a casual \$2.-something -

VICKI VELTRI: Billion.

REP. SCANLON (98TH): -- billion more dollars? Okay. We'll take that. And would you characterize what the benchmark does as more of a carrot or a stick approach?

DAVID SELTZ: I think it has elements of both, honestly. You know, part of what it can do and has done is really encourage conversations around where are the cost drivers and how can we actually tackle them and it's not done in a punitive way against hospitals or against health plans, but I think really begins with a spirit of this is our shared goal, how do we work together to achieve it, and I think of that as a carrot, but there are -- is an

element of accountability for health systems or health plans that have accepted spending growth and we can require them to take action to get their kind of cost growth in line through a performance improvement plan. We have to date not had to use that tool. We have that tool in our toolbox and it has been effective, but I think we have also been very judicious to say when we go the route of the performance improvement plan, it's really important to understand the entire context of why the spending growth might have been higher for an individual health system or payer in that year and was it truly within their control and so I think we've taken kind of a judicious approach to the sticks while also thinking about identifying and celebrating the people who are doing really well,

REP. SCANLON (98TH): But again, you've never had to utilize that because the peer pressure, for lack of a better phrase, of that stick potentially being used was enough so far to not have you to use it. Correct?

DAVID SELTZ: That is correct. So far, the sentinel effect and the fact that individual health systems and payers know that they are being tracked and are being identified, and we do have a confidential process where we will go and correct directly with the leadership of those systems to say, you know, what was going on with your data this year, what was going on with your spending, tell us, help us understand, and those types of kind of conversations have led to healthy systems and plans taking corrective action on their own, even without that being necessarily required by the state.

REP. SCANLON (98TH): Got it. And talking about conversations, we hear a lot -- Probably the most frustrating thing about chairing this committee in particular, is that everyone comes into my office and says it's the other guy's fault, it's not our fault. Do you find that because of the benchmark you have been able to sort of facilitate more constructive dialog where there's less finger-pointing and more broad-based we're all looking at this globally approach?

DAVID SELTZ: I think you said that very well. One of the first things that I did as executive director is create an advisory council that is made up of 30 different kind of all of the major stakeholders in healthcare in Massachusetts and we meet, all of us together, and talk about the strategies, the work of the commission, the work of the government agency, so it does need and requires that type of kind of buy-in and trust and -- but once you have that, you can unlock that to really be able to do things even without legislation or even without, you know, government mandates, but kind of through everyone sitting around the table identifying a problem and working together on a solution.

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

SEN. LESSER (9TH): Thank you, Representative Scanlon, and good to see you, all three of you, and thank you for your testimony today on a day I want to thank you for schlepping back to Connecticut. I know you've been here before. I also paid your state a few tolls, went out to watch the Health Policy Commission live in Boston. I was really impressed. You have some really smart people on the Health Policy Commission and some of the sharpest

minds in the country. I understand that this works. I'm still trying to get my head around how it works and I think that -- In part, I guess, one of the things that I, you know, I have to note is that the Massachusetts is really focused on just one very important cost driver, looking at hospitals. My sense is that we've been trying to get a more holistic view in Connecticut and I just wanted to see if you had thoughts about how that sort of evolved, if -- and this could be either to you or to Vicki or both, but how do we look at the healthcare spend as holistically as possible and is that something that, you know, Massachusetts is looking to expand?

DAVID SELTZ: Yeah, so I would say our goal is, and I think one of the strengths of this model, is trying to get a look at the holistic system, how do all of the different pieces fit together. I would say obviously hospitals are a major part of this spend and in some cases, we have the best data when it comes to kind of hospital spending and hospital financing, but I think one of the -- again, a strength of a process like this is that over time, you can start to really expand all of the different places that you want to look at to try to understand and we've done deep dives trying to investigate the role and growth of urgent care centers, we've looked into -- we're now looking much more into pharmaceutical pricing and spending and how that plays into overall cost growth, long-term care. There are so many different pieces of the healthcare system, so I do think we try to expand and think about all of those holistic pieces and understand where the drivers are and where those opportunities

are for efficiencies and they may not always be in the same place.

SEN. LESSER (9TH): And if you can give us a specific example. Again, I'm trying to wrap my -- I've been aware of what you're doing for a while now and maybe there's a specific example you can think of where you found, you know, duplicative services or unnecessary spending that had been resolved by this. What is -- Again, I'm just trying to figure out how this actually works. The numbers speak for themselves, but --

DAVID SELTZ: I would say that it really is -- there's a complement of factors, so it's really hard to pick out just one, but I will just -- I'll say two broad things and then give you one very specific example. So broadly, what we have seen is that year over year price growth, so the negotiated prices, has moderated significantly. So what we are -- the kind of annual increases and what we're paying for services, we have seen the market in those private negotiations, those, you know, negotiations they have moderated and both the providers and the health plans have said all right, if we're going to live within this benchmark, let's have a more reasonable kind of inflationary rate. We've also seen utilization drops, so we've seen reductions in avoidable emergency department utilization, avoidable hospital admissions, so we've seen that some services that are often characterized as avoidable or unnecessary have started to, you know, have gone down and we've actually closed our gap between where we were compared to the United States, so we're outpacing the United States in actually both pulling out some of that unnecessary care.

I'll give you one really quick specific example of how I think data and convening can actually play a role. So we did a data analysis that looked at the kind of how often certain services are being provided to Massachusetts patients, services that clinical leaders now agree do not provide value, so there's this great choosing wisely campaign where clinical -- you know, physicians and clinicians have said these types of screens, tests, imaging is not necessary and doesn't provide value and we shouldn't do it anymore and yet we know our health system actually still does a lot of these things. And so we did an analysis and we looked at how often are these tests and screens being ordered and we mapped all of that to our major health systems and we put that out publically and we reported it and we named names of the different health systems and how they ranked on this particular measure.

And I can tell you that that the health system was, you know, quote/unquote at the high end of doing more of these tests, they called me immediately and said this can't be right, this data is not true, we're really working on this. And so we brought in their team, we met with them, we showed all of our data, we showed all of our methodology and they kind of said, wow, that is all right. We thought we were doing better on this. We had only seen our own data and our own performance, but what you did for the first time was compare us to everyone else, and so we could see where we were with our competitors. And so while they thought they were doing great, once they could see -- get a look at everyone else, man, maybe there's more to be done. And then we did one final important thing; then we convened a medium where we took that kind of quote/unquote lowest

performing provider and we met with the highest performing provider on this same topic and we convene a mean of those health systems and kind of like backed away and just let them talk to each other so that the highest performing one could talk about some of the things that they're doing and that lower performing one could say you know what, that sounds like a great idea.

We're going to take that back and we're going to implement that in our health system. That's not about competition. That's about providing the best patient care and so even putting data out, convening a conversation, people walk out of that with an action plan to say how do we actually reduce that. We updated that data. That lowest performing provider is no longer the lowest performing provider on the provision of those types of services.

SEN. LESSER (9TH): Speaking of -- I think perhaps building on that, we did receive testimony against this proposal from one hospital in southwestern Connecticut. I don't know if they had a number of suggestions and tweaks and whatnot and I don't know, Vicki, if you had a chance to review the testimony that was submitted on this bill, but are familiar with their concerns, but just sort of speak to, you know, the fact that there are different providers in the state that have dramatically different costs and, you know, how this sort of addresses the landscape as we have it.

VICKI VELTRI: Thank you for the question. First of all, I will say yes, I have read the testimony. I guess I would characterize the testimony as not necessarily opposing it, but offering some suggestions for improving it and we welcome that

ongoing discussion and that particular hospital is actually on the stakeholder advisory board for this work, so we expect their input to be heavily represented in that board as we do along. That's not wrong, that statement is not wrong. People are differently situated in the kind of care they deliver, the size of the system versus a small system. You know, that's why the target is not necessarily -- You know, the target is something to drive to. It isn't a cap, as David said, but it focuses people laser like on the rate of growth for their particular operation.

There may have to be adjustments, whether it's in this bill or otherwise, to make sure we are reflecting the different kind of hospitals we have, the different kinds of primary care practices we have, etc., but I would say is to the particular hospital that testified is my door is open and I expect those conversations to be ongoing for the next couple months before we adjourn the session to get this bill in an ideal format that everybody can support, but that's not to say that we will have to take into account the different kinds of hospitals we have in this state, the different kinds of providers.

And I just want to, you know, piggyback a little bit on what David said in terms of opportunity. The fact is in the primary care space, you know, you could make the mistake and say we want to set a target and then everybody just starts cutting services. That's not what this is about. The primary care target actually allows us the ability to shape care delivery reforms and things that Connecticut really needs to get on the bandwagon on that we've been sort of lagging behind other states

on to shape the way we deliver primary care in a better way so that when we achieve that 10 percent target, it isn't just by cutting services, but we're actually designing an ideal primary care system for the patients of Connecticut. So it's an opportunity, as well as it is a challenge. I'm not sure what more I can say on that topic.

SEN. LESSER (9TH): Well, I want to thank you, you and Governor Lamont and Senator Kelly and Representative Scanlon and many other people crowded into my doctor's office earlier this year when the governor signed the executive order setting the benchmarking process and it was a surreal experience to see all these folks in my office.

VICKI VELTRI: We weren't literally in his office, I just want to like make sure everybody knows. We weren't crowded in the exam room. We were in the building.

SEN. LESSER (9TH): Well, I was wearing -- I was more dressed than I often am there, but apologies if that's TMI, but -- I'm sorry. Can you give us an update on the benchmarking process? When do we think we'll have something that we can discuss in more concrete details?

VICKI VELTRI: So right now, as I alluded to earlier, we just set up the technical teams and the advisory boards. We just completed a procurement for actuarial and healthcare economic expertise to support the work we're doing. We've set up meetings for this month for the technical team and the advisory board to start meeting. I don't think we're going to have a benchmark product for you immediately because this is a longer process to dig into data, to listen to the considerations that you

just alluded to from at least one hospital or other providers about how we measure. For instance, what's in the numerator, what's in the denominator of spending, I know that's a lot of math, but actually I enjoy math, but what expenditures are actually in -- that we're considering as part of that measurement.

That's going to take a little while and not only that do we have to consider the points of view of our stakeholders, the technical expertise that has to be applied to that is pretty deep. We need to do a gap analysis, as well, on the data that we have in our office to determine exactly which data serves the best purpose for this measurement and are there other streams of data we do need to collect to make this whole, so I suspect, you know, there will be updates, but I don't expect that we'll actually have a benchmark with the public hearings completed on it until November.

SEN. LESSER (9TH): And this is, I guess, for both David and for you, Vicki, if you could give us an update on -- I mean, I know Massachusetts, I think it was Governor Baker, that announced the proposal to increase the primary care spend last year, where is that, how is that working, you know, to me, a lot of this seems like, you know, like magic, so I'm just trying to figure out how --

VICKI VELTRI: It's definitely not magic. It's a lot of hard work by a lot of people in the system, so I will say --

SEN. LESSER (9TH): Well, anything you don't understand that does work is magic, I think, so that's.

VICKI VELTRI: So I will, just to -- Obviously, David answered for Massachusetts, but we don't have to really look any farther than Rhode Island to see what the impact was about setting a target and primary care spend. They saw a significant reduction of other kinds of services that they, you know, emergency department use by setting this target. That was from ambitious work on patient center medical homes, expanding those patients that are in medical homes, ensuring there was accountability around delivering primary care in the right way, so it works, and Oregon actually has done a lot of work in this space as well, so I will let David give you an update on it.

SEN. LESSER (9TH): And is that law -- Did that law pass? Is that is effect right now as a --

VICKI VELTRI: rhodei?

SEN. LESSER (9TH): No, in the common law, yeah.

DAVID SELTZ: Sure. Yeah, so our governor, Charlie Baker, proposed a comprehensive piece of legislation last October that really kind of builds off of the foundation that we set and I think that's another kind of advantage to this type of process where you can learn over time, you can look at the data, and then say okay, what are the -- how do we evolve our policies, how do we evolve our strategies, so he is proposing to still have the benchmark, of now it's 3.1 percent growth, hold that line, but underneath that, start to increase spending in primary care and in behavioral healthcare, two areas that have been historically underinvested in and under-prioritized by kind of typical market forces.

And so it is playing a little bit from the scale. He doesn't say exactly how that has to happen. He still kind of relies on the market to figure out exactly, but it's kind of like a sub-benchmark target. It has not passed. It is under active consideration by our legislature. Both our legislator leaders have committed to passing legislation this year, so we're very hopeful about that and that particular proposal.

SEN. LESSER (9TH): Thank you very much. I think that's all the questions I have. Thank you, Mr. Chairman.

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

REP. PAVALOCK-D'AMATO (77TH): Thank you, Mr. Chair, and I want to thank you all for testifying and David especially coming down. I really appreciate it and I enjoy listening to you. I know in the past you had discussed your desire to include prescription or that element into this and I was wondering if you recommend us doing that or do you think we should kind of keep it as simple as possible initially?

DAVID SELTZ: So the -- While when it was initially put together, you know, really kind of focused on healthcare providers and health plans and had accountability tools for kind of those two big component pieces. Pharmaceutical manufacturers were not included and so one of the things that we do every year is hold an annual kind of public check-in on how we're doing and we call -- we can call the CEOs and leadership of our hospitals and our health plans to come and testify under oath and in public around their strategies that they're pursuing. The pharmaceutical industry is not part of that process

and so we do believe in kind of a matter of one, pharmacy has been one of the biggest cost growth drivers in the last couple of years. It is an ever-increasing part of the healthcare dollar and per commercial plan, they can be up to 25 percent of the healthcare dollar is in that space.

So I think we do believe that everything should be kind of underneath the tent. If we're going to have a goal and we're going to have accountability, that should apply to everyone or else if you have someone outside that tent, it's not going to -- you know, they're going to be able to grow at whatever rate they're going to grow at and we may not have that type of insight or transparency to know what's actually driving that. So I think at a minimum, you know, we've done this in kind of an evolutionary way and so, you know, I guess my recommendation is to also think about, you know, how you can start with something and build off of that, but I would say that is a spot where, you know, a lesson learned and one that, again, is part of the governor's bill is to actually kind of more fully bring in pharmaceutical into this shared goal and activity.

REP. PAVALOCK-D'AMATO (77TH): Then thank you. I really like this part of the bill and, again, I hope it does move forward, so again, thank you for coming. I really appreciate all your input.

DAVID SELTZ: Thank you.

REP. SCANLON (98TH): Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Why is the pharmaceutical industry left out and not under the tent? What's the motivation?

DAVID SELTZ: So I would say -- Well -- As I was a part of the legislative process that helped pass this bill, I would say at the time we initially passed this bill, pharmaceutical spending growth was zero or negative and was not, you know, kind of a part of the conversation in the same way that it has been in the years since and so I wouldn't characterize it just as an oversight, but something that kind of wasn't of top of mind when we were initially putting this legislation together. That market has changed dramatically, the cost growth has changed dramatically, and the projections for the future in pharmacy are of, you know, high single digit annual growth and so I think the market and the dynamics kind have changed since we first did that and we are a state that has, and prides itself on, life sciences and innovation and the development of great new innovative treatments, we're home to some great companies, and so there's always a balance in that and we have -- we have or now have, do have, authority to look at drugs and drug pricing and value for some certain high cost drugs. So we've kind of built from where we did not have that authority before.

VICKI VELTRI: Now just to follow up, it still, the Connecticut bill, does have pharmaceutical spending as part of the analysis of healthcare cost growth. That really is -- We had a bill a couple years ago, Public Act 1841, which actually in a couple days will be putting up a list of the highest cost drugs from the Office of Health Strategy, so we will be taking pharmaceutical spending into account. It's the benchmark part that does not apply. One of the reasons we frankly made that decision in talking to David and other folks was look, we've got to get out

of the gate. Connecticut, you know, we're seven years behind Massachusetts in this process. We're not -- We're just coming out of the gate now. We need to learn from experience.

We need to figure out how to factor that pharmaceutical spending in a way that accounts for, you know, new drug development and things like that so it's reasonable, so you could have a year, for instance, I forgot what year it came out, but Sovaldi, a hepatitis C drug, and that blew the costs up that year, but it was a necessary drug. They wanted people to have access to it. So we need to figure out how to factor that in, so that's the reason we're starting where we are. We're not saying we may not get there, but we to at least start the ball rolling here in Connecticut.

REP. VAIL (52ND): Well, to me they're a big part of the problem. We just passed an insulin bill out of here capping the cost and my concern is that we're not really solving the problem. We're just spreading -- You know, we capped the insurance copays, but we didn't do anything to the pharmaceutical industry. They're constantly being left out of anything and I'm just curious as to why that constantly is. I don't know, is there a lobby that strong that they're not put under the same microscope as everybody else? That's the part I don't understand. They're a huge part of the problem, and yet we keep leaving them out of all these things and we focus in on that and it bothers me, so I don't know if you share those concerns. I understand you want to get, you know, over the goal line, but to me, I want to do it the right way, right from the start. I don't want to wait, get a little pinky toe over the goal line. I want to get

the whole foot in and so that's kind of where I come from in that and I don't understand over and over again, year after year, why they're constantly left out of all this legislation. It baffles me.

VICKI VELTRI: Well, we are -- I can assure you we are as concerned about spending increases on the pharmaceutical side as we are in any other area of healthcare. We just started this bill from two years ago, which became effective in January, to get our arms around some of the highest cost drugs the state is paying for and I think armed with that information, maybe next year there's a different, you know, a supplement, about the spending, but we definitely want to do it in a rational way that actually impacts the spending. A lot of what we do around spending doesn't impact the actual price of the care, you know, you've got to -- you have to look at the price. If you want to start bringing pharmaceutical costs down, the focus really needs to shift to prices. States do not have the regulatory authority over drug pricing. We only have so many levers we can pull, so this is the one lever we're starting with on this, as well as the legislation that passed two years ago, and we may have recommendations that come out of that as we analyze the data we're getting, in fact, in the All-Payer Claims Database. I think there will be -- Interested to see that report. We'll be sharing that list with this committee and other legislators over the next week so you can actually see what the spending is and that may inform the discussion of the bill going forward.

REP. SCANLON (98TH): Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair, and thank you for the testimony here and I just want to go back around to what Representative Vail was asking about because there is a distinct difference between spending and pricing and you're saying that the state has no authority in the pricing?

VICKI VELTRI: I am suggesting to you it would be very difficult for the state to survive a challenge on pharmaceutical pricing, to actually tell somebody what they can -- a pharmaceutical company what they can charge for a service. That has been litigated in many other states. That is why most people who are addressing drug costs in states are looking at the total spend and the utilization of those drugs as a way to put some pressure on pharmaceutical spending, just as the insulin bill puts a cap on the copays. It's not addressing the price of the insulin, it's addressing the spending on the insulin and what the consumer is facing. I'm suggesting that's a big challenge.

REP. DELNICKI (14TH): Because the real problem is the pricing, quite frankly, because my concern lies in the fact that if you can't get the pricing under control and you're controlling the spending, are you then causing or creating a situation where people aren't getting the pharmaceuticals that they actually need because we're controlling the spending and not the pricing and it creates a deleterious outcome? That's my concern listening to this discussion here.

VICKI VELTRI: All I can say about that is that is probably the top concern among policy makers across the United States, health policy people like me, like the people at this table. It's how we get our

arms around it and there are a series of national groups that have sprung up from the state health policy side to try to address this issue, including going to the federal government about some of these issues, but it is -- it's a very complicated field and it has become much more complicated because of the -- I think the design of drug pricing is much more complicated than any other area of healthcare.

You know, we have the manufacturers, we have wholesalers, we have PBMs, and we have the consumers. We're not just dealing with the healthcare provider, so it's become incredibly complex and it's hard to unwind and get directly to the price, but I can tell you there's lots of people trying to work on this issue across the United States. We're in a group, at least two of us at this table, are in a group with National Academy of State Health Policy with this very issue to try to address that issue and it's not easy.

DAVID SELTZ: And I just want to add a little bit from our experience here. You know, just, you know, the total benchmark, the target for controlling spending is a target. It is not a cap and we had actually seen over the last couple of years that pharmacy spending has far exceeded that target, so it has been a driver above the target and in the year Vicki mentioned, there was one year as a total state, we actually went above the target due to the introduction of Sovaldi, a one-time cure for hepatitis C.

So I think my point here is that we have not seen -- the benchmark has not resulted in any kind of lack of access or rationing of care. That is not how it works and because it is not a hard cap, it is not,

you know, kind of you can't go above this level, but I think it is fair to ask has it -- has the benchmark had the same kind of moderating influence on pharmaceutical spending as it appears to have had on all the other parts of the healthcare industry and that's why we have made recommendations to more fully kind of bring them, as I quote/unquote said, under the tent of kind of transparency and accountability to try to have that kind of -- that influence hopefully extend there in terms of being able to create some moderation. I would also say our quality has improved in Massachusetts since the years the benchmark has been in place.

Our healthcare workforce has grown, so this is not on the backs of access, quality, or labor or workforce that we've been able to make the progress that we have and if we had seen that it was, we would have failed. We can do all of these things. We can get efficiencies in our healthcare system and improve quality and improve access, but it requires kind of the balance and the data to make sure that you're doing this and keeping the patients and the consumers and the people that pay for healthcare top of mind.

VICKI VELTRI: And I would -- I guess I would just add, Representative Delnicki, because I know the pharmaceutical folks are here today. We've had significant discussions with them about the benchmark and strategies around the benchmark and I'm sure you can ask them some direct questions today about their feelings about being included directly under the benchmark, but we have worked with them on this issue, they know it's an issue, and we've had serious discussions with them over the last year about this, in part because the

prescription drug bill that just went into effect in January. So my thing is we all have to own this issue of healthcare cost growth, we're all part of it, and everybody's got to be around this table to address it and that's what this benchmark work is intended to do and we're hopeful.

REP. DELNICKI (14TH): Just a follow-up comment, perhaps question rolled into it, in any way, looking at the pending and not the pricing because your -- the statement was that essentially you can do nothing about pricing?

VICKI VELTRI: It's very difficult to see drug pricing. The comptroller talked about a contract that they negotiated where they're going to see rebates pass through to consumers so they'll have a better look. We don't see that, as we see in traditional healthcare providers spend. We can get an idea of what the prices are with our current data.

REP. DELNICKI (14TH): So that leads me to the follow-up, if we're looking at spending -- pretty much looking at spending alone when it comes to the pharmaceutical costs, do we run into a situation where people are not going to get a preferred medicine or pharmaceutical only because it is a much higher cost and that, in essence, would bump up against the benchmark and cause a situation where you spoke of calling in the CEOs and swearing them in and having them testify under oath, is that going to have a negative impact there in the decision-making process of the physician to make sure that the patient gets the best possible care and that could be a higher cost pharmaceutical that in turn

would trigger what you were talking about, about the hearing and them being sworn in and questioned?

DAVID SELTZ: So I guess I would say I don't -- it's hard for me to see that scenario exactly playing out that way. I -- In my conversations with some of the pharmaceutical manufacturers -- Well, let me take a step back. I think the challenge -- Let me try again. If we were ever looking at a specific pharmaceutical manufacturer and what their contribution to total spending is, we would want to know very -- and be able to understand what is the value of that drug? What is the value of that drug in relationship to the price of the drug and if it is a high cost and high price drug that provides tremendous value, value commensurate with that price, I think we would absolutely say that is warranted and should happen and the patient should absolutely have access to it?

Unfortunately, we know that there are many drugs for which the price and the value are not correlated and are not, you know, not together and right now, we do not have any tools to try to even understand that, examine that, or be able to expose that. So I think you're right to kind of raise the question of can this have an impact on access or on prescribing. You know, it's having not had the authority, it's hard for me to say what exactly would happen in the future, but I would say today the biggest challenge that people have in accessing drugs is what they have to pay out of pocket for drugs, so people are -- one in four Massachusetts residents are not filling the prescription they need, not because they didn't get the prescription, it's because they can't afford the copay or deductible at the pharmacy.

COMMITTEE PUBLIC HEARING

We have -- Massachusetts residents are splitting pills, sharing pills with their family members, so, you know, I think on a big picture, we have to think about how we can make sure that we can have the innovation and the, you know, the lifesaving, life-extending treatment, make sure that we have access to those, but also be able to set up a system where we can all afford it and that families and individuals can afford it out of their own out-of-pocket costs. And I don't know exactly what the right balance of kind of policies and strategies will get us there, but I think starting with a value statement and starting with the data would be kind of my recommendation. Vicki, do you want to.

VICKI VELTRI: I guess I would just supplement it is what you're seeing in the space because of the impact of drug pricing is some health plans contracting for value -- doing some value-based contracting on the pharmacy side, so in other words, if you're promising a level of effectiveness of that drug, it better show up in the outcomes for the patients or else we're going to pay you differently for it. So you're seeing some health plans interjecting in that space to try to make that happen. You're also seeing some comparative effectiveness research coming out about whether representations on certain medications about the level of effectiveness for a certain kind of condition is actually panning out over a few years and I think you're going to see a lot more of that happening in this space as costs continue to rise.

REP. DELNICKI (14TH): It seems to me that we need to be placing more trust in the physicians on making the determination on what the value is of the pharmaceutical, almost to the point where you need

to have an office of advocacy for the physicians because they're spending a tremendous amount of time to try to get the pre-approval on a particular drug therapy, a particular treatment, to the point where they end up hiring people to do nothing but, nothing but, call in for approval and there has to be some sort of circuit breaker for them that -- You know, the patient that gets the medical bill has the Office of Healthcare Advocate, but what do we have for the doctor?

VICKI VELTRI: One of the discussions that's been having a lot of play in the health information technology space, which is an area that's also under the Office of Health Strategy, is more information getting to providers directly at the point of care, so one of the things that was discussed earlier was about the providers actually having information right in front of them about the kind of drugs for a particular condition, the cost of those drugs, what's on the formulary or not because that really can affect the patient's access to a drug. That's something we're shooting for doing. It's not, you know, a snap of the fingers to do in terms of electronic health records and different formularies that different plans have, but it is a goal that I think everybody shares in making a reality to ensure that providers actually have that information when they're sitting with a patient in the exam room. It's not easy, but we want to get there so they have those kind of tools.

REP. DELNICKI (14TH): And I realize this question -- Well, it is somewhat germane to what we're talking about, at what point -- We haven't standardized on any format for electronic health records, have we?

VICKI VELTRI: No, we're not, we are not, and one -- We have not done that. One of the -- One of the rationales about the health information work that's going on now is look, there's been a lot of investment in this state by hospitals, hospital systems, provider practices, health plans, you name it. They've put a lot of money into these systems already, so to ask them to recreate the wheel seems a little, you know, it's a lot of imposition and potentially a waste of money to have to reinvent a wheel on a lot of that. We don't want to duplicate that. So what we've been spending time on is interoperability, the ability of those systems to talk to each other across networks and across provider types and ensuring that the information that is exchanged is the kind of information that's valuable, rather than any one practice's particular decision about what electronic health record they're using.

REP. DELNICKI (14TH): So do we have that interoperability?

VICKI VELTRI: Not yet. That's what we are working on on the health information exchange and actually, that's been a very -- another area where there's been a lot of stakeholder participation in in terms of designing it. Last night there was actually a board meeting to discuss a lot of these issues, but there's a lot of work going on in that space to make sure that becomes a reality soon.

DAVID SELTZ: I just wanted to add on one quick thing. One of the projects that we're undertaking this year is around kind of unnecessary administrative complexity in our healthcare system and ways that we think that we could have better

alignment, not as much unnecessary variation and duplication and prior authorization is one of those things we've been looking at. There has been a significant increase in the number of kind of procedures and treatment that are now subject to a prior authorization, double digit year to year growth. Physicians are hiring people. They are spending more of their time doing billing, doing prior authorizations, hiring nurses to do this. What if we could free up some of that time and hand that back into patient care. So you're right on and it is something that we're looking at, too, to try to say if this isn't providing value to anyone, then let's think about how we could improve that system and free up, you know, people and the physicians to actually be focused on patient care and not on billing and jumping through hoops.

REP. DELNICKI (14TH): Which leads to the other issue pertaining to billing and the fact that have to be bill collectors and that whole paradigm that shouldn't be with the doctor because their office should be focused on the patient and not on getting authorization from an insurance company and not on billing and chasing people down for payment. Because I think if you do that, you free up more time for the doctors to do a great job because they do a fantastic job given the constraints they have, so that's my two cents worth on that.

VICKI VELTRI: So that gives me one little chance to plug again a lot of the work that we've been doing on care delivery reform and payment reform, in a lot of these new models where providers are given a lot more latitude to treat their patients and a lot more flexibility in their practice, prior authorization is often eliminated in those situations in exchange

for the provider taking on some accountability for the outcomes and the quality of care that's being delivered. So those are the kind of arrangements that lots and lots of states have. We have some in Connecticut, but I expect that will probably increase over time where providers are actually spending time treating their patients.

REP. DELNICKI (14TH): That's what we want them to do.

VICKI VELTRI: Right. We all want that.

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

REP. SCANLON (98TH): Any further questions for our witnesses? Seeing none, I want to thank you all for being here today.

VICKI VELTRI: Thank you so much.

REP. SCANLON (98TH): All right. I apologize to the members of the public who are here because we have now only gotten through two of the first witnesses on the legislators, agencies, and municipalities, but in fairness to the public who is here, I'm going to begin alternating between those folks and the general public, which means that our next witnesses will come from Senate Bill 319, which our first up is Dan Davis.

DAN DAVIS: I want to thank for the opportunity to address this legislative body. We are blessed to live in a rate country where we fight to prevent discrimination of any kind. We recognize that discrimination of any type of wrong and Senate Bill 319 addresses discrimination against podiatric physicians in the state of Connecticut. For years,

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podiatrists have performed the same procedures as their allopathic and osteopathic counterparts, but have received less payments for the same services rendered. These are procedures that utilize the appropriate CPT codes that describe the medical and surgical services provided to patients. CPT codes do not discriminate by age, race, gender, or profession.

There is still confusion about the training of a podiatric physician. Just to clarify, we have four years of undergraduate education followed by four years of medical school where we sit side by side, medical students with same instructors, same textbooks, and same exams. Students in podiatric medical school take additional courses on the lower extremity and take additional anatomical dissection courses to ensure that they are the most highly trained lower extremity physicians in the medical field. We have a mandatory minimum three year residency program where we rotate through the same medical rotations as allopathic and osteopathic students. The number of foot and ankle cases completed by a podiatric resident in three years far outnumbers the foot and ankle cases performed by a five-year foot and ankle orthopedic resident, including their year of fellowship.

It is our obligation to know the lower extremity better than any other medical professional and we do. The most recent data from Thomson Reuters reveals podiatric physicians perform the majority of foot and ankle procedures in the United States. Podiatrists are part of the medical team of nearly every wound care center in the United States and provide the limb salvage care needed in a country where one in four diabetics would develop a lower

extremity ulceration in their lifetime. Eighty-five percent of lower extremity amputations are preceded by a lower extremity ulceration. The Centers for Disease Control and Prevention in the United States have predicted that by 2050, one out of three Americans will be diabetic. A recent Duke study revealed that one visit a year by a diabetic to a podiatrist significantly reduces hospitalizations and amputations in diabetics and saves the healthcare system over \$3.1 billion dollars a year.

Podiatrists are becoming increasingly employed by hospitals as an integral part of their healthcare team. We work in medical groups as part of the medical community that is relied upon to prevent the best foot and ankle care. Many podiatric physicians are on call in emergency rooms several months a year to handle any variety of trauma, infection, or unique foot pathology that presents at any time of day or night. It is difficult to explain to any young podiatric physician, who after 11 years of intensive training, that if they practice in Connecticut, they will be paid at least 35 percent less than their allopathic or osteopathic counterparts for performing a reconstructive bunion correction or 60 percent less for performing a hammertoe correction or 20 percent less for a new patient office examination.

In closing, several years ago, the Connecticut Podiatric Medical Association filed a lawsuit against Health Net for discrimination of payments for services rendered for identical CPT codes provided by other medical professionals. Under oath, the CEO of Health Net admitted that podiatric physicians are better trained, have fewer complications, and overall provide the best foot and

ankle care for the patients in Connecticut. When asked why Health Net discriminates against podiatrists in fee reimbursement, he replied "because I can." That is precisely why a study of the nature of that you are about to hopefully undertake is necessary and it is appreciated. We hope that it will lead to an end of the discrimination against podiatric physicians. We believe in the legislative process and hope you will move this issue forward. We have provided language for this bill and I am happy to answer any questions that you may have.

REP. SCANLON (98TH): Thank you, Doctor. At the risk of asking a question that I think might upset you, I'm going to.

DAN DAVIS: That's okay.

REP. SCANLON (98TH): Which is that your friends in the Orthopedic Society have testified and they are against this bill and they said that they are "confused as the need of such a study as it is the orthopedics communities' understanding that podiatrists, like other healthcare professionals, negotiate and contract their reimbursement rate for the care and treatment they provide within their scope of practice."

DAN DAVIS: That's a great --

REP. SCANLON (98TH): We'd love to hear your --

DAN DAVIS: I appreciate the opportunity to being able to address that because call me naïve after 38 years of practice going back several years ago when I was offered a contract, I believed that all physicians were being paid at an equal rate. Recently, whenever podiatrists were not part of

allopathic groups, osteopathic groups, a good friend of mine called and said do you know that I'm doing the same procedure I did last year and being paid 80 percent more, \$1,755 dollars, for a procedure I received \$485 dollars for last year. Is that fair? And it goes across the board with every CPT code. Once you realize that the insurance carriers are not playing on a fair game, that's why we are here to take this issue forward.

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

REP. VAIL (52ND): Thank you, Mr. Chairman. I have a follow-up on that question, so you -- are you -- do you participate with different insurance companies in your practice?

DAN DAVIS: Yes, I do.

REP. VAIL (52ND): And then there are some that you don't participate with?

DAN DAVIS: That is true.

REP. VAIL (52ND): Don't the podiatrists have the ability to negotiate what they get paid with the insurance companies that they participate with now, just --

DAN DAVIS: As an individual provider, we do not. They can say you take or leave it and that's the way you are and the bottom line is, when we're providing care -- For instance, a great example, was in a wound care center, when patients come in needing help, and they do, and we actually donate over 30 percent of our time to provide healthcare for diabetics, otherwise they'll lose their limb, and not to stop procedures, but you can't buy a limb on

Amazon even if you have Prime. Bottom line is there are certain times when you have to take it in order to provide the services in your community and it comes to a point where where do you draw the line to saying what's fair and what is not fair. We need to provide the services, the people really need the services, especially the diabetics, and when they belong to a healthcare plan that says we will discriminately pay you less because we know you have to take it, the only way you can change it is to change the law. We do provide the same services, we do it better than anybody else does. We save more limbs than anybody else does. We are the busiest providers in every wound care center across the United States.

In Connecticut, we are paid a whole lot less for those services and as I said, you can't put a price on a limb.

REP. VAIL (52ND): And I don't disagree and I'm sure you guys do great work. I don't question that in any way, shape, or form, but I think it's my understanding that maybe do you have a group that you belong to that represents all podiatrists in Connecticut that can negotiate better rates? Because I'm pretty sure that's who it works now.

DAN DAVIS: If you belong to an IPA, which actually years ago they tried to form one, the bottom line is that did not work. We cannot collectively bargain because there's an antitrust law against -- The Stark Antitrust says you cannot collectively come together and say let's go to this insurance carrier and see if we can negotiate the rates. They know that we cannot collectively come together as such unless you form an IPA, which again, discriminates

against some of the providers because then they set the rules as to who is going to provide the care for their particular insurance carrier.

REP. VAIL (52ND): But how do these other people that do similar work to you get paid 35 percent more than you do if they're not negotiating those rates? Why are they held -- Either they negotiate better or they're held in a higher standard for some reason, which I wouldn't understand, but what do you think is the reason why they're getting paid 35 percent more?

DAN DAVIS: The reason is because they have a different initial behind their name of training and that's an M.D. as opposed to a DPM. I'm a doctor of podiatric medicine and people -- going back, there's a stigma that goes back decades that felt that our education and training was just not sufficient and if you're not an M.D., you don't deserve to have that payment. Since that time, we have proven time and time again our value and Thomson Reuters, again, has gone out independently and so did Duke, they realized that we do provide a higher level of care, better success rate on limb salvage, better success rate on outcomes of bunion and actually any type of foot and ankle surgery. We do provide that and because we do it, we do it better, we actually do more of it.

REP. VAIL (52ND): Yeah, I looked on line and it says that you are considered doctors, but maybe different initials next to your name, but all right, that's enough information for me. I appreciate your testimony.

DAN DAVIS: I appreciate your question.

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

DAN DAVIS: I appreciate that opportunity. Thanks again.

REP. SCANLON (98TH): All right. Next up, Paul Lombardo.

PAUL LOMBARDO: Hello, everyone. Representative Scanlon and members of the Insurance and Real Estate Committee, thank you for the opportunity to submit written testimony, as well as oral testimony, in strong support of House Bill 5018. The core mission of the Connecticut Insurance Department is consumer protection. The department carries out its mission by enforcing state insurance laws to ensure the policy holders and claimants are treated fairly and by closely monitoring the financial condition of insurance carriers to make certain that they are solvent, appropriately manage risk, and are able to pay policy claims as they arise.

The Insurance Department fully supports House Bill 5018. This bill will help ensure that the rate of growth in healthcare costs will be better compare to other societal cost trends. Over the past 15 years, and I think we've heard this statistic a few times, healthcare costs have grown by 77 percent while wages have gone -- grown 21 percent. This bill will provide a framework. It will not only address healthcare cost growth through the codification of the Governor's Executive Order 5, but also address the high cost of prescription drugs through the Canadian Prescription Drug Re-Importation program established in Sections 10 through 15 of the proposed bill.

This bill will also codify the Insurance Department Stop-Loss Bulletin HC-126 in Sections 16 through 22. The department's bulletin has often been referred to as the national standard by both industry and other insurance departments. The bulletin provides regulatory guidance and clarity on stop-loss insurance policies. Stop-loss insurance policies provide another option to small employers and on average cost between 10 and 20 percent less than fully insured alternatives. Specifically Section 16 through 22 will identify minimum attachment points and aggregate attachment points and set forth formulas for these attachment points, identify items that will not be allowed in practice, identify situations when only lasering may be used and puts limits on such usage, and differentiates between active and retiree stop-loss products.

The Insurance Department believes this bill will address concerns expressed by consumers across the state. The department is happy to continue working with stakeholders to ensure Connecticut's consumers have access to reasonably priced healthcare by also providing options for small employers. And at this point, I'll take any questions you have.

REP. SCANLON (98TH): Thank you very much. Any questions from the Committee? Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. Does the department have any -- Do insurance companies have to put in a request with the department if they're going to change rates?

PAUL LOMBARDO: For stop-loss products?

REP. VAIL (52ND): Health insurance.

PAUL LOMBARDO: Health insurance, yes.

REP. VAIL (52ND): Okay. Do -- What is your -- When it comes to the cost of pharmaceuticals, is there -- do you have any oversight on that?

PAUL LOMBARDO: The -- As was mentioned before, the spend on pharmaceuticals as it relates to health insurance is included in the rate filings. It is actually spiked out, so the overall average cost of pharmaceuticals for a healthcare plan and the utilization of those pharmaceuticals is included in the data that is submitted to support the rate increases.

REP. VAIL (52ND): But we have no control over the cost from the pharmaceuticals to the pharmacist, the insurance companies?

PAUL LOMBARDO: Yes, the Insurance Department does not have any authority over the price of the drug. Now, we are, as mentioned before, Public Act 18-41, we are now going to start collecting additional information from the health insurance plans as it relates to the top 25 most costly drugs, the top 25 most utilized drugs, but in all instances, we do not have any authority over the price of the drug itself, just as we don't have authority over the price of an office visit or the price of a hospital stay.

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

REP. SCANLON (98TH): Any further questions? Seeing none, thank you so much. Back to the podiatrists, 319, Dr. Adam Mucinskas. He had to leave, okay. So I don't see Heather Somers, Senator Formica, Representative Gilchrest, Abrams, Commissioner Seagull, I don't see her. You're representing her? Okay.

RODRICK MARRIOTT: Hi and thank you. I am Rod Marriott. I'm the director of the drug control division for the state of Connecticut Department of Consumer Protection and I'm here supporting the Canadian drug importation part of the governor's bill and to express our support for it and our gratefulness for working with members of this committee and the Governor's Office on that -- the language in that bill.

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

RODRICK MARRIOTT: We did submit a written testimony as well.

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

SEN. LESSER (9TH): Thank you. And thank you, Rodriguez, for your testimony and for working with us on this important issue. We had, I don't know if you saw, we had the same language stuck on another bill up today up for public hearing and then we had a pharmacist from Canada fly down or drive down or train, I'm not sure how she got here, but she came and talked about, you know, regulatory harmony and track and trace program in the U.S. and in Canada and I just wanted to sort of get a sense of how you anticipate this program working and insuring patients?

RODRICK MARRIOTT: I just so you know, I did not see that testimony from that individual, but --

SEN. LESSER (9TH): I didn't expect you to, but you're familiar with -- Obviously you helped us draft this legislation, this governor's bill, and just sort of wanted to know how you're -- You're very familiar, I know, with the Canadian system.

RODRICK MARRIOTT: Yeah, so in general, this is designed to work where a drug from a manufacturer wholesaler from Canada is shipped to a company in the state of Connecticut and that company in the state of Connecticut will then hold that drug in quarantine and test a certain amount of that drug to make sure that it is safe and labeled appropriately. That company will then also create their own label or code for that drug so that we can track it as we need to for the track and trace type program and then be able to distribute that form -- that drug to pharmacies in our state with the goal of that being lower cost medication for residents of the state of Connecticut. That's the Cliff notes version of the way the bill works, Senator Lesser.

SEN. LESSER (9TH): Thank you and you were very good at answering the question while I was standing behind you while looking forward which is a skill that is hard to come by and I applaud you for that, so thank you for that answer. Look forward to working with you and the department and appreciate your work to help us get there and I'm sure the discussion will go forward to how best to implement this.

RODRICK MARRIOTT: I appreciate the compliment.

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

REP. DELNICKI (14TH): Thank you, Mr. Chair, and thank you for describing that process. How long will that process take?

RODRICK MARRIOTT: So once the bill is passed, the goal for us is -- The process of the drug being tested or the process of --

REP. DELNICKI (14TH): The drug being tested, the drug being repackaged, and the drug being distributed.

RODRICK MARRIOTT: So I don't anticipate a long delay in that part of the process. With the understanding the drug is going to have an expiration date and that expiration date needs to be honored in the U.S. as well, so the testing, depending on the relationship with the laboratory and the laboratory have purchasing and what their other work is, should be relatively quick and it also depends on the volume of drug that that company has imported for redistribution and the number of samples they will have to test. So it could be a week, it could be a month, it depends on the lab and the dedicated resources that they have.

REP. DELNICKI (14TH): So it could be a week, it could be a month. What kind of an impact would that have on the expiration date? What is typically -- and I realize that's a difficult question because it varies from medication to medication.

RODRICK MARRIOTT: So generally on average the expiration date is two years unless there's other extenuating circumstances. So the expectation would be that the person importing the drug is going want to make sure it has plenty of life on it because they need to move it, right, and so if the drug has a short lifespan on it, they're unlikely to want to purchase that drug.

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

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

RODRICK MARRIOTT: Thank you.

REP. SCANLON (98TH): I see the distinguished Senate president is here, so we will call him up and then go back to Dr. Richard Healy, followed by Senator Somers, who I see is also in the room now.

SEN. LOONEY (11TH): Thank you very much, Mr. Chairman. Good afternoon, Senator Lesser and Representative Scanlon, distinguished members of the Insurance and Real Estate Committee. First of all, I wanted to commend this committee for once again leading the way with so much consumer protection and consumer friendly healthcare protection in an area where we know people suffer more anxiety than in just about any other area of policy making in our state. A number of the bills on your agenda I'd like to comment on. I hope I can move through them pretty quickly in view of the Committee's time, as there are quite a few. I'd like to testify in support of Senate Bills 320, 321, 322, 323, 324, 333, 334, 335, 336, 328, and also House Bill 5018, also Senate Bill 319, Senate Bill 341, Senate Bill 346, in which you already a very extensive colloquy with our comptroller, Kevin Lembo, and also 347.

To begin with, Senate Bill 320, AN ACT PROHIBITING HEALTHCARE CARRIERS FROM REQUIRING THE USE OF STEP THERAPY FOR DRUGS PRESCRIBED TO TREAT DISABLING, CHRONIC, OR LIFE-THREATENING DISEASES OR CONDITIONS, would strengthen patient protections regarding insurer's use of step therapy. While there are legitimate uses of step therapy, too often it's implemented in a manner that interferes with patient care and leads to insurers preventing physicians from providing the best care for patients and delays

getting to the actual care that the physician believes is necessary.

The protections in this bill should also apply to mental health and substance abuse treatment. In 2014, Public Act 14-118, AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY, create certain patient protections regarding insurance carriers use of step therapy, however, patients and providers continued to have situations in which the carriers' step therapy policies prevent the patients from receiving the treatment their healthcare providers have decided is most appropriate. In some cases, this has delayed effects of treatment that can leave patients with diminished health outcomes. In Public Act 17-228, AN ACT CONCERNING STEP THERAPY FOR PRESCRIPTION DRUGS PRESCRIBED TO TREAT STAGE IV METASTATIC CANCER, recognized these continued patient struggles and further regulated the use of step therapy in certain cancers only, however, the use of step therapy continues to be particularly problematic for other chronic diseases, as well as cancer patients, and Senate Bill 320 would ensure that the physician is able to provide the best treatment for patients.

Senate Bill 321, AN ACT CONCERNING THE BURDEN OF PROOF DURING ADVERSE DETERMINATION UTILIZATION REVIEWS, would create a presumption that treatment that's ordered by a physician is medically necessary treatment. Generally in law, the burden of proof in any case is placed on the party who has the relevant information and knowledge and Senate Bill 321 would bring appeals to adverse determinations in line with most areas of the law. Here the insurer is the only party with knowledge as to why the claim was denied an appeals of adverse determinations, neither the

patient nor the provider know why the payer declined to cover a service. Despite this reality, under the current framework the burden of proof in these appeals remain on the patient and the provider. In fact, prior to Public Act 12-102, the patient and the provider didn't even have the right to access the record that the insurer used to make the decision. That was corrected back then. In addition, an insurer is not licensed to practice medicine and its judgment as to what is medically necessary for a patient should hold far less weight than that of a treating physician. The insurer could still, of course, deny claims under this framework. It would simply have to prove that the treatment was not medically necessary.

Senate Bill 322, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO CONSIDER AFFORDABILITY IN REVIEWING INDIVIDUAL AND GROUP HEALTH INSURANCE POLICY PREMIUM RATE FILINGS, would add the word affordability to the criteria that the Department of Insurance should consider when approving or denying health insurance rates. Clearly, the affordability of the plan for policy holders is of extraordinary importance when analyzing these rates. Senate Bill 323, AN ACT CONCERNING SURPRISE BILLING AND COST SHARING FOR HEALTHCARE SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS AT IN-NETWORK FACILITIES, this bill, I believe, needs revised language to -- so that it would represent the multiparty agreement that the only changes to surprise billing are out-of-network emergency department billing would be to add the word facility, which includes laboratory to the definition of provider.

Senate Bill 324, AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE FOR AMBULANCE SERVICES AND

REQUIRING NOTIFICATION AND CONSENT REGARDING THE POTENTIAL COST OF SUCH SERVICES IN CERTAIN CIRCUMSTANCES, this bill is somewhat of a work in progress, but the intent is to address ambulance surprise billing and we know that there is bipartisan and bicameral interest in this bill. Public Act 15-110 required that ambulance services make a good faith effort to determine whether a patient has health insurance prior to directly billing that patient. This act was passed in response to numerous complaints by residents who were billed sometimes with aggressive collection techniques immediately after requiring a ride by ambulance to the emergency room. It appears that some ambulance companies were then not making any attempt to discover whether a patient had insurance that would cover these expenses and Senate Bill 324 attempts to address out-of-network ambulance billing and would require health insurance coverage. The ambulance services then would require these services be provided at an in-network cost-sharing level. The legislation would also prohibit balance billing for these services and ambulance rides to the emergency department are not shoppable services for a patient can make a leisurely examination of various options and a patient who requires immediate emergency medical exemption should not be left with a large bill for an unavoidable service.

Senate Bill 333, AN ACT CONCERNING REIMBURSEMENTS FOR CERTAIN COVERED HEALTH BENEFITS, this bill also bipartisan interest, would establish site neutral payment policies for certain services in Connecticut. Back in 2015, Public Act 15-146 originally had contained a provision to create site neutral payment policies between physician-owned

practices and hospital-owned outpatient practices. The site neutral reimbursement provision was then ultimately removed in order to facilitate passage of that bill. The disparity in pricing for the same procedure at different prices -- different sites of service goes beyond any rational explanation. For example, we've done some research that shows that an infusion of the drug Tysabri is billed at \$6,700 dollars and reimbursed at \$6,400 dollars at an independent infusion center, while one Connecticut hospital bills as \$33,000 dollars and is paid \$12,000 dollars while another Connecticut hospital bills \$37,000 dollars and is paid \$16,000. These are just unconscionable variations and this is for the same infusion of the same drug. There are a variety of ways to move forward to site neutral payment policies and would be prepared to work closely with the Committee on them, knowing your commitment of equity in this area.

Senate Bill 334, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO STUDY METHODS OF ENHANCING DATA PRIVACY FOR BUSINESS ASSOCIATES AND COVERED ENTITIES UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, the new stories about the Project Nightingale Agreement between Google and Ascension to share patient data without consent made it clear that current patient privacy protections may not be sufficient and we must ensure that Connecticut residents' health data is not misused by insurers, providers, or other entities and this would be a first step toward updating patient protections to the 21st Century. Senate Bill 335, AN ACT CONCERNING THE ROLE OF CLINICAL PEERS IN ADVERSE DETERMINATION AND UTILIZATION REVIEWS, is another bipartisan effort which would create a more

stringent definition of the phrase clinical peer in the appeal process for adverse determinations, including in the peer-to-peer conference that the health carrier is required to offer to the treating physician upon the initial adverse determination. Requiring that clinical peers be used to evaluate adverse determination reviews, a certified specialist in the same subspecialty would result in more accurate and appropriate determinations. In addition, the legislation would require that the peer that's provided for the peer-to-peer conference have the authority to overturn the adverse determination. This would benefit all parties involved and make our healthcare system more effective and lead to speedier resolution of these issues.

Senate Bill 336, AN ACT PROHIBITING CERTAIN HEALTH CARRIERS AND PHARMACY BENEFIT MANAGERS FROM EMPLOYING COPAY ACCUMULATOR PROGRAMS, would prohibit insurers from implementing these programs that use patients as hostages in the battle of insurers and pharmacy benefit managers versus pharmaceutical companies and while the high price of prescription drugs is an enormous problem, the answer is not in taking more money from patients. According to Jeffrey Joyce, a pharmaceutical economist at the University of Southern California, there are offenders on both sides of this. Under copay accumulator programs, any copayment assistance that a patient receives, whether directly from a pharmaceutical manufacturer or from coupon cards, such as Good RX, does not count toward the patient's deductible. An article in *Health Affairs* describes it this way, "these programs change the calculus for patients by no longer applying the copay coupons,

the patient deductibles and out-of-pocket maximums. Patients must spend more out of pocket to reach their deductible, sometimes thousands of dollars more. For too many patients, this makes the drugs they depend on unaffordable. The pharmacy benefit managers claim that these drug coupon cards incentivize the use of brand name drugs, however, 87 percent of the cards are for drugs that have no generic equivalent and appears these programs may allow insurers to double dip because they get their full copays while also extending the duration of the patient's deductibles, so we should protect our residents from this practice. This is another bill on which there has been bipartisan study in the interim leading up to this -- for this session. I know that Senator Fasano and his team have been researching this as well.

Senate Bill 328, AN ACT CONCERNING HEALTHCARE COST GROWTH BENCHMARKS, CANADIAN DRUG REIMPORTATION, STOP-LOSS INSURANCE AND REINSURANCE, and also House Bill 5018, AN ACT CONCERNING HEALTHCARE COST GROWTH IN CONNECTICUT, all of these add to the scope of duties of the Office of Health Strategy, setting cost growth benchmarks in our healthcare system, setting benchmarks and requiring outliers in price to submit performance improvement programs has been effective in limiting healthcare cost growth in Massachusetts and it should have the same effect here and these bills also address the issue of reinsurance and prescription drug re-importation from Canada, which I certainly support and I know that this committee was -- had developed a bill on this last year and hoped that we will go forward with it this year. also, Senate Bill 319, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO STUDY REIMBURSEMENT PARODY

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FOR PODIATRISTS, it's my understanding that podiatrists are reimbursed at only 90 percent what orthopedists receive for the same services. It isn't clear to me that there's any justification for this price differential and it may be a deterrent to podiatrists practicing in our state and in many cases, podiatrists treat many lower income patients that orthopedists opt out of treating. The last three bills, as I mentioned, Senate Bill 347 is a bill that going back to 2018, the General Assembly took meaningful action to ensure essential benefits under passage of Public Act 18-10 and last year, Public Act 19-34, provided some protections for those with preexisting conditions, but currently decisions to repeal the entire ACA are pending in federal appellate courts and we must continue our pursuit to protect Connecticut residents from the detrimental fallout that the Act's repeal would cause, so accordingly, I encourage the Committee to adopt Senate Bill 347, which would adopt a medical loss ratio modeled after the ACA's. Under the ACA, an individual health plan must spend at least 80 percent of the premium revenue on actual care and patient supportive services, leaving 20 percent for overhead, salaries, marketing, and other costs.

Large group plans must adhere to an 85 percent to 15 percent ratio and if a plan fails to meet the threshold, it must issue rebates back to the policy holders proportionate to the amount of spending exceeding the permitted amount and Senate Bill 347 would be contingent in that it would only take effect if the medical loss ratio in the ACA is repealed, thereby ensuring these provisions continue to protect against inflated premiums. Senate Bill 341 also addresses the bureaucratic minefield that

is insurance claims. Many families are paying tens of thousands of dollars a year in premiums and deductibles and if a request for coverage is initially denied, the best case scenario is that after weeks or month of delay, appealing the decision would lead to approval by the insurer and this is all burdensome, costly, and not attainable for many people and negotiating the grievance process is often very frustrating and it can take 10 to 20 hours of a provider's time in making the case to why the coverage should be in place and most insured individuals at their best are not familiar enough with insurance contracts or their personal care to navigate the process and what may be most frustrating is how much harder it is to mount an appeal when people are also suffering emotionally and physically from the ailment that they're seeking coverage for.

And anything we can do to make this process easier and result in more claim approvals prior to the appeals process would be in the public interest and that during the initial interview, the provider almost exclusively submits the claim to the insurer and the application may have all the underlying medical information, but during the grievance review process, the patient has the opportunity to share new information about his or her personal situation and we believe that this is providing patients an opportunity to tell their story earlier in the process before -- it would help resolve claims before the lengthy appeals process. So there are two components to this bill, first it requires insurers to accept the patient's statement with any information the patient deems worthy of sharing. At the same time, the insurer accepts the request for

authorization of coverage and second, the bill would require providers to inform patients that they have the opportunity to provide the written statements to supplement that provided by the provider.

And finally, of course, Senate Bill 346 that has extensively been discussed, the establishment of a Connecticut health program and creating a public option to leverage the buying authority of the comptroller's office to offer an additional option for the people of Connecticut. Obviously that's a very, very critical bill that we had a press conference on earlier prior to the beginning of this public hearing and I believe that this is an issue of such great importance that it's something that more families in Connecticut worry about than any other issue is the lack or potential lack of health coverage and the lack of being able to afford health coverage. It's something that I believe is also an economic development issue because we have many, many people who might otherwise be willing to take on an entrepreneur role and establish a small business, but they're afraid to do that and they can't afford to do that and it would be imprudent for them to do that if it would mean forfeiting the health coverage they have with a current employer, especially if they have families.

So this, I think, would open up a whole new area of activity for more fearless activity on the part of those that have a good idea that could potentially be developed into a profitable small business, but now is impeded by the fear that people feel about being exposed not having health coverage and so the option to bring in small businesses, to bring in unions, and to create the much larger buyers pool that is advantaged by the comptroller's office under

this I think would be an important national model and as I said, would actually be a spur to economic development in this state and would open the door to more people venturing into that area of creating small businesses than we see now under the currently intimidating healthcare market. We know that there are some people who operate small businesses whose health insurance premiums are more than \$10,000 dollars a year. In addition, some of those policies then have over \$10,000 dollar deductibles, so they have to spend \$20,000 dollars or more before they get any coverage, so what that means in most cases, they really don't have insurance at all. What they have, really, is a catastrophic health plan that only comes into effect when something major happens and in most years, thankfully when nothing too serious happens, they never actually reach the deductible because it is so high that it really is only an insurance in the case of a disaster involving a lengthy hospital stay. So we have to do better than that for the people of our state and I want to commend the chairs of this committee for once again taking leadership on this issue as you did last year. Thank you so much.

REP. SCANLON (98TH): Thank you, Senator, and thank you for your work alongside Senator Fasano on a lot of these bills, which I think we're going to hear from him a little bit, but I want to open it up to questions. Senator Lesser.

SEN. LESSER (9TH): Thank you, Senator Looney. I think you just sat a legislative management record for the most testimony on the most number of bills by any single legislator in a single setting, so I applaud you for that and in all seriousness, your work expanding consumer protections all up and down

the gamut of healthcare has been incredible and so as the Chair pointed out, look forward to hearing from Senator Fasano as well about the areas where there's bipartisan consensus, As well as a member of your caucus. I'm just grateful that some of these items are priority items for our caucus in codifying portions of the ACA and expanding consumer choice for health insurance. Your testimony was comprehensive and there's not a whole lot more that I can add other than I look forward to working with you and I'm sure the other members of the Committee while we zero in to look to these proposals that can be moved forward and we had an extraordinary productive year last year and I'm sure we will have one as well this year.

SEN. LOONEY (11TH): Thank you, Mr. Chairman. Again, I want to add my thanks in advance to Senator Fasano for all the work that he and his legal team have done in creating, you know, bipartisan initiatives on a number of these bills, so I want to thank Brian Zeffirelli who has worked closely with Dana Berlin and with your committee on helping to shape any of these bills in a bipartisan way, so thank you Mr. Chairman.

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

REP. PAVALOCK-D'AMATO (77TH): Thank you. I just want to double check here the last maybe minute or couple minutes of your testimony. Was that about S.B. 346?

SEN. LOONEY (11TH): The creating the -- Yeah, the bill creating the --

REP. PAVALOCK-D'AMATO (77TH): Public option?

SEN. LOONEY (11TH): -- public option.

REP. PAVALOCK-D'AMATO (77TH): Okay, I think so. Thank you. And of course, thank you for your testimony and review of those bills. That was very helpful. Then about S.B. 346, you had mentioned the unions, will the unions be part of those plans as they're set forth in that bill?

SEN. LOONEY (11TH): Potentially so. As the comptroller mentioned earlier, that there is a vision that these Taft-Hartley plans would participate. There were a number of union officials who were present at our press conference prior to the public hearing, including Mr. Luciano from AFSME.

REP. PAVALOCK-D'AMATO (77TH): And do you think that would open the pool so that way it would be a probably more viable or more viable plan, cheaper premiums for everybody if it was set up that way?

SEN. LOONEY (11TH): Yes, and that's the plan, to create a pool with a broad level of participation so that it would also be one that would have significant power in the marketplace for negotiation purposes.

REP. PAVALOCK-D'AMATO (77TH): All right, yeah, I agree, and that's what I remember how the comptroller initially talked about it at a, I think it was last year or the year before, hearing and that was my understanding of it, so I agree with you and I appreciate it. Thank you very much.

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

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

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

REP. SCANLON (98TH): All right, back to 319, Dr. Richard Eli.

RICHARD HEALY: Good afternoon. Thank you for the opportunity to address this issue. My name is Dr. Richard Healy. I practiced podiatric medicine for 37 years in Bristol. I had a very active practice and was able to service a large number of patients. I'm here today to ask you to support Senate Bill 3019. I believe a comprehensive review of the restructure for podiatry versus physicians doing the same work needs to be performed. Our specialty should be fairly reimbursed for the work that we do as licenses, credentialed podiatric physicians and surgeons in this state. It is an unfair trade practice not to pay us the same fees as our physician colleagues performing the same procedures in the same office or hospital setting. I have seen podiatrist after podiatrist leave Connecticut because of the unfair way that we are being treated by the insurance reimbursements. It's very difficult to expect the person just coming out of training to go into a specialty where you are paid substantially less than physicians performing the same services in the same environment. Connecticut simply cannot compete.

This is sad since we producing very highly trained podiatric physicians and surgeons who will take their talents elsewhere. I appreciate the different competing interests that you need to balance in making healthcare policy and this change is long overdue. I urge you to approach our bill to launch

a study to correct this inequity. I have noticed that the Orthopedic Society has submitted a statement to you opposing this bill and frankly, I'm not very surprised. They have a very good deal right now with higher fees as opposed to us and they just want to maintain that status quo. The cost of correcting this discrepancy is not significant either. Approximately ten years ago, the state society of -- the Connecticut Podiatric Medical Association sued Anthem Blue Cross and Blue Shield for fee disparity and won. The math that led to this correction of this disparity amounted to less than five cents across the reimbursement fee schedule to the other providers to absorb the cost of equalization of reimbursements with podiatry. Again, I thank you for this opportunity and would request that support.

REP. SCANLON (98TH): Thank you for being here today and thank you for your patience. Any questions for -- Seeing none, thank you so much.

RICHARD HEALY: Thank you.

REP. SCANLON (98TH): We lost Senator Somers, it looks like lost Senator Fasano. I do see Ted Doolittle is here, though, so Ted, would you like to join us? And then we will be moving to 320, Todd Falcone.

TED DOOLITTLE: Good morning, Chairman Scanlon, Senator Lesser, Representative Pavalock-D'Amato, other members of the Committee. Thank you very much for your time today. My name is Ted Doolittle. I'm the head of the Office of the Healthcare Advocate and just for the benefit of folks in the room who may be in reach of my voice, we help people who are struggling with their healthcare coverage, if

they've had a claim denied, something of that sort. We have a staff of nurses, attorneys, paralegals, and others that can represent them for proof, so contact our office and we'll help you with that. I wanted to briefly comment on the public options bill, Senate Bill 346, and I will actually supplement my written testimony that I've already filed because I want to keep my remarks brief because of -- out of respect of the members of the public and the Committee.

To me, one of the attractions of this bill, which the office strongly supports, is that over the long term it's going to implement a cost control measure. I don't need to remind anybody on this committee that our country among our economic competitors pays twice as much as our economic competitors. Over the past 100 years and especially in the past 30 years, our system together has had trouble controlling costs, especially in the commercial sector. We've done a little bit better job in the public sphere, Medicare and Medicaid, with cost control. So our system is not working. We've let our folks down in terms of having -- and let the businesses -- it's a business competitive issue. Warren Buffet said that medical costs are the tapeworm of the American economic competitiveness, so it's not just a consumer issue, it's also a business issue.

The healthcare providers are quick to say the reason why their commercial costs are high is because of cost shift. They are essentially subsidizing the public programs and that is no doubt true to an extent, but it still leaves us with a question; why are our hospital and drug costs so much higher than the other countries, why are they higher, and it's not just the presence of the insurance companies.

You can't demonize the insurance companies because there are several of our economic competitors, notably the Netherlands and Israel, that heavily use insurance companies, but yet they still have half the costs. What is the difference?

Well, the difference is that -- and there are other countries that also more lightly use insurance companies, but anyway, a lot of them, the point is, do use insurance companies, they still have the lower cost, what is the difference? In my view, the difference is that in the other nations, the -- there is public involvement, some type of public involvement, to support the insurance companies in the cost control battle with the providers. That's lacking in this country. So this, the public option here, is a step in the right direction in terms of backing up our insurance companies, providing some downward pressure on the prices. That is also true of the benchmarking bills, the Senate Bill 328 and 5018, but I would just leave that -- you with that thought, that in other countries that successfully use insurance companies, there's a partnership between the insurance companies and the government that results in lower cost. So I think this bill would result in a downward pressure over the long-term on prices. I think it could possibly be renamed to not be public options, but be a public/private partnership option bill because again, as you heard from the comptroller, this is not going to be the creation of a large government bureaucracy. It's going to be run by the private sector.

It's going to provide a new choice for consumers and businesses, but my hope is with some added features of cost control that we'll bleed over into other

segments of the market. So I'm optimistic about that. Now, Representative Delnicki, in your colloquy with Ms. Veltri and the visitors from other states with regard to, I think that was Senate Bill 328 and House Bill 5018, you mentioned about the providers and the patients fighting with the denials and should their treating physician, treating provider, be paramount and I would agree with that. If you look at our testimony with respect to the public options plans, the written testimony, I won't go through it, but there is a -- we could possibly encourage that type of behavior in the new plan to say that the plan should very much honor the treating physicians and my background, when I worked as a senior official at Medicare, I was deputy director at the program Integrity division there, and we spent several years trying to shift program Integrity from views onto one specific claim onto the providers, right?

In other words, it's great to stop a \$200 dollar claim that's wrong, but what you really want to do is find out the providers that are the outliers, educate them or discipline them and kick them out of the program. So that is perhaps an option as we set up a creative new program that we would have an option or tier within the plan that was a low denial or a no denial type of health plan and then we wouldn't have to do so much utilization review if they believed and trusted the doctors. They wouldn't have to review those claims and that could be an expense saving as well, but you mentioned that so I just did want to add an answer to that question. I'm happy to take any further questions, but as I say, I want to keep my remarks brief and I

will probably file some supplemental written remarks.

REP. SCANLON (98TH): I thank you, Mr. Doolittle, for your testimony and for your work at the -- as the healthcare advocate. I do see there's some questions, but before I do, I had a question not about your testimony, but about another bill that's before us and that's the governor's bill, specifically the portions of it relating to the regulation of stop-loss insurance and I was wondering if you had -- I didn't have a chance to prep you for this beforehand, but I didn't know if you had a chance to review that proposal.

TED DOOLITTLE: Yes, and I believe we filed some testimony on that. I do think that -- And by the way, the plans, the self-funded plans, with stop-loss plans on top of it, are being marketed in our state down to groups of five, so they're really getting down into really small areas, small companies, small employers, and -- but the stop-loss plans are in fact insurance the state does have the ability to regulate. The insurance department did put out a bulletin that was very positive recently on stop-loss plans. In terms of the bill, I would say -- one thing we mentioned in our written testimony is I do disagree with the bill's -- what I took to be the bill's position that the CID should no longer be able to put out bulletins with respect to stop-loss. I disagree with that because the market is changing fast and I think CID does need to be able to react. They can react much quicker than this body can if a problem emerges when you're not in session or something to that nature.

REP. SCANLON (98TH): Thank you. Questions from members of the Committee? Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. You mentioned in some countries that the insurance companies and the government work together. What countries are those, the Netherlands?

TED DOOLITTLE: So in the Netherlands and Israel, those are the two countries that I'm aware of in the developed world that really heavily use insurance companies in a way that's almost analogous to here, but the insurance companies don't negotiate the prices. You know, there is -- there is a back and forth process, not unlike the Massachusetts process you just heard described that ultimately results in some type of rate setting or cost control measures, so that's what I meant by the partnership. In other words, it's not just the insurance companies negotiate with the provider; there's some type of public role in that mix.

REP. VAIL (52ND): So in your opinion, and it sounds like it, that that would be in the actual best interest of the community and the people at large, correct, and the rate payers?

TED DOOLITTLE: Yes, I do think so.

REP. VAIL (52ND): Because again, this is my sixth years on this committee and it always seems like the government is battling the insurance industry here, but there's a very -- they're always up against the wall, defensive and all that, and I certainly don't feel too sorry for them, but again, I don't feel like we have that open dialog. We always have them on a hot seat and we're always trying to solve

problems, problems I recognize in here, but just passing it on to the insurance company. Well, the insurance companies do it, then pass that on to somebody else, and we never really get it to the core root of any of these problems, which is not always insurance-based. Sometimes it could be, but I think that would be a good approach and I'm glad you mentioned it. Maybe moving forward, that would be an approach that would be better served for us in Connecticut, so when we actually look to solve problems, we don't just look for the quick solution, which is making insurance companies do it, so I appreciate it and I guess that's it. Thank you.

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

REP. DELNICKI (14TH): Actually this isn't a question, I want to thank you for your quick response and the testimony you gave in response to my comments. Thank you.

TED DOOLITTLE: My pleasure, thank you.

REP. SCANLON (98TH): Thank you. All right, on to 320, we have Dr. Todd Falcone, followed by Senator Abrams.

TODD FALCONE: Thank you. Good afternoon, Senator, Representatives, and other distinguished members of the Insurance and Real Estate Committee. My name is Dr. Todd Falcone. I'm a board-certified otolaryngologist practicing in Farmington here. I'm here today on behalf of the over 1,000 physicians practicing in this state from the specialty medical societies of dermatology, urology, ophthalmology, and otolaryngology. I'm hoping to speak on a number

of bills and if permissible, I can briefly provide testimony on those bills, now starting with step therapy RB 320, of which are societies are in strong support of. The Center for Medicare Services defines step therapy as a type of prior authorization for drugs that begins medication for a medical condition, but the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions. It sounds like a desirable goal, but a more accurate description might be a type of trial and error prior authorization requiring the patient to fail the least expensive medication and treatment before being allowed to receive the more appropriate and often more effective medication.

Nobody wishes or should be subjected to suboptimal therapies. Requiring this of patients jeopardizes the patient's health and takes crucial and valuable treatment time, potentially jeopardizing a favorable outcome. Some health plans even force patients to return to treatment if they were ineffective when tried previously under a different insurance plan. Insurance plan formulary changes are beyond the control of most of our patients. RB 320 reinforces existing laws to ensure that patients have access to their prescription medicines. Health insurers are now required to expeditiously grant a step therapy override determination request if, in professional judgment of the prescribing physician, the step therapy requirement would be medically inappropriate for that patient. This law has actually served as a model for more than a dozen states that have recently enacted or introduced the legislation to reform step therapy.

For the sake of our patients health and wellbeing, it is critical that this law is maintained and enforced. RB 320 specifically addresses the importance of removing inappropriate step therapy for disabling, chronic, or life-threatening conditions like cancer where delays can spell disaster. Our physicians know our patients' medical history the best which enables us to identify potential contraindicating adverse reactions and retaining physicians' medical judgment in patients' treatment plans is a cost effective way to prevent healthcare dollars for being used on medications that are not effective. Hence, patients with prolonged sequence of treatment that include making multiple visits to their physician, wasting money on prescriptions, they are not effective.

As physicians, our number one priority is the health and welfare of our patients. Please support RB 320, which will improve access to prescription medications that are in the best interest of our patients. We understand the need to contain healthcare costs, so we are concerned that misguided step therapy strategies for medication and other treatment selection will add risk and impact patient outcomes and quality of life. I'd be happy to answer questions on that or move forward with the bills regarding adverse determinations and utilization reviews.

REP. SCANLON (98TH): Please proceed.

TODD FALCONE: Okay. So we're also in support of Bill 321, 335, and 341 regarding adverse determinations and utilization reviews. The Connecticut medical community has testified on adverse determination bills for many years. On a

regular basis, physicians are challenged on their medical authority and decision-making by insurers. We applaud the efforts of this committee to better understand the issues facing patients and the physicians when they deal with denial of services and the process that follows. Here are some principles that us doctors hold sacred and should be codified in the health policy. The belief that each health care service under review is medically necessary and the burden of proving otherwise should fall squarely on the insurer prior to denying coverage for that service. For over 20 years, Connecticut's professional medical societies have been completely consistent in our methods that no one is more qualified to determine the most appropriate and necessary treatment for each patient than the physician and caregiving team. If a utilization review is needed, the reviewer must be a like kind provider, someone with identical credentials and similar education and specialty training. In other words, if an otolaryngologist like myself is being reviewed, then an otolaryngologist should be reviewing the claim, not a provider with lesser credentials or training or a non-surgeon.

Why is like kind providers so important? Adverse determinations and utilization reviews literally call into question our decision-making process. Only providers with similar credentials, similar education, similar training would understand the nuances and complexity of the claim and current standard of care and we believe that any adverse determination must be clearly explained to both the patient and provider in a written and/or electronic notice that should include the following components;

a detailed explanation of the benefit, the reason for denial with the medical literature that supports the opinion, and the adverse determination notice must contain the description of the plan's review procedures and the time limit applicable to such procedures, including a statement of the member's right to bring a civil action following an adverse benefit determination.

In cases involving medical necessity or experimental treatment, health plans must provide free of charge and explanation of the scientific and clinical judgment used for the determination, not just the literature. Physician burnout and provider dissatisfaction is a growing and widespread phenomenon in our field, leading to loss of drive, enthusiasm on the part of physicians and providers, leading to early departures from the profession, diminished health, and sadly even loss of life. High on the list of stressors and causes of burnout in our field is the vast amount of time and energy required to counter adverse determinations and utilization review rejections. It is particularly frustrating when cases are denied, not based on sound medical decision-making, but rather by adherence to an arbitrary checklist by an individual who is often not intimately familiar with the items discussed since he or she is not training in our specific specialty.

Precious time is robbed from patient care and often denies the providers and patients opportunities for timely care and treatment. We strongly believe that the burden of medical necessity should be shifted away from providers and on to the healthcare -- the health plan or the utilization review company. This requires clear-cut documentation and the rationale

used when a service or treatment is denied, provided by a like kind provider. Thank you.

REP. SCANLON (98TH): Thank you, Doctor. Any questions from the Committee? Seeing none, I appreciate you being here and for testifying on a couple of bills today. Thank you. Senator Abrams, followed by John Peters and then followed by Representative Gresko.

SENATOR ABRAMS (13TH): good afternoon. I'm Senator Mary Daugherty-Abrams. I represent the 13th District and I'm here to testify in support of S.B. 346, the Connecticut Plan. Really, I'm here just to say thank you very much to the chairs, Senator Lesser and Representative Scanlon, and all the members of this committee for not giving up on this idea. I'm new to politics. When I got in and started doing door-knocking, healthcare was probably the biggest issue that I heard about. People's ability to have access to quality healthcare is so very important to our constituents and I think that's true for all of us, so I thank you for not giving up.

I'm here to say I support you and I offer myself to encourage you in any way I can to give me the honor of pressing the green button in the Senate this session. It would mean so much to me and on a personal note, I have had health issues. I had kidney cancer about eight years ago and I know what it means to have your entire life change in an instant, to get a phone call that makes -- just takes your breath away and I was very fortunate. I was in a position where I had sick leave, where I had good medical coverage, and I just from that moment on realized that there are other people that

did not have that same opportunity and I believe that healthcare is everyone's right, and so I just applaud you for doing this and for making my life a better one for being able to support you in it. Thank you.

SEN. LESSER (9TH): Thank you, Senator, and I must say you are such a breath of fresh air. It's been a pleasure to serve with you on the Public Health Committee, where actually both Representative Scanlon and I serve senior leadership and advocacy for people with healthcare needs. Other questions or comments from members of the Committee? Yes, Representative Hughes.

REP. HUGHES (135TH): oh, thank you, Mr. Chair. Thank you, Senator Abrams, for your testimony and for your personal story. We hear a lot about the costs to families. We don't hear enough about the personal health costs when either you sort of dodge a bullet by having that safety net and how we've normalized that so many of our citizens don't have that safety net and that we just accept that that's the cost of -- astronomical cost of healthcare in this country and in this state and I was wondering if you could say something more about how you hope that Connecticut can pilot and demonstrate a sustainable model for the country.

SENATOR ABRAMS (13TH): Well, I think the Connecticut Plan is a good step forward. I think just giving people affordable access to having some kind of insurance coverage that's meaningful, that isn't just an idea there, but doesn't really provide the coverage that they might need in that kind of a situation. I believe that people need to know what they're not going to be financially ruined should

they face a healthcare crisis or a member of their family does. I think they need to know that they have options in getting the kind of healthcare they might need. On a different note, I also appreciate the fact that people won't have to think about not starting businesses or taking jobs because of the healthcare benefit.

I am the mother of two adult children and I am very guilty of the fact that when they were out looking for their first job that I was pushing them to make sure that they were getting benefits because although the Affordable Care Act allowed me to keep them on my insurance until 26, that's not forever, and to look for careers, and so to limit people's dreams and opportunity, we're limiting everyone. We're having our own lives are affected by that because people are taking jobs that perhaps are a sure thing, so to speak, because they offer some financial security, including insurance benefits, but might not be what they really want to do to fulfill themselves and might be something we need them to do as a community that could make us -- all our lives better, so I think this is a step forward in that direction and that's really important to me.

REP. HUGHES (135TH): And your children are how old now?

SENATOR ABRAMS (13TH): Oh, my goodness, do I have to tell my age?

REP. HUGHES (135TH): I just wanted to know what your --

SENATOR ABRAMS (13TH): I'm a grandmother, I'll tell you that, three years old and eight months and my children are 30 and 32.

REP. HUGHES (135TH): So among their colleagues, what are you hearing in terms of where they're choosing to put in roots and raise a family? I'm just wondering what the impact, coupled with paid family medical leave, of making Connecticut a destination for a talented workforce?

SENATOR ABRAMS (13TH): Well, they were both already in other places when paid family medical leave came in, but there's a lot of legislation including that that I've thought about. Actually my daughter and son-in-law and my grandchildren just moved to Germany and they are -- available to them is subsidized daycare, so when they were living in the United States, they were paying for one child over \$2,000 dollars a month in daycare costs and now it's going to be for two children \$100 dollars a month. In addition, they will not have daycare for their children until my youngest grandchild is a year old because in Germany, you get one year of medical leave with pay, so it's very difficult to find daycare for a child under a year old. So when you start to look at things globally and what other countries are able to do for their citizens, I feel like we're better than this, we can do better, and we should be doing better. That's just to name a few. I mean, I could go into other things that have nothing to do with healthcare and insurance and jobs, but -- My son-in-law, because my daughter went over on a work Visa, he's allowed as a spouse to take any -- he's available to any job, so yeah, so it's really interesting when you start to see what other countries are doing and I think that we can learn from them and do better for our own citizens.

REP. HUGHES (135TH): Well, thank you for that because I really do believe that we are in a global

economy and not just a New England economy and these towns' skilled workforce can go anywhere in the world and why wouldn't they go somewhere that offers paid family medical leave, subsidized childcare, or, you know, first year paid leave to stay home. Why wouldn't they go there?

SENATOR ABRAMS (13TH): I agree, but I want them here, so I'm going to work hard to try to keep them here.

REP. HUGHES (135TH): I do, too. I want your children here, so that's why I'm wondering, you know, if we can sort of continue the groundwork for making this a destination. We are the country of Connecticut, you know, 3.7 million people come here. Okay, thank you.

REP. SCANLON (98TH): Thank you, Representative. Any further questions of Senator Abrams? If not, thank you.

SENATOR ABRAMS (13TH): Thank you.

REP. SCANLON (98TH): John Peters, followed by Representative Joe Gresko and then we're going to move on to our third bill of the day, S.B. 321.

JOHN PETERS: Thank you. Good afternoon. My name is Dr. John Peters. I'm a resident physician at Yale-New Haven Hospital specializing in neurology. The testimony I have today represents my personal views, not necessarily those of my employer. I'm here today to support Senate Bill 320, prohibiting the requirement of step therapy for individuals with chronic, disabling, or life-threatening diseases because I believe it will improve care for patients with neurological diseases, specifically multiple sclerosis, also known as MS. MS affects the brain

and spinal cord. As recently as 15 years ago, there were only a few medications to treat MS and they were only moderately effective. Since that time, newer, more highly effective medications have been released that are much better preventing disability, especially in patients with aggressive disease. Insurance companies, however, often restrict these more highly effective medications to patients who have failed older, less effective, less expensive ones.

This is a big problem. I guess many studies have shown that early treatment with effective medications is the best way to prevent disability in MS. I recently saw a patient with MS in our clinic. Her disease had stabilized on one of these highly effective medications and she didn't have any day-to-day symptoms and then she changed jobs, her insurance provider changed as well, and her new company, insurance company, refused to cover the medication that she was taking. She had never been trialed on the older, less effective medication that was their preferred medication. The patient and her physician made numerous phone calls and letters to her insurance company to request an exemption, which they eventually got later, however, for her it was too late because this delay in her treatment, to miss doses of her medication, caused a flare of active disease in which she lost vision in her left eye.

Our field of medicine is constantly evolving with new treatments being developed faster than ever. Our patients should be able to benefit without interference from insurance companies and is often based on outdated information. Current fixes to this problem, like having physicians apply for

exemptions, are inefficient and don't go far enough to help our patients. It places too much of a burden of paperwork and phone calls on physician and we are already limited in our face-to-face time with our patients and with people with diseases like MS, like the woman I saw in clinic a few weeks ago, treatment delays can have significant consequences. Step therapy does have a role in reducing healthcare costs and I don't oppose its use in more limited circumstances, but it does not have any utility in potentially disabling diseases like MS where outdated requirements can lead to the development of consequences that have much higher long-term costs for the patients and insurers. I thank you for your time today and hope you support Senate Bill 320. I think it will help our ability to care for our patients. It will make our ability to get our treatment meaningfully better and I'll be happy to take any questions you have.

REP. SCANLON (98TH): Good to see you first of all, Doctor, and second, good to see Dr. Kennedy with you today. I want to thank you for sharing that important story. I think it's a very important perspective for us to keep in mind. Any questions from the Committee? Seeing none, Doctor, thank you for being here today. Representative Gresko.

REP. GRESKO (121ST): Thank you, Mr. Chair, distinguished member of the Insurance Commission. I'm here to testify in favor of Senate Bill 320. Step therapy, you've heard from the doctors before being much better, more competent in the situation than I am. I'm going to give you two quick scenarios that some of you might have experienced here or some of you might not have. One of our - Two of our former colleagues had experienced this

firsthand in their lives. Representative Orange used to put this bill in every session and Kevin Ryan was nice enough to do it with her and so I kind of picked up the gauntlet here and she had a lot of issues that she dealt with even before her own with her family and so she was very much in favor of this bill and I could tell you from personal experience working with my predecessor and helping him through his ordeal that this bill would have helped Terry out in a big way.

He did not take part in any of the step therapy because he was convinced that he, I'm going to be honest with you, he used a compound that he got from the University of Edmonton in Canada that he was convinced was the reason why he stayed alive for six extra years, so that would not have been available through this step therapy and he was convinced that it saved his life for six years. So if we can explore this going forward. I know it's a short session, but if we keep the conversation going, hopefully one of these sessions will be successful. Thank you, Mr. Chair.

REP. SCANLON (98TH): Thank you, Representative, and obviously we all know how close you were to one of those people, Representative Backer, and obviously we were all close to Linda and we miss her today and I know we're thinking about her in this debate, so thank you for being here on her behalf today. Any questions from the Committee? If not, thank you. Okay. Nobody was on 321, so we'll go to 322, Steve Hunt. Steve Hunt in here? All right, followed by Representative Gilchrest.

STEVE HUNT: I've been doing this for some 20 years now, both individual and small group health

insurance, Medicare products, etc., so I have a very good idea of what people actually get when they get out there in the real world. A couple corrections, there is no \$10,000 dollar deductible on a fully insured product. The Affordable Care Act sets the maximum amount the out-of-pocket can be in-network and it's currently at \$8,150 this year, so there are high deductibles to be sure, but not always quite as high as we want unless, of course, you go out-of-network. Now, I've seen a lot of these and if you don't mind, I'm going to kind of combine it because I signed a few things, but for in the interest of time.

A lot of issues being discussed today I support. Re-importation of drugs, it is ridiculous that we pay twice as much. What happens is the drug company wants \$200 dollars to make their numbers. Canada goes you're going to \$100 dollars, choke on it, so they sell it America for \$300 dollars and split the difference. What should be noted is yes, we don't want our arm wrapped to bring down the cost, but we also don't want to put the companies out of business and/or not have them develop the drug. Re-importation would effectively split, it would bring the cost down here, but it would bring the cost slightly up in other places, thus allowing the market to supposedly work. So in that particular aspect, I think they're spot on.

As far as re-insurance, it's not a bad idea. It's been shown to have some success in other states, I believe Alaska uses it, and to some extent successfully. So these are all things that I think could help us and there's been a fair amount of emphasis on cost, which I find a little bit refreshing because normally it's all just beating up

the insurance companies as opposed to trying to actually lower the cost of what's being insured. There's a note about rate increases, which I had to see an official thing. I would only tell you that while they should consider affordability, affordability is a, a very fluid topic, and b, if you make it so that they can't make any money, they're going to exit. Now we have two carriers left offering individual insurance Blue Cross and ConnectiCare. Prior to the Affordable Care Act, I had eight that I could offer people.

Now you're coming and saying we should have a public option. Well, could be good, could be bad. I suppose my logical question to the Committee and everybody else would be, am I as an agent being asked to go out there and train my replacement here or am I going to be allowed to sell this and be paid for it like any other product? If it's the former, nobody in my shoes is going to support it because well, you'd be more efficiently putting yourself into the poor house. I'd remind you that we also are small businesses, we also are middle class families. Most of us are independent contractors, which means we also have to buy the insurance that we show, etc. If, on the other hand, it's the secondary thing, well, then you've got another product to add and you could turn around and probably make some use of it. If it's the former, where it's just essentially a competitor to you that you can't do anything with, the response to the people in my shoes is probably going to be to take the people who have the worst health conditions and send them deliberately there in a delivered attempt to try to bankrupt the program because we don't really have much choice otherwise.

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So I guess I would say in my conclusion to the Committee is, it is refreshing. You hear it talk about partnership. It is refreshing when you hear them talk not as if we're somehow the enemy, but are people out there and much like the front line provider that you mention, the PCP or the OB-Gyn, we're sort of the front line people that do this because while we might only be a couple thousand people, we're a couple thousand people advising a couple hundred thousand people. They're going to call us and they're going to ask us what do I do. If the guy in my shoes simply has a third product to offer, we're going to analyze it and do it. If the guy in my shoes doesn't, well, you've essentially got your back up against the wall facing the firing squad and people are going to react to that in a variety of ways, not the least one of which is, like I said, they're going to try to adverse selection. So please look at some of these proposals.

They are good. It's nice to hear that some of these things are not quite as adversarial as they used to be, but try to remember that there's people out there in the field that have to deal with this in real time. The amount of the premiums has gotten to the point of impossibility unless, of course, you're subsidized and if you knew the difference between say the standard silver plan for a guy making \$62,000 dollars a year for a couple and the standard silver plan for a couple making \$70,000 dollars a year, the difference in premium, and I am not joking, can be anywhere from \$10,000 to \$25,000 dollars a year. So there are these cutoffs that happen. If you're getting the subsidized plan, very few people are going to look elsewhere because why should they, it's subsidized, and let's face it, you

can make a Ferrari cost less than a Fiat if you put up enough money.

The other people won't, so what you've got to ask yourself is how you really want to re-jigger the market and do you want to do it smoothly and cooperatively or is this going to be another battle. Anyway, that's my two cents worth on the subject. If anybody wants to ask me any questions, feel free.

REP. SCANLON (98TH): That was like ten cents worth, that was a lot of good information, so I appreciate that. Any questions from the Committee? Seeing none, I just -- Yeah, Representative Vail.

REP. VAIL (52ND): Again, just so people know. Good afternoon. How much training do you have to go through to be able to sell health insurance in Connecticut?

STEVE HUNT: Well, the -- you have to have an insurance license, so that would be based on the Department of Insurance's program to get a life and health license, okay. Beyond that, I will be honest with you, the vast majority of the training is you figure it out, it's on the job, it's always been. There's no formal training program that really has been set up other than the Access Health will provide their own tutorial program and actually they've been useful in a lot of ways. They've gotten a lot better, so my sort of review of the exchange is that they have tried and they have improved a lot from where they were originally starting and they were also asked to do probably three years' work in a year and a half type thing, so it really wasn't fair to jump down their throats quite as much as it is.

If everybody works together, including the guys in my shoes, their shoes, and everything else, you could actually smoothly transition some of this stuff. And you have an opportunity take people that may not have been otherwise doing this or may not be employed at all, particularly in the places like your inner city communities, and if you could give them a product that was sellable and get them the ability to sell it, then you could actually have some, you know, kind of a double win, where you could take the people within the community and enroll the people within the community, but you've got to have something that's sellable. Most of these people, of course, are going to be Medicaid, so it would likely not fall on that. Most of these things that you're mentioning are either going to be small businesses or non-subsidized individuals and the non-subsidized individuals, they're just going to be anybody over the income cutoff.

So as far as an actual formal training program, you guys could do that if you so desired, but as an independent, no one carrier is going to do all of the training, so they're all going to provide their own podcast or various things that you can go to, but it's not -- there's not like a test that you have to take other than the license itself and, of course, your annual certifications. If you want to be selling the exchange, you have to be certified and pass their test, if you want to sell the Medicare plan, you have to do the Medicare test. Each carrier can have their test, so that's kind of how it works. I hope that answers your question. Anyone else?

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

REP. PAVALOCK-D'AMATO (77TH): Thank you, Mr. Chairman. So what do you think would be the impact on the Affordable Care Act market in Connecticut?

STEVE HUNT: Can you be -- Do you mean introducing the public option?

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

STEVE HUNT: How's it being introduced, what is it being priced at, am I able to sell it, am I going to be able to be paid to sell it.

REP. PAVALOCK-D'AMATO (77TH): So it all depends --

STEVE HUNT: Well, if it's another product that's relatively the same as the products that are out there, if you're going to take the actual state program and not water down the deductibles and things, you're just going to take the actual thing, then you're talking about like a gold plan, okay, so it would compare roughly equal to maybe the gold, you know, exchange products. It's a little bit cheaper, somebody might buy it, but the vast majority of people that aren't getting subsidized are going on the bronze HSA plan because it's actually to hit the deductible than it is to payer the higher premium in a lot of cases.

If it's a product that can be used, if the agents can be paid, and understand that when we get paid, okay, it's not thousands and thousands of dollars. Last year, the highest pay that you could get for an individual plan was \$30 a month, that was for a family. For a premium of \$2,000 dollars, that's a very negligible amount. As long as there's something that's relatively equal to the rest of the things, it doesn't have to be exact, where the guy isn't being asked to basically put himself out of

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business, it will get offered along with the other plans and it will get fit in and if you're patient with it and give it a few years, look at Health ECET. We were just working that into the market, I just built a pretty good book around it, and then the Affordable Care Act, which created this mandatory co-op which was supposed to lower cost, also had a provision in it that said if you do come in so much deeper than everyone else, you have to give the other people that aren't coming in cheaper money, which they couldn't do, so we shut it down.

What has to happen is you have say okay, here's a new product, you're not our enemy, we want you to work with us, give us a couple year trial period, and see how it goes and make it a work in progress. If the guy sitting in my shoes trusts you, they're going to go out and they're going to tell all the people that are asking him, because people are going to comment, well, what is it, and the answer is it's whatever I want it to be because I'm there and nobody in the committee is, okay. If the answer is hey, the state's allowing this as a way to try to control costs, it's a new product, give it a try. If you don't like it, we can always change at an open enrollment, etc., etc., etc., and you do it in such a way as that the other two carriers don't go well, forget this, if we can't compete with the state we're out and that's it and that's all you have as a plan, then yeah, you could make it into something that could potentially help. You can certainly take a lot of the other ideas that were mentioned here, like the free insurance and stuff, that will certainly help. It's do we want to be -- Do we want to fight each other or do we want to try to bury the hatchet a little bit and all work

together and maybe make things a little better. I think we can, but that's up to -- you guys were the ones voted into office. I'm just a constituent.

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

REP. SCANLON (98TH): Any further questions? Seeing none, thank you for being here today.

STEVE HUNT: Thank you, guys.

REP. SCANLON (98TH): All right. We have Representative Gilchrest, followed by Dr. Gary Shangold, followed by Senator Heather Somers.

REP. GILCHREST (18TH): Senator Lesser, Representative Scanlon, and members of the Insurance and Real Estate Committee, thank you for having me today. I'm Jillian Gilchrest, state Representative for the 18th District of West Hartford, and I'm here in support of Senate Bill 336, AN ACT PROHIBITING CERTAIN HEALTH CARRIERS AND PHARMACY BENEFIT MANAGERS FROM EMPLOYING COPAY ACCUMMULATOR PROGRAMS. I'm here on behalf of Colleen Brunetti, a West Hartford resident, fierce advocate, and woman living with a rare disease -- pulmonary hypertension. Colleen would be here today, but she is Philadelphia participating in a clinical trial in a desperate bid to lessen the time and complexity of the medication she has been on for a decade. Colleen's life-saving medications cost more than \$250,000 dollars per year. She has a high deductible health insurance plan with an out of pocket max of \$7,450 dollars. Because Colleen's medications are so expensive, the drug company offered her a copay card. In 2018, Colleen had a \$6,000 dollar copay card which she was apply towards her high deductible, but by 2019, the

insurance companies had caught on and no longer allowed Colleen to apply the copay card towards the high deductible. This is referred to as a copay accumulator program. Copay accumulator programs prevent patients from using copay cards to cover their out-of-pocket drug costs. A patient must pay the full out-of-pocket cost to access medications.

Programs like copay accumulators present a huge financial burden, and also an emotional one.

Programs like co-pay accumulators present a huge financial burden and also an emotional one. They create walls to access the care doctors say a patient needs and create unnecessary work and worry on the part of a patient and their family about how to afford the same medications that were otherwise affordable before copay accumulators were introduced to the market. Colleen and I recommend that Senate Bill 336 require all insurance plans to accept all copay assistance, be it from copay cards or charitable foundations, and apply that assistance toward a patient's deductible. There is a loophole in the Affordable Care Act which allows insurance companies to deny copay assistance in any form. As currently drafted, Senate Bill 336 requires insurance companies to accept the assistance, but it does not require insurance companies to allow that assistance to be applied toward a deductible.

We encourage the Committee to do both. We also recommend that the bill be explicit that both name brands and generics be covered by copay assistance and applied to the deductible. We don't want to inadvertently create another loophole. While the availability of generic variations may have reduced the list price of some pulmonary hypertension

therapies, that therapy is still financially out of reach for many patients without copay assistance. We remain committed to the idea that all copays count and should count towards a patient's deductible, whether from copay cards or charitable assistance, and regardless of what tier or formulary a drug may fall under. Thank you for the opportunity to testify.

SEN. LESSER (9TH): Thank you, Representative, and, you know, I note that Senator Looney testified in support of the same bill earlier and I assume you are working with him on this legislation. This issue is something that we continue to scrutinize, as well as the, you know, growing problems of rebates, whether to consumers or to pharmacy benefit managers throughout, that seem to be manipulating and affecting the ability of the patient to get the prescription drugs that they need, so thank you for your testimony and our advocacy on behalf of your constituent and hope that she's doing well in the clinical trials. Are there questions or comments from members of the Committee? Yes, Senator Anwar.

SEN. ANWAR (3RD): Thank you so much, Representative, for your testimony and pulmonary hypertension is very dear and close to me because this was a universally fatal disease in very young individuals and more women and thankfully now people don't die from it, they die with it, because we have some so far in our treatment, so this is a life-saving treatment that's there, but what's happened is that the cost of this treatment is so significant that on average, a person is paying about \$100,000 dollars to \$250,000 dollars to be able to be managed on these medicines, but in the absence of those medicines, these young people die. It's truly life-

saving and the pharmaceutical industry defines or decides the cost of medicine based on what the market is willing to pay and that's part of the challenge, but also these mechanisms of the copays and the deductibles truly have people to make a decision about what to eat, where to live, how to live the remaining part of their lives or make some other choices that nobody should have to make those choices.

And at times, these medicines have not necessarily reached many of the other countries to the level that they are over here right now, but if somebody else was making them, they would be far less expensive and while we wait for that, I think we have to address this and I truly thank you for speaking not only on behalf of your patient, but thousands more in our state. Thank you so much.

REP. GILCHREST (18TH): Thank you.

SEN. LESSER (9TH): Thank you, Senator. Any other comments or questions of the Committee?

Representative Vail, it looks like he was going to ask one, but I think he's passing on this one. Thank you, Representative Gilchrest.

REP. GILCHREST (18TH): Thank you very much.

SEN. LESSER (9TH): Next up we have Dr. Shangold, followed by Senator Somers.

GREG SHANGOLD: Good afternoon, Senator Lesser, distinguished members of the Committee. Thank you very much for the opportunity to present the testimony. My name is Greg Shangold. I'm the president-elect for the Connecticut State Medical Society. I'm an emergency physician and I was also a member of the High Deductible Taskforce, so,

although I'm here to give testimony on Senate Bill 323, hopefully I'll see you again when you take up a bill some of those recommendations. I read Senator Looney's testimony and heard it in regards and we have no issues with the mild technical changes that he proposed, but the bill that was actually submitted dramatically changes the bill and we oppose that.

In 2015, through a compromise, this committee and the state legislature passed a model legislation for the entire country on surprise billing and it has been working very well, so as other states struggle with this issue, nationally struggling with this issue, we actually have a bill that protects patients from being in the middle of out -- what's considered out-of-network. So I just want you to be careful about definitions that are already in statute. For your reference, it's Statute 15146, but surprise billing is non-emergency care and what the edits in this bill do is to try to put emergency care into that surprise billing. Emergency care is slightly unique. For those that don't understand EMTALA, there's an EMTALA mandated care. The care is 24/7. We are the safety net, Representative Hughes talked about the safety net. The emergency department is the safety net for Connecticut. We see 1.75 million visits every year here in Connecticut and so there is some unique natures and I believe that's why this compromise was struck and brought it out.

I just want to give you a small anecdote, right. So today's issue, the crisis, is Coronavirus. Every year we have influenza that kills multiple patients per year. Imagine a Friday night, patient has a fever, chest pain, shortness of breath, there's no

other options. They go to the emergency department. That patient can have a large differential. It could be influenza, it could be Coronavirus. We are there to take care of that patient. How we get paid is out of it and the patient should be taken care of, but if that patient then gets a bill after the fact, it should only be what's in-network and that's what today's bill already accounts for. If we change that bill and put more pressure on insurance companies -- or on the doctors to just take it or leave it or partners with insurance companies, that would dramatically affect the ability to staff emergency departments and make that safety net available.

The professional component, which is what this addresses, is a very small component of the entire emergency department bill and what this does is it gives a tool for emergency physicians to negotiate with insurance companies and ultimately the patient is protected as it is now, so I urge you not to make any changes other than those that were indicated by Senator Looney. Thank you.

SEN. LESSER (9TH): Thank you, Doctor, and it's been a pleasure working with the state medical society on all -- on a number of different healthcare reform issues. Just a question about -- Obviously we rely on, depend on emergency room care and that is a critical part of the healthcare system, but my sense is that there's been an increase in the number of emergency rooms that are currently out-of-network. Can you -- Is that accurate and if so, what do you see as the main driver of that?

GREG SHANGOLD: So in Connecticut, there's a couple models. Some emergency departments have hospital-

employed emergency physicians. Other ones have looked to other models where there's large corporate groups and then there's a few that are private emergency physicians just like an anesthesiology group or a radiology group and hospitals make the decision of what is the best product, so what is a good product for emergency medicine? I'm sure if we asked people to raise their hands in here, how many people have access to an emergency department, you want to be seen quickly, you want to have high quality care, you want it to be nice, you want it to be clean. I mean, we all have a definition of what that is. And the hospitals choose that model. I personally serve in a private model. My group takes care of 115,000 emergency visits a year at four of Connecticut's emergency departments and I believe we provide excellent care. Our median door to doctor time is 10 to 12 minutes and our discharge patients on average stay 120 minutes. So there are multiple models out there. I don't think there's been a huge, dramatic change over the years, but sometimes it's a financial and quality and all that goes into that value-based decision of cost and quality and patient satisfaction.

SEN. LESSER (9TH): Okay. Thank you very much. Other questions? Yes, Representative Delnicki.

REP. DELNICKI (14TH): Just a quick comment. I want to thank you for coming forward and actually giving us a check on that language and what you're concerned about an unintended consequence because at times there's an unintended consequence through some action that we may or may not take and that's good to get a check from somebody who deals with this every day.

GREG SHANGOLD: Thank you, Representative.

SEN. LESSER (9TH): Thank you, Representative. Are there other questions? If not, thank you very much for your testimony. Senator Somers. Following Senator Somers, we'll have David Lowell. Senator, apologies, I know you've been waiting for a while.

SENATOR SOMERS (18TH): That's okay. I'm testifying between a couple different hearings today. So thank you for affording me my space out of turn. To Chairman Lesser and Chairman Scanlon and distinguished members of the Insurance Committee, I'm here to testify on a few bills, so I'll go quickly. The first bill I'd like to testify in support of is S.B. 319 for podiatrists. They do quality work and really, they don't have parity. Nobody knows the foot better than a podiatrist, so I fully support that bill. I also would just like to make a comment on S.B. 328 as far as the Canadian drug re-importation, I don't want to go into it now because I know that you have a very long hearing in front of you, but I have serious concerns about re-importation from Canada that I'm happy to go through with any of you in detail and the problems that I see on the horizon for that particular portion of the bill.

Today, I am here to bring a perhaps a different perspective on the public option bill from somebody who spent my career in healthcare overseas. For 18 years, I have seen government-run healthcare systems intimately and have seen -- oops, I forgot to do my wipe down here, the less than panacea effect of a government-run healthcare system and I think it's important to keep that in perspective and I hear a lot of misinformation about how other countries are

run as far as their healthcare system and I'm happy at some other time to talk to you about what I have personally seen. Today I have with me JP Wieske, who is the former deputy commissioner of insurance from Wisconsin and also right now is the executive director of Health Benefits Institute and I think he can shed a different perspective on the potential public option bill here in the state of Connecticut. So thank you and I'm going to yield my time to him.

JP WIESKE: Thank you. I am JP Wieske. I am a recovering regulator in the state of Wisconsin. I left the department earlier this year. I would note that we have some concerns with the state-run public insurance pool. We -- In my experience in the state in regulating the ACA, from the start of the ACA, it has been very important to understand the nature of your market and we ran into a number of problems and this proposed pool is risky and that's my ultimate concern is it's risky. When we look at healthcare financing, when we look at the market at large, there is a hydraulic financing sort of system where when you push up in one area, it goes up in another area and that's where the concern comes from. You have two insurers left in the individual market and if you look at what the key protections that the state insurance departments have in place, it's listed in my testimony, looking at the rates, looking at the market at large.

The problem with a state-run pool, as this state-run pool is, is that it's set up on a system that is not the same as the ACA. It will damage the ACA marketplace significantly. A few specific examples, if you look at rate review, we not only look as a regulator at whether or not the rates are sufficient and excessive, we also want to make sure that

they're not too low to upset the market. There are rules going back to 1996 that limit the ability of an insurer once they exit the market to come back. If you look at Kentucky in the late 1990s when they proposed a similar plan for state employees to allow individuals and small businesses inside their state pool called Kentucky Care, Kentucky Care eventually went bankrupt and had to be restarted. I understand that that's not the intent here and I understand it wasn't the only reason Kentucky Care went under, but it had its significant effect. Every single business that went on the pool had a loss ratio in excess of 100 percent. Pricing for these issues is extremely important. You need qualified actuary to sign off the rates. It is a vastly different market in the individual and small group market than it is in the group insurance market and large employer. I would also note that it's inaccurate to say that the proposal reflects a federal only requirement on regulation. In fact, what the proposal is is a state-run MEWA, multiple employer welfare arrangement, and maybe some area with the AHPs from the Trump Administration, which is one form which is this is not of, but it is -- those are primarily and exclusively regulated by the states. They are regulated by the states because in the 1980s, a number of those MEWAs went under and there were significant financial problems.

In the state of Wisconsin and the state of Connecticut, the private market is not, in fact, allowed to sell MEWAs. They have to become licensed insurers. It's a very important distinction because the nature of that risk, there's an accessibility risk that attaches to all of those employers in that pool and as the insurance agent talked about before,

it's likely, especially if the agents are not selling them and especially if you look deeply at the market. I ran -- I also ran Wisconsin's healthcare stability fund and reinsurance pool, if you look at the unsubsidized pool that would likely go into this market, it tends to have a much, much sicker population than the market at large. That means that the risks of this pool are significant and it's important that the pricing is appropriate so it does not drive the other carriers out of the market and it's important that the pricing is appropriate so you have -- it's to have an ability to not have to share the risk across the pool. So we have a variety of concerns, a lot of them are detailed and a lot of them are consumer pieces in the network adequacy requirement, which is required. There's no ACA requirements being met. By and large, it's -- there are a lot of promises without language being put in the bill and I appreciate the comptroller's commitment to putting all that language in the bill. All that language needs to be in the bill if you're going to even consider moving forward, but you also need to have the Insurance Department review the rates and make sure on what the affect is on the marketplace. So I'll stop there and I'm happy to answer any questions.

REP. SCANLON (98TH): Senator Lesser.

SEN. LESSER (9TH): Yes, thank you, and thank you, Senator, and thank you for coming all the way -- Did you come all the way from Wisconsin?

JP WIESKE: From Green Bay, Wisconsin, yes, sir.

SEN. LESSER (9TH): Okay, well, enjoy our tropical Connecticut weather.

JP WIESKE: It's warmer than it is in Wisconsin, sir.

SEN. LESSER (9TH): Fair enough. I have some questions about your testimony, but before that, Senator Somers, I just have to out of curiosity, do you participate in the state employee health program?

SENATOR SOMERS (18TH): Yes, currently I do.

SEN. LESSER (9TH): Thank you. So just with regard to the questions that you experienced in Wisconsin, when you were serving in Governor Walker's administration, were you involved in Governor Walker's implementation of the Affordable Care Act?

JP WIESKE: I was, yes, directly.

SEN. LESSER (9TH): And were you involved in his litigation regarding the Affordable Care Act?

JP WIESKE: I was not.

SEN. LESSER (9TH): Okay. So when you're talking about the potential impact of this proposal on the marketplace, it seems like you see two potential -- you're outlining two potential paradises of horrible on the marketplace, one is that pulls all of the bad risk out of the marketplace, which I assume would be good for the private insurers who are currently in it, and then the other would be that it pulls all of the good risk out of the marketplace, this being bad for the insurers. I -- Obviously, both of those can't be possibly be true, so which is it that we should be concerned about?

JP WIESKE: Yeah, I think you -- I think to be fair, you do need to look at both as an issue and I think as the prior insurance agent talked about, the way

the plan is structured is important. That's why you need to take a lot of time to design these and you need to study it in detail for a long period of time and have a ramp up and have a final bill with a lot of details like other states have sort of looked at and in a number of cases have substantively changed their approach, like Washington State, and you know, I think the concern is that if you priced the product too low and you pull too many people into especially a small group market, you lose your small group market and if individual -- if carriers exit that market, they can't come back for five years. Similarly in the individual market, if you have too much business going in, that's poor risk.

It's going to drive the cost of the pool at large. There are no reserves set up in this. The structure is bizarre. We ran three separate insurance pools in federal office, as well as sitting on the state employee plan and I haven't seen any structure that's similar, where there's no sort of firewalls that are attaching. It's just sort of regular reporting. We had all of that in each one of those, you know, there are different pools where that was in each one of these pools. That's a concern as well from a financial perspective.

SEN. LESSER (9TH): All right. I understand and I think I heard the comptroller say this morning that he intended to address some of that, certainly the network standards and certainly response to comments and work out some of the legislation last year. There was comment about reserve pools. If that all was added, would that mean that you would support the legislation?

JP WIESKE: No, again, when you sit in the chair that the insurance commissioner sits in, at least where I sat in Wisconsin, and we had 13 carriers in the state, but there were areas that only had one and my home region had a single carrier left, it was our co-op, which still exists. The rates went up 105 percent for all the consumers. We were facing the possibility of a market without carriers. You get a three-year requirement to stay inside this pool and a five-year out for the carriers. It's possible that when the three years is up, they don't have any place to go. If you ask Kentucky, when they looked at their market, it takes a long time for a market to recover if carriers need to exit the market.

SEN. LESSER (9TH): Would you say that the small group market is working right now?

JP WIESKE: I'd say there are affordability issues in the small group market and would say that we're working on a project in North Dakota separately looking at hospital costs as well as insurance costs in the small group and individual markets. I just sent seven pages of potential policies and solutions as part of the final report that we're going to eventually do in North Dakota to try to find some solutions. I think there are problems in the small group market, yes.

SEN. LESSER (9TH): So, you know, to the extent that you're arguing that this bill would -- Well, you sort of move back and forth between individual and small group, it wasn't clear what you were representing. The bill does not contemplate allowing individuals to purchase into a state-run pool, but --

JP WIESKE: It does, correct me if I'm wrong, it does have the fully insured piece for individuals. Correct?

SEN. LESSER (9TH): Correct.

JP WIESKE: Okay. Thank you.

SEN. LESSER (9TH): Yes, so the -- but to the extent that, you know, I guess you would argue that this would somehow have a destabilizing effect on the small group market, you would agree that the small group market is already destabilized, is that -- I don't want to put words in your mouth, is that what I hear you say?

JP WIESKE: I think there are issues in the small group market and I think when you look at the small group market, it depends on who you talk to and where they're at and I haven't studied this specific market, right, but I can tell you that we allowed small businesses to keep their pre-ACA plans and about 55 percent of what Wisconsin consumers or businesses were still on pre-ACA plans when I left. There's an affordability issue there because there's not a lot of flexibility inside the small group marketplace and so I think a piece of that is having some plan flexibility for small business to be able to do it in the market at large.

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

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

REP. PAVALOCK-D'AMATO (77TH): Thank you, Mr. Chair, and thank you for your testimony. Could you -- If you could just go over a couple more details about that Kentucky Plan and what happened there. I

don't really have any background, like when it was implemented and then you said you thought there were a couple other factors that contributed to it. I was just wondering what those were to the decline.

JP WIESKE: Yeah, so Kentucky in the early '90s did a health reform plan that significantly impacted the individual and small group market which caused carriers to leave. They were in a similar situation with only a few carriers left in the market and so they decided that the solution to that in part was to add state -- add individual and small employers to their small group, into their what's called the Kentucky Care Plan, which was also a self-funded plan. They did not have sufficient reserves. They did not run it in a reporting requirement like you would expect. They ran it similar to the way this is proposed to be run, which is run like a Medicaid sort of style system where money comes in and money goes out and then you figure out, you know, what your loss ratio is, so it wasn't sort of a normal insurance practice.

It did not have reinsurance, like there's no requirement in this bill to have reinsurance, and so the net result over time was you -- if you don't have consistent checks on the way these things operate, there's a pressure to keep the premiums artificially low in a given year for whatever reason and when you start doing that, it snowballs into a bigger and bigger problem as times goes on. You need sufficient controls and recording consistently to get there. You need reinsurance for something like a Coronavirus having an issue so you would have some protection in case you're having large dollar -- large amounts of claims come in so you can protect your state budget. It provides a smoothing effect

over the course of thing. They didn't do any of those and so the net result was they had to restart their state employee system again.

REP. PAVALOCK-D'AMATO (77TH): And so did they have to go to the general fund for that money or what did they do?

JP WIESKE: They did. There was -- That's correct. They did have significant losses in the state employee plan and eventually every carrier except those that were physically domicile in Kentucky left. Now certainly, some other companies do exist, they just -- nobody could buy insurance in the individual and small group market.

REP. PAVALOCK-D'AMATO (77TH): Now Senator Looney expressed an interest in having the plan open to the state employee plan also participate in that. What are your thoughts if that were to occur? Do you think it would be more viable if that was the case?

JP WIESKE: I'm sorry, I --

REP. PAVALOCK-D'AMATO (77TH): We discussed having the plan actually include the state employees. Do you think that would make it more -- Would you be more comfortable with that?

JP WIESKE: You know, it provides -- it obviously provides a bigger base, but the problem is that you start violating ERISA and you become an ERISA plan and I don't know all the -- I'm not a lawyer. I don't know all the legal requirements, but that starts getting complicated. It's not something that anybody has done, to pull that plan into an entirely different regulatory scheme, and I think when you're dealing with subsidies going back and forth between state employees and the private business, that

starts getting complicated. I think there are better, more effective ways to properly deliver subsidies if you have a concern about that.

REP. PAVALOCK-D'AMATO (77TH): And just one last question, so you're -- as far as reinsurance, what are your --

JP WIESKE: I can only speak to our experience. We ran what's called the Wisconsin Healthcare Stability Plan in the state of Wisconsin. We ran a \$200 million dollar program in the state; 65 percent of the cost of that program were funded through the 1332 Waiver coming back from the federal government. That -- So the state was on hook for about \$64 million dollars a year. I mean, we have a bigger population and a bigger exchange population than you have here. It resulted in about 11 percent savings. We also have higher rates in Wisconsin and it resulted in 11 percent savings in the first year and savings each of -- actually net lower premiums the next two years after. So it wasn't just that the -- we dropped the rates 11 percent, it was that they were actually lower both years from the year before on average. There are exceptions to that, obviously.

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

JP WIESKE: Thank you.

REP. SCANLON (98TH): Any other further questions from the Committee? Where did you fund the \$64 million dollars for the reinsurance?

JP WIESKE: We funded it directly out of the general purpose revenue. When you fund it -- When you fund it with the insurers, the effect is you're spreading

-- you're essentially doing risk spreading, right, and you're not actually having any real savings. If you're funding out of the general purpose revenue, you actually get a net decrease. The savings in the programs, you know, it's roughly \$200 million dollars. We estimated at the time that I left that it would save about \$210 million dollars in premiums for consumers in the state.

REP. SCANLON (98TH): And do you know what -- Do you know if Kentucky had what percentages dropped premiums during the time that it was in existence?

JP WIESKE: So it's been in existence two years. The first year, I know it was 11 percent and I think the net premium drop was 1 to 2 percent, it might have been as high as 5, and I think last year there was a drop of about 5 percent, but don't quote me on those numbers.

REP. SCANLON (98TH): And has the current governor continued to fund that program or did that go?

JP WIESKE: In fact, I met with the insurance commissioner, the new insurance commissioner, last week and we chatted about that and they're very happy with the effect of the reinsurance program and they continue to run it and continue to support it and it was completed as a continuing piece in the state budget. Yes, sir.

REP. SCANLON (98TH): Thank you. Any further questions? If not, thank you again, both of you.

JP WIESKE: Thank you.

REP. SCANLON (98TH): All right. We're on 324 and David Lowell.

DAVID LOWELL: Good afternoon, Senator Lesser, Representative Scanlon, distinguished members of Insurance and Real Estate Committee. My name is David Lowell. I am the chief operating officer of Hunter's Ambulance Service, but I'm also the president of the Association of Connecticut Ambulance Providers, which is American Ambulance, Aetna and Manchester Ambulance, Trinity Health EMS, and Hunter's Ambulance, and I'm here to thank you for raising this bill and speak on behalf of S.B. 324, AN ACT CONCERNING REQUIRED HEALTH INSURANCE COVERAGE FOR AMBULANCE SERVICES AND REQUIRING NOTIFICATION AND CONSENT REGARDING THE POTENTIAL COST OF SUCH SERVICES IN CERTAIN CIRCUMSTANCES.

I have provided written testimony. In the element of time here, I would like to just summarize some of what I believe to be the most important points. Connecticut's ambulance services across the state are regulated, both in terms of their service area for emergencies, typically by geographic township, as well as rate regulated, so annually rates for all services, whether they be volunteer, municipal, commercial are regulated by the Department of Public Health. Maximum allowable rates are set and it's a very transparent and consumer centered process. Secondly, the territories are assigned by nature of primary service areas. That's important as we look at this bill because when we talk about emergency calls, the emergency calls are assigned to those proprietors by statutory authority, there's no selection by the consumer to do that, and so you have a private volunteer municipal provider who is going to go, by statutory authority, to that 9-1-1 call, so that's the public safety element of our regulations, which is very good. They're going to

go and treat and transport that patient within designated protocols.

And again, the financial aspect of that is regulated by the Department of Public Health and those rates are available for that, and so as we talk about in-network versus out-of-network, the vast majority of Connecticut geographically is covered by a single ambulance volunteer type services. They don't contract with commercial services to be -- commercial insurances to be in-network or out-of-network, they simply go out and do the calls. And the problem is, when they file or their billing agent files the bill on their behalf for their services provided, they get denied as being out-of-network, when in fact, you know, there is no discretion to do that any differently. So one of our asks was to put in language that the emergency calls would be billed as if the provider was an in-network provider. I'm not sure that this language does that. I get concerned when it talks about in-network level. To me the word level means rate orientation. I don't think that that's the Committee's intent there, but I would like to work with the Committee and offer suggestions.

In the non-emergency side of the ambulance business, that's where licensed providers to their work. The transport by stretcher is done by a medical clinician. Most often these non-emergency calls come from skilled nursing facilities, hospital discharges where a skilled medical clinician is making a determination that a stretch is the only viable means to convey that patient from that hospital back to their residence or nursing home, so they determine medical necessity for stretcher, and typically the services that provide that are

designated to those facilities. It's part of the overall capacity in our state of ambulance services and again, there's not a lot of selection at that time.

I think the language and the intent to try to get the ambulance company to get authorization and provide the transparency on their rate and get a signature is out of place here. The hospital will call for the discharge, they'll notify the ambulance provider, the ambulance provider will travel to the hospital, all of that is already in motion before there's an interaction with that patient to be conveyed on the stretcher. So again, I'll end my comments and be available for questions and just thank the Committee for raising the bill and look forward to working with you on modifying the language.

REP. SCANLON (98TH): Thank you both very much for being here today. Any questions from the -- Senator Lesser.

SEN. LESSER (9TH): Thank you, David, and I've -- I can say as a Middletown resident, I have on occasion been a client of Hunter's Ambulance Service, not voluntarily, but I did appreciate the service that I received. I look forward to working with a variety of stakeholders on this language to see if there's a possibility of making something work, so thank you for your testimony.

DAVID LOWELL: I'm sorry to hear that, Senator. We do have a limousine arm that we much prefer that you use for your pleasure, not the ambulance, but thank you very much.

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

DAVID LOWELL: Thank you.

REP. SCANLON (98TH): Senator Formica, followed by -
- going on to S.B. 326 and Dr. Tony Lasala.

SENATOR FORMICA (20TH): Good afternoon, Chairs Lesser and Scanlon, Ranking Member Pavalock-D'Amato, and esteemed members of the Committee. My name is Paul Formica and I'm the current senator of the 20th District and I come to speak in support of S.B. 326, AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR CORONARY CALCIUM SCAN TESTS. I did submit some written testimony, I believe, in conjunction with Senator Fasano you have there. I just am here for a short minute to put a personal touch on this and to try to impress upon you the value of moving, in this case in particular industry, from sick care into healthcare and I think we have an opportunity to do that with this bill. This bill would provide the opportunity for insurance to cover a very inexpensive scan of one's heart and related arteries and we all know it is the number one killer of women and a leading cause of death in men, mostly because of blockages that occur in the arteries. This scan would take a preemptive look at what's happening.

I'm here because a little over ten years ago, I woke up to find my bride on the floor of our living room unable to -- I was unable to get her back and I don't know if this test would have saved her life, but this test would have given us probably a better look at what was going on and my feeling here today is we talk so much about the high cost of healthcare and I can tell you that the damage it does to families far exceeds any of that cost and the cost

to treat someone with a heart event pales to the cost of a test and so I think it's -- I appreciate the opportunity that this committee has done to bring this bill forward for consideration and I hope we seriously consider it because I do believe it takes us, as an industry, from sick care, which is monitoring after events, to healthcare, which is diet and determination of testing that can give us an insight into what may happen so that we can perhaps alter our lifestyles and to try to change it. So I thank you very much for the opportunity to be here. It's a bit difficult even after ten years, so I'm sorry if I'm a bit quiet in here, but it was nothing that we ever expected and it has been very difficult. Thank you for your time.

REP. SCANLON (98TH): I want to thank you, Senator, for being here today and sharing your story with us. It's one that you have shared with this committee before and I know it's never easy to do it no matter how many times you do it, but you did it for a reason, which is to help us understand why this is so important, so I want to thank you for doing that.

SENATOR FORMICA (20TH): Thank you.

REP. SCANLON (98TH): Senator Lesser.

SEN. LESSER (9TH): Yeah, I don't have a question, Mr. Chairman, but I do want to thank you, Senator, for sharing your story and, you know, this committee is all about stories, right? It's about how healthcare impacts everyone, whether you're rich or poor or Democrat, Republican, you know, we all have our health and that's what we're trying to do in this committee is make sure everyone in this state get the healthcare that they need, so I don't have anything. There's nothing I can say to add to what

you've already said other than my heart goes out to you and we will do what we can.

SENATOR FORMICA (20TH): Thank you much.

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

REP. PAVALOCK-D'AMATO (77TH): Thank you and thank you for your testimony. I was just wondering if you could tell me a little something about the test. It's the first I've heard of it in this bill, so I don't really know much about it, if there's anything you -- additional information you could provide.

SENATOR FORMICA (20TH): It's a scan. It's called a coronary calcium scan and it takes a picture basically, a specialized x-ray test that provides a picture of your heart that can help doctors detect and measure calcium-containing plaque in your arteries and most often that's what causes the blockage, so this is just basically an x-ray or an ultrasound or a picture you can take now that will measure that buildup, if any, and then you might have an opportunity simply with diet or medication to, you know, reverse it or help it along.

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

SENATOR FORMICA (20TH): Thank you.

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you so much for your testimony. I know my sister lost her 41-year-old husband 20 some odd years ago and it never gets easier, so I think you're doing your wife a huge amount of service in her honor to be here today and sharing your story, so thank you. I also wanted to

talk about the test here because I know there's a lot of people within the population that have naturally high cholesterol and for one reason or another and it may or may not be dangerous for them because it's the way their bodies react to it. I think the one thing interesting about this test is it looks at -- is the cholesterol causing damage to a patient and I think one reason this test is so valuable is it can determine that the scan can help, so it can either prevent people from unnecessarily going on cholesterol-lowering statins and realizing that there may be some other issue involved, so I appreciate you advocating for this because I do think it's very important, so thank you so much for your testimony.

SENATOR FORMICA (20TH): Thank you for your comments. I appreciate the opportunity to be here and I hope we have further conversations about it.

REP. SCANLON (98TH): Representative Vail.

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

SENATOR FORMICA (20TH): Good afternoon.

REP. VAIL (52ND): Is this scan not being -- If a doctor wants to do this scan, are insurance companies denying them the ability to do that now?

SENATOR FORMICA (20TH): I don't want to profess to speak for all insurance companies. There may be some in this room that can answer that question better than I, but it's my understanding that this is not a covered test and it's a test that costs about \$100 or \$400 dollars, \$100 to \$400 dollars, to take.

REP. VAIL (52ND): Okay, and I'll certainly be asking them when they come up.

SENATOR FORMICA (20TH): You know, it would be my hope that any doctor that recommends any test, you know, gets cooperation from the insurance company. We need to make sure that health professionals are, you know, hold the key to our health decisions and not just insurance companies.

REP. VAIL (52ND): I agree. Thank you, Senator.

SENATOR FORMICA (20TH): Thank you.

REP. SCANLON (98TH): Thank you, Senator. Any further questions? Senator Bizarro.

SEN. BIZZARO (6TH): Thank you, Mr. Chairman. Thank you, Senator Formica, for being here today. You have been an inspiration to me for many different reasons in the short time that I've been here and today's a perfect example of why. You know, the first time I heard about this test was actually in one of our caucuses not too long ago. One of our fellow senators was telling me about this. He and I were having a very informal conversation and I was mentioning that I have a history of heart issues in my family and I had resisted for many years prescriptions for statins, probably unwisely, and he was telling me about this test and he said it's a test and most insurance -- You know, it sounded like it was really easy to do and it didn't take very long, but the kicker was that most insurance companies did not cover it. So -- And that was the first time I heard this and then, of course, I saw the term come up again as I was preparing for our hearing today.

So, you know, I think it's certainly something that I would encourage everybody, and I'll start with myself, to bring themselves up to speed on and understand and have that dialog with their care providers about and, you know, if it's something that is relatively easy and doesn't -- it doesn't seem like something that would upset the market in terms of having insurance companies provide this as coverage and when we talk about things that are preventative in nature that can really make an impact on the public health, this is a perfect example of one of those things. So I thank you very much for bringing to our attention today. Thank you. Thank you, Mr. Chairman.

REP. SCANLON (98TH): You're welcome. Senator Anwar.

SEN. ANWAR (3RD): Thank you, Mr. Chair. Senator Formica, thank you so much for your testimony and thank you for being here and bringing this issue up. I'm actually going to be -- I've already put in a request for co-sponsoring it earlier when I saw it. Look, this is actually amazing that at times the insurance industry is so behind in strategic thinking. First of all, if we have a risk stratification which is well studied and you have a one single test that actually allows you which patients would need further testing, they will end up saving money and that's something that's missing from their thinking process at times is that a simple test, which would tell us the calcium score and the probability of coronary artery disease or heart problems going forward in the next many years, and then subsequently after that they have an opportunity to do more detailed workup on the ones that are a high risk.

And it is sad, actually. I had it done myself because my doctor had asked me just because I had family history of -- my father had some heart problems and I did this. It was a pretty straight forward and simple thing except I had to pay out of my pocket as well, and then like everybody else does, and there's no reason why we would have to go through this and it's a fascinating that we now have to go after individual procedures, to bring them through the legislators, for the insurance company to do what they insure the people to do and that's where we are in Connecticut, but I want to thank you for your advocacy.

SENATOR FORMICA (20TH): Thank you very much and you would think it would be less expensive in the long-run --

SEN. ANWAR (3RD): Yes.

SENATOR FORMICA (20TH): -- for insurance agencies and so it's a win-win, but I thank you for your comments and I appreciate it.

REP. SCANLON (98TH): Thank you, Senator, for being here today. All right. We're going to move on to S.B. 326, Dr. Tony Lasala.

TONY LASALA: My name is Tony Lasala. I'm a clinical cardiologist. I've been working for 41 years. I work out of Hartford Hospital. The main disease that I deal with is cardiovascular disease and cardiovascular disease has only one cause, elevated bad cholesterol that sticks to the inside lining of our hearts' arteries. That substance is an irritant. That substance builds up on the inside of our arteries and stays there unseen, non-suspected, not a good way to detect up until this

test was developed, and without symptoms, kills you in most cases. Most patients that I've met I've met in the emergency room in the catheterization laboratory after they've succumbed to a heart attack. I have little to offer to help this patient come back from his disease. He has lost segments of his heart. Being that heart disease, cardiovascular disease, is the number one killer of all Americans, that's two and a half times the number that die from all cancers, and that the money spent to salvage these hearts after a heart attack is three times the amount that is spent for all cancers, we need a better way to detect this terrible disease.

Right now, the insurance companies allow payment 20 times the amount that they allow for screening for heart disease for screening for cancer, so there's something wrong. In 1959, a group of physicians took upon themselves to study a group of people who live in Framingham, Massachusetts. These are middle-aged people, mostly men, mostly Italians that they followed for 35 years, trying to find out what clues they had to identify this terrible disease. They came up with a risk score and I'm here to tell you that that risk score does not work. People that have high risk scores don't die of heart attacks. People with low risk scores die of heart attacks. This test will tell you whether or not you're going to die of a heart attack.

Back in 1989, two radiologists, one in Australia and one in Connecticut, while doing CT scans of the chest looking for lung cancer, noticed that they were picking up calcium deposits in the arteries of these patients. These patients went on not to die from lung cancer, lung problems, but they died from the calcium deposits, the plaquing deposits, in

their heart. This gave them the idea to develop a specialized test where the x-ray would be taken just of the heart, sensitive to particles of calcium located in these arteries, and this was the calcium score. I have been using calcium scores for over ten years and I feel that that test has helped me identify patients that would have had heart attacks in their lifetime.

So it's a no-brainer in my mind that we mandate insurance companies to defray the costs of this very inexpensive safe test to pick up calcium in these patients arteries. We are behind the time. Connecticut is behind the time. There are three states who already have mandated that the insurance companies pay anywhere from \$100 dollars to \$200 dollars for this test ordered by a qualified physician in order to identify this disease.

REP. SCANLON (98TH): Thank you, Doctor. At what point in somebody's life would you recommend that they get one of these tests and under what circumstances would that person get one of these?

TONY LASALA: Okay, that's been worked out. So males over the age of 45 that have either a family history of premature cardiac disease in a parent, brother, or sister, high blood pressure, smoking at any time of their life, obesity, prediabetes, sedentary lifestyle, and an elevated LDL.

REP. SCANLON (98TH): And then how often does one get one of these tests?

TONY LASALA: This is a once in a lifetime test.

REP. SCANLON (98TH): Once in a lifetime, okay.

TONY LASALA: This tells you your risk. If you have a zero calcium score, you have very little chance in the next 10 to 15 years of having a cardiac event. You do not need a statin, you do not need a stress test, you do not need a nuclear stress test. A calcium score of 100, 200, you know, the risk goes up.

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

SEN. BIZZARO (6TH): Thank you, Mr. Chairman. Thank you, Doctor, just a couple questions about the logistics of this. Would this be a test that's ordered by a primary care physician or is it always through a cardiologist after referral?

TONY LASALA: So this is where you have to be careful. There are radiology groups that want to make money on this, so they'll advertise what is your risk. The patient will come in, have the test. He may not know or she may not know what to do with this. There may not be any understanding of what that number means, so I would recommend that the test be ordered by a qualified physician, presumably a clinical cardiologist, that understands the risk score and knows how to change the natural history of that risk score. I mean, I didn't mention that to you, but there is evidence that you can change the natural history of that disease by changing lifestyle habits, stopping smoking, exercising, going on an aspirin, going on a statin.

SEN. BIZZARO (6TH): And do you know, has there been a concentrated effort within the industry to educate professionals, to educate the physicians regarding this particular test?

TONY LASALA: Are you talking about my industry?

SEN. BIZZARO (6TH): Yeah --

TONY LASALA: Cardiology, American Heart Association, yes.

SEN. BIZZARO (6TH): Or just for primary care doctors, just to make them aware that this is something that, you know, that the test is easy, that it's --

TONY LASALA: I think they are up to date and they read their literature. This is common knowledge.

SEN. BIZZARO (6TH): All right. Thank you very much.

REP. SCANLON (98TH): Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. So obviously if we took this test and we had some signs that, you know, the people met these requirements and we thought they should have that test and they had a certain percentage of calcium, they're at higher risk, and then you'd recommend whatever you would recommend, but would also maybe by not doing this, if you take this test, can you also find out that someone doesn't have a risk that might -- will these other tests that are used now or these other criteria, they decide whether to put people on statin drugs, that they might not have ever needed that?

TONY LASALA: Yes.

REP. VAIL (52ND): Would you be able to find that out as well?

TONY LASALA: So a zero calcium score is no indication to be on a statin, so we like to try non-

pharmacological means to bring down your LDL. You know, your LDL should be 100 all across the board, every American should know their LDL, it should be 100, all right?

REP. VAIL (52ND): And so do you think there are people who are on drugs because they had a different test or a stress test or the indicators that wouldn't need to be on those things had they had this test instead?

TONY LASALA: I'm embarrassed to say there are doctors that without knowing if they have the disease or not will take a statin thinking that, so this is a very good test -- it's a very good test to convince a patient that they should be on a statin. You know, the literature is filled with fears about how bad statins are. This test, seeing is believing, convinces a lot of my patients that they better be on a statin.

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

REP. SCANLON (98TH): Thank you, Doctor. I was just telling Senator Lesser that my grandfather died at age 40 of a heart attack, so I think one of these might be my future at some point and hopefully our insurance will cover it, so thank you for being here today.

TONY LASALA: It's your parents, not your grandfather.

REP. SCANLON (98TH): Okay. So I'm good?

TONY LASALA: You're good.

REP. SCANLON (98TH): Okay, God willing. Any further questions? Senator Anwar.

SEN. ANWAR (3RD): Thank you so much for your testimony. Again, I just want to share another story of a similar situation where a person had a calcium scoring CAT scan and lo and behold, they had a lung nodule and it was a lung cancer and they found it in a timely fashion and saved the life in another manner, so there are lot of secondary benefits you can get, but primarily there's a lot of data. There's no data on the lung cancer with respect to the calcium scoring, but there's plenty of data on the coronary perspective, so thank you for your testimony. It helps us further make up our minds. Thank you.

TONY LASALA: You're welcome.

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

TONY LASALA: Thank you.

REP. SCANLON (98TH): Next up is 328, Paul Kidwell. I don't see him though, so we'll go Jill Zorn.

JILL ZORN: Thank you, Representative Scanlon, Senator Lesser, and members of the Committee. My name is Jill Zorn. I work at Universal Healthcare Foundation of Connecticut and I'm here to speak about Senate Bill 328, one aspect of which we support strongly and one aspect of which we have some concerns. First of all the cost growth benchmark of the bill we definitely support. It was great to hear the testimony about it this morning and we're glad to see it's a very comprehensive approach to looking at healthcare costs and an opportunity for everyone to sit around the table together to try to work on this problem together to lower healthcare costs and we have great faith and the ability of the Office of Health Strategy to

implement this important initiative fairly and skillfully.

Now I want to talk about reinsurance, which I know there's a lot of talk here in Connecticut about this is something we should do, but I just want to make sure that members of this committee are aware that are some downsides to reinsurance and the main one is first of all, the state has to put in some money and I saw the number \$21 million dollars -- not to exceed \$21 million dollars and for that, maybe we're going to get 5 percent, I've heard 7 percent, drop in premiums. The goal of this is to help those that hit the cliff of over 400 percent federal poverty and no longer get any subsidies and you go from having, you know, some help with paying for your care to no help in paying for your premiums.

But the problem is, when you use that money to try to help those people, you actually have an unintended consequence of lower subsidies for the people that are getting them now and who is more likely to be uninsured in our state? It's people with lower incomes and so there is no free lunch and using state money to help people above 400 percent of federal poverty, but actually hurt some of the people with lower incomes and lower their subsidies is not our idea of a great way to spend precious state dollars. I'd much rather see using that money, if we have that money, to go towards subsidies and there's many different ways you could use that. There's -- Different states have tried different approaches, but there is a downside to reinsurance and I just wanted to make sure that you are aware of it.

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

JILL ZORN: I'd be happy to answer any questions.

REP. SCANLON (98TH): Any questions? Seeing none, thank you. Paul Kidwell. Good to see you.

PAUL KIDWELL: Good afternoon, good to see you back in Connecticut. I'm Paul Kidwell, senior vice-president from Connecticut Hospital Association. I appreciate the opportunity to be before you this afternoon, specifically on S.B. 328, but also by reference to H.B. 5018, as well, and specifically wanted to speak a little bit about the implementation of the Executive Order No. 5, the cost growth benchmark, primary care spending targets, and quality benchmarks. I think this committee knows that CHA is certainly committed to access and understands that affordability is essential to that commitment. We believe that statewide coalescence around a more sustainable growth rate is an important opportunity to alter the trajectory of healthcare spending in our state.

I had the opportunity to listen to Director Veltri earlier and was happy to hear that she believes that needs to be a collaborative effort with stakeholders and we're pleased at this point that hospitals are certainly represented on the advisory board that the governor announced late last week. We do also believe, though, that everyone in the system has a role to play and Representative Vail, you had some back and forth with Director Veltri about this as well, hospitals, payers, pharmaceutical companies, device manufacturers, government payers certainly, and long-term care providers all make up the spending in our system and we think that an appropriate cost benchmark should include all of those factors. Like I said, we believe this should

be a partnership and we're committed to working with the legislature and OHS.

In that spirit, we do have a number of items in the written testimony you can see where we think further discussion would be warranted. First, we think that the legislation should memorialize robust stakeholder participation in the development of the benchmarks and subsequent periods of evaluation. We think the legislation, there's an opportunity to better define the parameters, including those costs which could be accepted to the extent pharmaceutical costs increased exponentially in one year. We think the Committee should consider how those types of costs would be considered in measurement in performance against the benchmark.

We think you should consider avoiding legislatively hard-coated targets to retain flexibility in future years, ensure that the base benchmark here and any subsequent re-based benchmarks include consideration of state spending agreements. Like is said, provide that all healthcare spending is captured in the benchmark calculation, consider an appropriate growth factor and include appropriate adjustment factors. I'd be happy to answer any of your questions.

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

PAUL KIDWELL: Good to see you.

REP. SCANLON (98TH): Good to see you, too. All right, Senate Bill 336, Mark Zatyryka.

MARK ZATYRKA: Thank you for having me here today. I appreciate it. My name is Mark Zatyryka. I live

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in West Suffield, Connecticut. I was born with severe hemophilia A, a bleeding disorder. I also have two beautiful twin daughters who are about to turn seven, Iliana and Koby, who are carriers of hemophilia as well. Hemophilia affects every part of my life from the moment I simply wake up in the morning and get out of bed to the moment I go to bed at night, a lot of time convulsing in pain from the bleeds in my body. At the age of three, I fell and I bit my tongue and I almost bled to death. The doctor couldn't infuse any of my veins because of the amount of blood that I had lost. At the last moment, the doctor tried to do two venous cut-downs, where they have to cut open my skin to look for the vein in order to be able to try to infuse my factor replacement therapy. He did one in my arm, was still unsuccessful, and at the last moment was able to do a venous cut-down in my foot and hit that vein which ultimately saved my life.

Yes, the medicine that I require to stay alive is very expensive. I feel horrible about being a burden on society with the high-cost medication that I need and I'd love to control rising costs in healthcare and medication. I have to give myself an infusion into my veins every other day and each infusion is approximately \$3,000 dollars, so it's a very high cost medication that again I wish was cheaper and that's why I'm asking for support of Bill 336 today. Currently I have a high deductible insurance plan and if I'm able to find an in-network provider, I have a \$3,000 dollar individual deductible that I have to meet, plus another \$3,000 deductible for the rest of my family. Come January 1 every year, because my medicine is so expensive, I owe that \$3,000 dollars right off the bat in order

to hit my deductible to be able to afford my medication.

And that's why I can't tell you how grateful I am to have copay assistance that I'm able to use from the company that makes my medication. I know it's hard on my family and I have a good job. I know a lot of families that are in much tighter positions than I am and how difficult it is for them to be able to afford their medication. I know payers want their subscribers to be cost-conscious consumers, but at what cost are we willing to go down that road. By taking away these assistance programs, we're not only turning back on those in the need the most, but you could be literally bankrupting families and possibly even sentencing children and adults to an unbearable life without their medication or worse and just because someone may not be able to afford to pay the extraordinarily high cost medical bills doesn't mean that they always qualify for public assistance either.

And now we're considering pulling that support, sometimes the only support system that these families have that are keeping them afloat. Is the healthcare system broken and can use some improvements? For sure. I think there's a lot better places to start than pulling this support away from those that need it. Most people with severe chronic illnesses like hemophilia are not choosing their medication based on copay cards. We don't have a generic medication to choose from. All pharma companies typically provide the same benefits, benefits that allow their families to afford their life-saving medication and to remain compliant on the therapies that their physicians prescribe. So just remembering my story of when I

was three and I almost bled to death, if my family wasn't able to afford that medication, I wouldn't have the privilege and right to be here today in front of you, so I ask you to please support Bill 3336. Thank you.

REP. SCANLON (98TH): Senator Anwar.

SEN. ANWAR (3RD): Thank you for your testimony. Thank you for your courage to come and speak and I want to disagree with a small part of your testimony. You are not a burden, you are a blessing.

MARK ZATYRKA: Thank you.

SEN. ANWAR (3RD): And please never, ever think that way and very important testimony, very moving testimony, one more reason we need to do the right thing and support this bill. It means a lot that you're here. Thank you.

MARK ZATYRKA: Thank you very much.

REP. SCANLON (98TH): I was going to say something similar, but Senator Anwar took the words out of my mouth, so thank you for being here today. Any further questions? Seeing none, thank you.

MARK ZATYRKA: Thank you.

REP. SCANLON (98TH): Sam Hallemeier? Going once. How about Pat Carroll? How about Lesley Bennett? All right, it's been a long day, so we're losing some folks, but we are going to move on to S.B. 345, Sam Dynowski and Ann Gadwah.

ANN GADWAH: Senator Lesser, Representative Scanlon, and distinguished members of the Committee, my name is Ann Gadwah and I'm the chapter chair of Sierra

Club Connecticut. Sam Dynowski had to leave. Thank you for the opportunity to testify in support of Senate Bill 345, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO STUDY AND REPORT ON ISSUES CONCERNING CLIMATE CHANGE. Sierra Club Connecticut is focused on protecting our environment. We are deeply committed to addressing the causes of climate change and finding solutions based on science and research that will protect lives. Climate change is accelerating and recent events like the wildfires in Australia, where a thousand people had to escape into the ocean to escape from the wildfires. If you missed that in the news, you should look it up. And the record-setting high temperatures in the Antarctic Peninsula are warning signs that we must act quickly and boldly.

Connecticut has been a leader in taking action on the issue of climate with robust greenhouse gas emission reduction targets in our Global Warming Solutions Act and with Governor Lamont's Executive Order 3 signed last year to set a goal of 100 percent carbon free electricity by 2040. Additionally, countless residents, like ourselves, are taking individual action to reduce our own carbon footprint, doing things like energy audits, efficiency audits, changing to LED lightbulbs, solar panels, taking the bus, etc. We already see our state government making some changes. We need the entire economic community to make some as well.

This is why it's particularly concerning that 40 of the largest United States insurers hold over \$450 billion dollars in coal, oil, gas and electric stocks and bonds. U.S. insurers are also major insurers of the global fossil fuel industry. Backing fossil fuels undermines the efforts of our

residents and our state government that are making strides to address climate change. Sierra Club Connecticut strongly supports S.B. 345 to better understand the role Connecticut insurance companies play in backing the fossil fuel industry and how they're assessing the risks of those investments. Thank you for raising this important issue. Here in Connecticut we hold the unique position and responsibility to address the role insurers play in climate change and I'm happy to take any questions.

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

REP. VAIL (52ND): Thank you, Mr. Chairman. So what is it your expect the insurance commissioner to do?

ANN GADWAH: We're expecting to have the insurance companies to disclose their assets in fossil fuel and the insurers.

REP. VAIL (52ND): Okay. I don't see the connection. Thanks.

ANN GADWAH: Well, I think the connection is the transparency and, you know, insurance companies are expected to insure us against disaster, so we'd like to know how they are insuring us with fuel companies.

REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you so much for your testimony today. Just curious, in other parts of the country and other parts of the world, are insurance companies looking at trying to figure out how they are going to be insuring against this sort of risk and things that have been coming up from climate change?

ANN GADWAH: Well, I think that's what we were hoping this bill would do is so that we --

REP. DATHAN (142ND): No, I mean, is there any other precedent to it?

ANN GADWAH: In California, they do have a similar law to this.

REP. DATHAN (142ND): What about other countries because I feel like in a lot of ways the U.S. is behind the rest of the world in terms of climate policy, so I'm curious what other -- maybe other countries around the world have done to mitigate the risks of climate change through insurance.

ANN GADWAH: I can't really speak too much to that. I don't have any of those -- have any of those numbers in front of me that I would have to say, but I do know there are some insurance companies that have started to back away from their fossil fuel investments in insuring because of the risks, frankly, because of the risk that there is -- to climate change and with -- Yeah, the risk of climate change.

REP. DATHAN (142ND): I guess in particular I'm thinking about countries like Australia that have recently been engulfed in fires for several months and they're just getting to the end of their fire season and the amount of damage that has been the result of those fires, not just to the cost of life and environmental things, but to people's personal property and to businesses and things like that, so I think it almost -- and this is becoming the new normal. In California, you see this quite a bit. The fires have grown in numbers almost every fire season and also duration and intensity and we're not

just seeing it in America, we're seeing it in other parts of the world and so I really think, you know, looking at these is the smart thing to do to hopefully mitigate future risks for individuals and for businesses. So thank you very much for your testimony.

REP. SCANLON (98TH): Senator Lesser, followed by Senator Anwar.

SEN. LESSER (9TH): Yes, thank you, Mr. Chairman, and I want to thank you for your testimony and I do agree with what you had said earlier, Representative, because I think European insurers have largely divested from coal and tar sands projects. There have been steps by U.S. insurers, CHUBB, and put out a policy that got a lot of attention recently, but more interestingly for those of us in this room, The Hartford has put a very aggressive policy seeking to at least partially divest from those industries and it's a statement that they made on a voluntary basis. There has been work on a national basis by the National Association of Insurance Commissioners and through an outside group as well to try to get more information about what insurers are doing to address and understand their climate risk, both in terms of their investments, but also in terms of their underwriting and that information, I think, would be helpful for policy makers. Thank you very much for your comments.

REP. SCANLON (98TH): Senator Anwar.

SEN. ANWAR (3RD): Thank you, Mr. Chair. Thank you so much for your testimony. You know, the way I am sensing things and understanding them right now, if there's any industry, broad or large-scale industry,

that is recognizing the climate change, it's the insurance industry. The reason is that they're the ones who are having to pay for the hurricanes and the fires and the storms and the various impacts that we are seeing, so this bill suggests that they are the culprits or they are investing in that industry. My feeling is that they are probably, because they are also now becoming the victims of the climate change because they are the ones who have to write those checks to millions of people, they have smartened up and recognized the signs and they are already moving away from this. That's my sense, so -- and that's why I think, while I understand the intent of it, there are probably other industries that should need to look at this more than the insurance industry because I think that this is one industry is paying truly every bit of their savings to try to deal with the climate change impact, so what are your thoughts on this?

ANN GADWAH: I think Connecticut, you know, is uniquely positioned because we have so many insurance companies to tackle the issue with the insurance companies but I agree with you. I agree with you that they are starting to, you know, realize the potential for very -- for the cost to be very heavy for climate change and I wouldn't be surprised to see them not insure coastal houses and things where there are a lot of wildfires and things like that.

SEN. ANWAR (3RD): I think one situation where the market pressures themselves have made them make the right choice moving in the right direction because if they -- if anyone without doing their homework have continued to invest in some of the industry which is -- industries which are having the negative

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impact on the climate, they're actually shooting themselves in the foot. That's what it would be and maybe this bill will highlight anyone who is not doing this already to start to move in this direction, but it's going to be interesting to see intellectually what this would show, but my feeling is that the investments that we are anticipating are not as much there proportionately as one would have expected, I hope.

ANN GADWAH: I hope, too. I think we're always in favor of transparency.

SEN. ANWAR (3RD): Thank you so much.

ANN GADWAH: Thank you.

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

ANN GADWAH: Thank you

REP. SCANLON (98TH): All right. We are on the final bill of the day, 346, and I'm going to call Joanna Dornfeld first.

JOANNA DORNFELD: Thank you very much, Mr. Chair, members of the Insurance and Real Estate Committee. Thank you for the opportunity to testify in support of S.B. 346, the Connecticut Plan. My name is Joanna Dornfeld. I'm senior director for state affairs with United States of Care. United States of Care is a nonpartisan nonprofit that was founded two years ago by a former CMS administrator, Andy Slavitt, and diverse board that includes Senator Bill Frist and Founder's Council, around a mission that every person in America should have access to quality, affordable healthcare, regardless of health status, social need, or income.

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We've been partnering with stakeholders in the state of Connecticut over the last year to work on policies and initiatives that align with our mission to expand access to care for the people of Connecticut and I'm honored to be here today. It's no surprise to you that according to a poll conducted by Altarum Healthcare Value Hub, 50 percent of people in Connecticut have had difficulty affording healthcare, 43 percent of Connecticut adults reported delaying or foregoing care because of costs, and 24 percent struggled to pay a medical bill. More than a dozen states across the country are exploring ways to leverage their existing state infrastructure, such as state employee health plan, to add another more affordable insurance option to the marketplace, to best meet each state's unique needs. Washington State is currently implementing Cascade Care and today, legislative leaders in Colorado introduced a bill to create a new state option.

Just as these states are forging their own paths, the Connecticut Plan has been carefully crafted to initially target the challenges in the state's small group market. As you know, small businesses employ more than 700,000 people in Connecticut, almost half of the state's workforce, and yet less than half can afford to offer health insurance to their employees, leaving a quarter of employees with no access to healthcare from their employers, according to the Employee Benefit Research Institute. A recent poll conducted by a small business majority showed that 47 percent of small businesses nationally cited healthcare costs as a top barrier to maintaining and growing their businesses and nearly 90 percent of

small business owners ranked making healthcare more accessible and affordable of high importance.

The cost to both employees and small businesses are real. For example, one study found that workers who are uninsured missed almost five more days of work each year than those who had insurance. This means those working people lose wages and their employers lose productivity. A state's economy is only as strong as its workforce and strong economic growth in the state means insuring that Connecticut workers and their families can afford the care they need to stay healthy and thrive. The Connecticut Plan builds on a successful existing approach to provide more affordable coverage options and increase choice, responding to the needs of small businesses and their employees. Thank you very much for your time today.

REP. SCANLON (98TH): Thank you, Joanna, and obviously as you know because you've been working with us for quite some time on this, we did a lot of homework on this to try to figure out what plan made the most sense for Connecticut and there's a lot of different options out there, as you know. In your experience having worked on this in other states, do you feel like we have found something that is unique to Connecticut that would maybe work better here than it would in other states and vice versa?

JOANNA DORNFELD: I do. I do. There was a lot of work that went into kind of identifying what the various options and plans are. There are various ways to look at a state approach and we're seeing that across the country, but to my knowledge, Connecticut is the only state in the country that's

looking at a state employee plan as the framework for that state option.

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

REP. VAIL (52ND): Thank you. I could almost say good evening. You said you've worked with all the stakeholders over the last year, like could you give me an example of who you've worked with regarding this?

JOANNA DORNFELD: Certainly. Unites States of Care, our approach is that we believe that all stakeholders need to be engaged in the process and so we engage in partnerships in states. We feel it's very important to develop relationships with elected officials, advocacy organizations, and other, you know, stakeholders that are part of the conversation.

REP. VAIL (52ND): The insurance industry at all?

JOANNA DORNFELD: We have had conversations with insurance industry.

REP. VAIL (52ND): In Connecticut?

JOANNA DORNFELD: Yes.

REP. VAIL (52ND): Pharmaceutical industry?

JOANNA DORNFELD: Not to my knowledge.

REP. VAIL (52ND): All right, that's it. Thank you.

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

JOANNA DORNFELD: Thank you.

REP. SCANLON (98TH): I appreciate it. Stephanie Thomas followed by Francis Padilla.

STEPHANIE THOMAS: I will say good evening. It feels like it. Thank you. Good afternoon, Mr. Chairman and members of the Committee. My name is Stephanie Thomas and I'm very happy to be here in support of S.B. 346. I'm a small business owner and I'm really here to put a personal face on this need for affordable healthcare options for small businesses. Like many small business owners, I'm very nimble. I live in Norwalk. I have an office in Manhattan and in my dining room. I have clients in Connecticut, New York, and frankly wherever I can find them. All small businesses are unique, but we share the same hardships and although I'm only representing myself here today, over the past couple of years I've had the unique opportunity to knock on thousands of doors and what I hear -- the people who are home when you door-knock are small business owners working from their dining room tables.

So I've had an opportunity to hear many of their concerns and their challenges have been the same as mine and if you've ever run a small business or a nonprofit, you know that it requires long hours and often these are the people who don't have an opportunity to come to Hartford and sit here all day or to even organize and speak out. So I'm hoping that I will lend voice to some of the comments I've heard from them as well. The high cost of insurance has been a problem for a long time for small businesses and each session in each year that this gets -- goes unaddressed it's a loss for Connecticut. Small businesses play an important role in our economy. In cases like mine, I went

from poverty as a child to owning my own business, which in turn has benefitted society, in my opinion.

In addition, I work as a nonprofit consultant so in addition to the \$75 million dollars that I've helped nonprofits raise, my income has really funded my volunteer time and my own personal charitable donations to many nonprofits and my local community, but it wouldn't have been possible if my husband didn't happen to have a good insurance plan. I could not have taken the risk in starting my own business without having that peace of mind. And when I did open my business and whenever I've tried to hire people, the first question they ask is what insurance is being offered and when they hear none, you can guess what happens next. Many of us small business owners rely on younger workers able to participate in their parents' plan. Even last Saturday, I was at an event and a small business in Fairfield echoed the same experience. He was there. His son was helping him, but his son was about to age out of his father's healthcare plan, so he said he might not be able to work for his own father because he needs healthcare.

So on the one end is a challenge in starting companies and on the other, the growth is often hampered and some people worry that bills like these might impact insurance companies or other entities financially, but right now, we're not spending the money, we're not insuring our employees, but we would if we had an affordable option. I believe our economy suffers when the small business and nonprofit workforce do not have access to affordable healthcare plans, so I say give us a chance to help spur the economic development. I'm confident that

what we will contribute to the state economically will outweigh the administrative costs. Thank you.

REP. SCANLON (98TH): Thank you so much, Stephanie, for your testimony and hoping to see what we can do to help small businesses and folks in this state. Are there questions or comments from members of the Committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman, and thank you, Stephanie, today for coming up, making the big trip from Norwalk. I do it every day, so I know your pain for the day, so thank you so much. It's so important for small businesses. I actually spoke -- questioned earlier, I'm not sure if you were in the room, when the comptroller, Lembo, spoke about the initiative and that's one of my concerns. My question first of all was about small businesses. I'm guessing you're pretty cost sensitive?

STEPHANIE THOMAS: Yes.

REP. DATHAN (142ND): Okay, so that makes sense. As a cost sensitive person, do you spend time shopping around to find the best cost product for whatever you're looking for?

STEPHANIE THOMAS: I do.

REP. DATHAN (142ND): So if you -- When you're looking for insurance, let's say, you know, this is one of the options, would you shop and compare it to maybe another insurance broker or another organization that might offer such insurance?

STEPHANIE THOMAS: Absolutely.

REP. DATHAN (142ND): Okay. So you would -- This would just be one of the options that you would look at?

STEPHANIE THOMAS: Absolutely.

REP. DATHAN (142ND): Okay, that's really helpful. The other thing you mentioned briefly in your testimony, you talked about nonprofits and I know a lot of nonprofits in our area aren't able to always offer health insurance to their employees and maybe that is an inhibitor for getting good talent on board. Can you speak a little more about what you think how this might benefit the nonprofits, particularly I'd love to hear your experience in Norwalk, but anywhere in Connecticut you worked in or sent to?

STEPHANIE THOMAS: Since I work as a nonprofit consultant and belong to many nonprofit consortium groups, I talk to nonprofit people all the time and if anyone has it worse than small businesses it's nonprofits. I think they get squeezed everywhere because they are one, often trying to solve the most intractable problems that are very difficult to solve and require a lot of man hours to get it done. They are often doing government work that's been subcontracted to them by government, but yet they're being squeezed because everyone's looking at things like GuideStar to see how much they're spending on administration.

So they have to keep that percentage very, very low, so the incentive for both individual funders, corporate funders, and foundation funders, it is to spend as little money as possible on staff overhead and so all of their money tends to get funneled into very baseline salaries, especially smaller

nonprofits, so they have -- historically had very bad employment packages. So as a result, they're trying to solve these really big, important problems, but they're relying on just like us, 22-year-olds who can't a job anywhere else because, you know, they have insurance through their parents and they don't need a good corporate job or, you know, other benefits.

So they -- I think they have both hands tied, arms tied, behind their back and now they're really -- they've moved into a space now where they have to compete with things like work/life balance, up-to-date technology, cybersecurity and the list goes on and on and compete with corporate America, but yet they can't afford to give the same type of packages. So I think we would see, hopefully, greater influx of the type of talent that could be recruited for nonprofits if they had access to good plans. Did that answer your question?

REP. DATHAN (142ND): Yeah, that's real helpful and I'm sure they're just as cost sensitive to make sure that they would be shopping around through maybe a consortium of nonprofits that offer insurance.

STEPHANIE THOMAS: Most nonprofits are required by their own internal policies to solicit three bids for any major contracts. When they hire me, they usually have to get two other bids.

REP. DATHAN (142ND): Got it. That makes a lot of sense. And, I mean, presumably it's the talent that they can bring on board, like you were saying, they have to hire a 22-year-old rather than some -- not that all 22-year-olds -- Will Haskell wouldn't be happy for me saying that because I think he's wonderful, but I'm suggesting that, you know, you

might be losing some great valuable experience that may really help move the needle in our communities because they can't hire people with this issue. So the same problems that you have as a small business are faced there. Thank you so much for your testimony today. Thank you, Mr. Chairman.

REP. SCANLON (98TH): Thank you, Representative. Other comments or questions from the Committee? If not, thank you.

STEPHANIE THOMAS: Thank you.

SEN. LESSER (9TH): Next up, Frances Padilla, followed by Susan Halpin.

FRANCES PADILLA: Good evening, everyone. My name is Frances Padilla. I'm president of Universal Healthcare Foundation. Thank you, Chairman Lesser. I'm here to speak in favor of Senate Bill 346, AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTHCARE. Here's the problem and we've heard it all day long in one form or another. Over the last 15 years, premiums and out-of-pocket expenses have grown exponentially and consistently outpaced median income in Connecticut, which is still one of the highest cost states in the country, not just for healthcare, but for other costs as well such as housing and childcare. It is -- Healthcare is unaffordable. It's the prices period. Small businesses and nonprofits in Connecticut employ over 700,000 people, we've heard that a few times today. Right now, less than half of them are able to offer insurance coverage to their employees and those that do offer quite often have high deductible health plans that really pose challenges to people who still face outrageously high and unpredictable costs.

The Healthcare Cost Institute states that the average American has \$1,000 dollars in saving and if anyone who thinks that an \$8,000 dollar deductible is more affordable than a \$10,000 dollar deductible should think about what happens if you only have \$1,000 dollars or less in the bank each year. I can certainly relate as the leader of the foundation because we're an employer, we're a small nonprofit business. We seek to align the health benefits that we offer our employees with our values. Every year we face several digit increases to give our employees the kind of benefits that meet their needs.

With cost savings health insurance, I could have maybe another staff person or be able to make more money, put more money out in grants to other nonprofit organizations. I will say I have my own story. I have a daughter is an entrepreneur. She's 34 years old. She's legally blind in one eye. She has to wear special contact lenses. She needs corneal transplants and her health insurance requires that they prove medical necessity every time she needs to change her contact lenses to be able to see because without them, she really cannot see. So I'm sorry that I have used up my three minutes and not really said why I think Connecticut -- the Connecticut Health Plan is a good idea, but here it is.

Okay. It makes sense, it will have --

SEN. LESSER (9TH): I'm sorry, Frances, I'm going to have to cut you off, but I do have one question for you, why do you think the Connecticut Health Plan is a good idea?

FRANCES PADILLA: Thank you very much for that question. So -- Well, first we've heard it will have the clout to negotiate, the use the state's leverage to be able to give small employers, nonprofit organizations, and labor union members access to affordable and quality care. The really important thing about the state employee health plan is that, in fact, enrollees have the opportunity to focus on preventive care, they have the focus on managing chronic illness, and on primary care and they have been able to -- they've got a pretty demonstrated track record of keeping rate increases to a minimum, far below those of private employers while at the same time focusing and improving and maintaining employee's health.

Companies like Pitney Bowes have been able to achieve that as self-insured employers. Why? Because they're big. They use their negotiating leverage to be able to offer good coverage, make it more affordable for their employees, and improve health. That's what our state employee health plan can offer and we are unique in the country in wanting to use our state employee health plan and I think we can be a leader in the country on that front. Any other question?

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

REP. HUGHES (135TH): Thank you, Frances, for your patience and kind of bringing us full circle today. What I keep hearing is some of this like projection of costs as if everything stays the same and here's what you just alluded to is that when people take an active, much more engaged role in preventative care, in managing chronic illness before it becomes acute,

then you have essentially a healthier population that is enthusiastically opting in, rather than a what we end up with is there's a status quo of people on high deductible health plans that are putting off preventative care, so then we end up with an unhealthier population and, you know, waiting for critical illness. Can you speak to -- I'm sure you're on the employee health plan, but again, we keep looking at this at the macro and then at the micro and the micro, you were talking about your daughter, which I would love to hear the end of that, what happens every time she tries to get the just basic care, the basic eyewear to function.

FRANCES PADILLA: She has to put the money out first.

REP. HUGHES (135TH): I see.

FRANCES PADILLA: And her doctor keeps appealing and the -- so as she's building her business, she has to ensure that she brings in enough revenue to be able to pay for health insurance because she has to be able to see in order to keep building her business. The -- I think, you know, the focus on prevention is very important and we saw it with the Affordable Care Act, there is an aftermath when people aren't able to go to the doctor. The U.S. Care folks referenced, Joanna, referenced the Altarum Study. There are many people making choices because they're worried about the cost of healthcare to not seek care and so we're in the same place that we've been stuck in for the last 20 or 30 years, which is that people are afraid of incurring debt and so they don't go to the doctor, they don't take care of the problems in the immediate until they need more serious care and then it costs more.

The Affordable Care Act allowed a lot more people to go into care and so at the front end, there is that level and what we have not done, and I really want to make this point, we have not taken seriously the need to address costs of healthcare and the prices and reform. The Affordable Care Act was a set of compromises with all the major industry players and so while the Affordable Care Act is accused of increasing healthcare costs, it actually modulated some healthcare costs because of the fact that in Medicare, it was designed to control costs. The need to build in price standardization, the need to build in an understanding of why -- what the underlying causes of healthcare costs were not fully built in. Well, this plan can, through negotiation and through standardization, actually help us understand in synergy with other experts like the cost benchmarks, the cost growth benchmarks, can help us understand really how we can together make our healthcare more affordable on a sustainable basis.

And that's not to say that the insurance industry, the pharmaceutical industry, the hospitals shouldn't be able to make what they need to make, but there is enough to go around and for the consumer to not be left with either a deal with the devil of not going to the doctor or untenable medical debt, which is not right.

REP. HUGHES (135TH): Yeah, thank you.

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

FRANCES PADILLA: Thank you.

SEN. LESSER (9TH): And thank you for your comments this morning. Next up, Susan Halpin, who almost always agrees with Frances.

SUSAN HALPIN: Good afternoon, Senator Lesser, members of the Committee. My name is Susan Halpin for the record and I'm here on behalf of the Connecticut Association of Health Plans. Our association includes Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim, and United. I don't think I forgot anybody. There's two bills. We've submitted a lot of written comment today on your very full agenda, but there are two bills that I would like to comment on specifically and the first is Senate Bill 323 regarding surprise billing. This is an issue that we were, as previously speakers talked about, very engaged in back when the infamous Senate Bill 811 passed in 2015 and we were concerned about that -- passage of that bill at that time because what it did is it allowed out-of-network emergency room services to be billed and paid by carriers under what's the called the Greatest of Three and the Greatest of Three was the in-network rate, the Medicare rate, or a rate in accordance with a benchmark called fair health and that fair health benchmark is based on charges, which means if that is utilized for out-of-network services, it is an inflated rate that is paid.

At the time, we didn't really have any out-of-network emergency room practices. If you went to an in-network hospital, you pretty much had an in-network emergency room doctor. We know that's not the case in many other states. I'm going to call her out over there, Maggie Moree from Aetna knows very well in New Jersey what the experience was there and it was pretty serious and when Connecticut

adopted this, we were very concerned that the incentives were going to be misaligned so that we would encourage that practice and, in fact, we have started to see that grow and have remained concerned about that since 2015. So this bill before you fixes that solution, encourages emergency room practices to be in-network and that's where we believe they should be and that is ultimately a consumer protection and we would encourage your support.

I know I'm probably going to have the buzzer soon. I want to associate my remarks on Senate Bill 346 on the public option bill with the previous speaker, JP Wieske. We share many of the same concerns that he raised. As large employers and a large part of the economic sector here in Connecticut with 25,000 jobs and a complete downstream job employment, if you consider all the other, you know, impact jobs that surround the 25,000 core jobs, we're at about 48,000. A 10 percent reduction in insurance jobs would equate to about 4,000 jobs and what we see Senate Bill 346 as doing is establishing a path towards, you know, a single payer type healthcare system.

Public option has a lot of different definitions. It really depends on who is saying the words public option. What Connecticut's public option is very different than what you see in the rest of the country and -- but what it is essentially is a government-run state system and the way it derives its savings, frankly, is by a reduction in provider rates. One way shape or form, it's a reduction in provider rates. What happens, as the former speaker said, when you reduce rates here, they're going to come up over here and we've seen that, we know what

happens. We know Medicaid pays -- has at least a 20 percent differential that gets picked up by the commercial carriers and I know many of you around this table sit on other committees where you hear routinely from providers that aren't compensated enough under the Medicaid program, but they're not meeting those costs.

Well, who makes up those costs? The commercial carriers make up those costs and one of our fears with this program is that if the rates aren't sufficient, as we have seen in the past, aren't sufficient to cover the claims, two things are going to happen. One, they're either going to reduce the rates, which is already predicated in the budget that you passed last year in terms of hospital negotiations, and/or two, they're going to raise taxes and in the meantime, when -- because if it lower and it isn't being priced in a competitive way with the carriers and you do have a migration from the small employer market and elsewhere into this plan, there is going to be an impact on the health insurance market, particularly if folks are locked into the state employee plan or the partnership plan or the Connecticut Plan, however you want -- whatever you want to call it. They're locked in for three years.

I think you heard the previous speaker say that if a carrier exits the market, they've got to be out for five years. So those two things overlap and a zipper effect that doesn't bode well for the state of Connecticut and therein lies our concern and why we have taken this issue so seriously and we urge your opposition. So I thank you for the opportunity to comment.

SEN. LESSER (9TH): Thank you, Susan, and I note that in addition to those two bills, you have submitted testimony for and against I think all of the bills on agenda.

SUSAN HALPIN: Yes.

SEN. LESSER (9TH): I want to take you back a little ways to March 15, 2007.

SUSAN HALPIN: That's a long way.

SEN. LESSER (9TH): It is a ways ago, but you testified that day on a bill that then Governor Jodi Rell put forward. It was called the Charter Oak Health Plan and that was a public option and you testified in support of that bill and I was wondering if that industry was there then, what's different about this proposal?

SUSAN HALPIN: If I can think, I was here then and I would dig back in my files and certainly comment. What I can tell you that I remember about the Charter Oak Health Care Plan, and Christine, you can help me out, I do believe it -- First of all, I remember it being priced pretty highly, that there weren't a lot of folks who came into it. Yeah, come up.

SEN. LESSER (9TH): Sorry. I didn't mean to give you pop quizzes from over a decade ago.

SUSAN HALPIN: I'll beg your indulgence. I'm trying to remember here. Your name for the record.

CHRISTINE CAPIELLO: Christine Capiello, Anthem Blue Cross/Blue Shield. So the Charter Oak Plan was pre ACA, so you had -- you didn't have guarantee issue in the marketplace then for individuals, so it was medically underwritten and so it was a capped

premium of \$250 dollars and it was built off of -- they were with -- it sat on, I'll say, the best way to say it, it sort of sat on the HUSKY platform, so it was administered through DSS and it was called the Charter Oak Plan, but it was a HUSKY in essence and it was for people that were 21 to 55 who couldn't get insurance because it was medically underwritten, right, because we used to be able to say we're going to take you or we're not going to take you based on your medical condition.

And so at the time, you know, there was an -- we didn't have Medicaid expansion then either, of course, because it's pre ACA and we were in the HUSKY program at the time serving the children and so there was a big need because there wasn't an uninsured -- There was a high risk pool that was there, it was quite expensive, and the governor brought us in and talked to us about look, it was this very segmented population of the uninsured and we did -- we were very clear with the Governor's Office at the time the difficulty that would happen with that program, which is that their claims were going too far exceed that \$250 dollar set premium, that you didn't know the risk that you were taking -- that you were coming in there, but it was the uninsured population, which I think is an important distinction, and again, as I said, pre ACA.

And it was administered -- it would be administered through the plans that were in the HUSKY program and it was not self-insured. It was an insured product and so I think that it's not -- it's certainly not apples to apples to this. I mean, I think the point that it's important to kind of get across and the distinction that we have here is that this is an unlevel playing field and if the partnership or

whatever you want to call it once it has commercial people in it, right, it has non-municipal, non-state employees in it, if they come in and they're treated -- and the product itself is treated the way it is in the insured marketplace and they play by the same rules that we have to play by, then I think it's a very different conversation. The issue is that they don't have to follow the same kind of rules that we have to follow and so inherently, you're going to have this imbalance.

And, as we all said previously, it's a self-insured product. It's, you know, there's a lot of other things, considerations for the state as a policy to have to go into it, but the difference between Charter Oak and this plan were very different. So I think it's the part about let's level the playing field -- And I think there's just one other piece I just want to make sure gets across and I actually agree with Frances, this is about the cost of healthcare, you know. I think that's an important piece. The ACA attempted to go through and didn't reach far enough into what's driving the cost of healthcare. You're looking at the premium at the end. We're just a reflection of the cost of what people are getting in terms of benefits. But anyway, that was the difference between Charter Oak and this.

SEN. LESSER (9TH): Thank you, Christine, and if you weren't prepared for that question, it certainly sounded like you might have been.

CHRISTINE CAPIELLO: No, I just had like a moment, I remember now.

SEN. LESSER (9TH): So -- But, you know, I guess what I was sort of reacting to, whether, you know,

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there are proposals out there to build public option based on Medicaid and Husky and Charter Oak was one of those that, you know, we could have done a Medicaid buy-in and this is built off of the state employee plan instead and so to Susan's comments earlier, I think that is why there were a whole bunch of doctors standing behind this morning in support of the bill because is based off of the state employee plan rather than going down the, you know, the Charter Oak public option choice of being built on Medicaid. And those are, you know, those are policy choices that we get to make in this building, but when we use, you know, phrases like a government takeover of healthcare, that to me seems to send the message that any government participation in healthcare is unwelcome. When I think, you know, your own explanation of the whole history indicates that not only has the industry not always had that position, in fact, in many cases it's welcomed that. Certainly your members are participants and Medicare Advantage Program, and both you and -- actually both of your clients testified in support of the Charter Oak Plan.

CHRISTINE CAPIELLO: Wait, but I think the distinction is that they were on the same level playing field. It was an insured product licensed by the insurance department, the same way that I -- that Anthem or any other company in Connecticut has to function. I mean, in great respect to you also, are contemplating a health ministry bill outlawing health ministries. They're not licensed insurance companies. They basically literally collect the basket, right, it's church and if there's enough to pay out the claims, they fill out the claims, if

there's not, then that person is shorted what it needs to be paid on a claim.

That's our issue, right, because -- in the same way we don't like health ministries, they don't play on the same -- I mean, I have solvency requirements, the department licenses me, they can come in and do market conducts, they can do a cease and desist. It's a very regulated industry and that's what we're saying. It's not necessarily that it's government -- I mean, that's an important distinction. The government part about it is that it's not a level playing field with what I have no choice but to function in.

SUSAN HALPIN: If I could just add it really is hard to compare 2007 to today and there wasn't an existing exchange at the time. We have a functional exchange right now. I'm not sure most of the folks that aren't purchasing on the exchange understand what is out there to purchase and the fact that we have a very functional exchange with two very successful large carriers in Connecticut operating on the exchange over -- How many members now? With 206,000 individuals purchasing on the exchange. We are -- The industry is already being assessed, \$36 million dollars, to pay for that exchange. It has a small group, small shops, small employer components, that small employers can buy in. There hasn't been a big uptake on that. I think there's valid questions as to why. I think there's perhaps some changes in tax policy at the federal level that may -- people may be more interested in going on the exchange coming forward, but it is -- not just not exactly apples to apples, it's completely apples to oranges between 2007 and today.

And we are active participants or have been in the exchange products, either in Connecticut or across the country, so I just -- I guess I can't -- That piece is not, I don't think, reflective of the companies today and are engaged in Connecticut and our market today and I do want to go back to one other thing that you said because you did indicate some of the testimony elsewhere, we are supportive of the benchmark generally speaking. We think it's a conversation that its time has come. In Connecticut, we tend to want to run before we walk and I think I heard Vicki Veltri say earlier, I think we're seven years behind that. You need to build that platform so you can make some of those decisions about what the next policy should be. So, you know, we're -- the devil is always in the details.

We always look forward to continued conversation, but we do believe that is the more appropriate path to take on this than to just kind of disrupt the market, and I know there are people who will say well, we want to disrupt the market. I think Connecticut is in a much different position than other public option quote/unquote states across the country. They don't have the economic base of the insurance industry that we have. They don't have the 25,000 jobs that I started out with. So I hope that helps explain the issue a little bit from our perspective.

SEN. LESSER (9TH): Well, it does, and obviously I understand your need to represent your clients and they are certainly a big part of this region's economy and many of my constituents work for them. More of my constituents don't work for them and the policy questions that we're struggling with is how

to make sure that people have access to healthcare and the stories we heard earlier about how employers -- the decisions that employers have to make when they spend all of their time and all of their money trying to figure out how, especially small employers, how to afford the cost of healthcare is meaningful to me. I think that the question we're sort of wrestling with is what do we do? What is that doing to our economy when somebody can't take the risk of starting a new business because they can't afford to lose their large employer healthcare and I wrestle with that.

So I think that the reason this keeps coming back up is because in parts of the healthcare market, I don't think everywhere, it has been a real pronounced market failure. I'd love to say that that's not the case, but you can talk to any small business owner and the legislature, I'm in the legislature, on the streets and you'll find that they're having significant affordability issues and this wouldn't keep coming up if those issues had been addressed by the marketplace as it is. There are a lot of good things that happened since 2007. A lot more people have health insurance in Connecticut and a lot of those folks tell us that even though they have insurance on paper, they can't afford to access it and that remains to be a concern that we have to now address in this committee. So I'm not sure we're going to reach a yes or a consensus on this issue today. We may have to put that off for our next meeting where we work that out, but I always appreciate hearing from you and certainly ask if any members of the committee have any questions. Okay, well, thank you very much.

CHRISTINE CAPIELLO: Thank you.

SUSAN HALPIN: Thank you.

SEN. LESSER (9TH): I don't know if Sal Luciano is here, but -- Oh, he is. Oh, my goodness, I didn't see you. Apologies, Sal. After Sal, Sal's best friend, Joe Brennan, is coming up. No, we like this sort of alternating.

SAL LUCIANO: Good afternoon, Senator Lesser, Representative Scanlon, and members of the Insurance and Real Estate Committee. My name is Sal Luciano. I'm proud to serve as the president of the Connecticut AFL-CIO. Thank you for the opportunity to provide testimony in support of S.B. 346. Senate Bill 346 creates a new evidence-based option for those most often excluded in the current employer-provided health insurance marketplace, employees of small businesses and nonprofit organizations. Many small businesses and nonprofit organizations cannot afford to provide health insurance to their employees. When people can afford health insurance, they often avoid the doctor, skip medications, or delay recommended screenings. That's not good for anyone's health or wellbeing and it also ends up making healthcare more expensive for everyone.

Senate Bill 346 authorizes the comptroller to establish the Connecticut Health Program to offer evidence-based, high quality, low cost health insurance coverage to small businesses, nonprofits, and unions with multi-employer Taft-Hartley plans by January 1, 2022. The plan's design emphasizes preventive care and wellness, encouraging patients to utilize high quality, lower cost providers, unlike the high deductible plans currently flooding the small group and individual markets. Nonprofits and small businesses will be able to voluntarily

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choose between a range of network and benefit designs, including dental care offered at competitive prices realized by leveraging the negotiating power of the state employee plan.

Comptroller Lembo has historically kept rate increases far below those experienced in the private sector. Without the motives of profits, without high paid executives to compensate, a much greater percentage of premium dollars can be spent on actual healthcare. The bill also allows the comptroller to leverage the power of state employee health plans to create new options for labor unions with multi-employer Taft-Hartley plans. Unions can choose the plan that most align with their negotiated benefits allowing them to retain bargain wage increases and other benefits. Recognizing that employees of small businesses and nonprofit organizations can earn less than other employees, Senate Bill 346 also authorizes the creation of state financed cost-sharing subsidies for that who do not qualify for subsidies under the Affordable Care Act.

It's another way to give everyone the best possible opportunity to have affordable, high quality, evidence-based healthcare. Senate Bill 346 does not replace health plans offered by private insurers on and off the state health insurance exchange, Access Health Connecticut. It does not replace Medicaid/HUSKY for low income, disabled, and elderly residents. It does not replace Medicare and it does not replace existing employer-sponsored coverage. Senate Bill 346 provides a new, voluntary option small businesses and nonprofit organizations that currently find cost coverage costs prohibitive. We urge the Committee to support this bill.

SEN. LESSER (9TH): Thank you so much, Sal, for your testimony. Perhaps you can tell us a little bit more about Taft-Hartley plans. I understand it's important for many of the folks in labor that you represent.

SAL LUCIANO: So Taft-Hartley plans are group plans that many benefits, mostly healthcare benefits, come from the employer. Taft-Hartley is a little bit different. The union pretty much ends up managing the healthcare costs and benefits and they're not experiencing anything different than the rest of this country is experiencing, double digit increases year after year, prescription drugs that are probably -- You know, the good news is we have medicine that will cure you. The bad news is you can't afford it and so, they're facing the same kinds of pressures and so what they're finding is that instead of people going and being able to get a raise, a lot of the negotiations is simply to try to provide health insurance and to stop eroding the benefit levels that they get.

SEN. LESSER (9TH): Thank you. Other comments or questions from the Committee? Representative Hughes.

REP. HUGHES (135TH): Thank you, Mr. Chair, and thank you, Sal. Can you speak to how, if -- I'm thinking about unionize or labor, small businesses could shift their costs from providing healthcare to wages, what would that look like?

SAL LUCIANO: So the -- One of the reasons I really like this plan is because it's evidence-based, which means that you get -- you're saving money -- as I like to tell people, I take my high blood pressure medication not because I'm afraid of having a stroke

and dying, but because I'm afraid of having a stroke and not dying. When you don't take care of yourself, just like if you don't take care of your car and change the oil, you end up having what I call personal bridge collapses. If you can't afford the diabetic medication, then you have to have a limb cut off or you go blind, you're -- it's costing the system.

Forget about the human tragedy, you're costing the system a tremendous amount of money, so that's one of the reasons I like this plan. I think it's one of the reasons we've been able to keep costs lower than what we've seen and we have situations -- I know where we actively represent people who aren't in any hurry to negotiate a new contract because all they see are greater cost-sharing and also a greater erosion of the benefits that they do have, so they'd rather be without a raise than know what the inevitable is, which is that they're going to get less money and they're going to pay more for healthcare. And so this would dramatically change the landscape and maybe allow these people to be able to have a break and, you know, when you look at just some of the demographics.

I mean, the median income in Hartford is under \$18,000 dollars, but median means half the people in Hartford earn less than \$18,000 dollars, so anything in their pocket -- You know, everybody says well, how come we can't fix Hartford's problems. Well, when you half of the residents are earning less than \$18,000 dollars, there's not a lot you can do. So, you know, America needs a rise, working people need a raise, and they also need access to high quality healthcare and we're seeing that dream harder to reach every year.

REP. HUGHES (135TH): Thank you.

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

REP. VAIL (52ND): Thank you, Mr. Chairman. Good evening. I want to ask you a little bit about the Taft-Hartley plans. Are those self-insured or are those -- do you purchase insurance with?

SAL LUCIANO: Well, at the -- They're self-insured.

REP. VAIL (52ND): Okay. And so does that money pool -- So do you, the union members, do they chip into that and does the union chip on some as well or does that strictly come from -- Is that 100 percent participation on the union members?

SAL LUCIANO: So -- Well, the money for the Taft-Hartley comes in several ways. The employer pays some of it and then the employees pay some of it.

REP. VAIL (52ND): Okay. All right. Thank you for the clarification.

SEN. LESSER (9TH): Thank you, Representative Vail. Other comments or questions from members of the Committee? If not, I'll let you go, but I do want to just thank you for your work on the Healthcare Cost Containment Committee and in developing the Centers for Excellence Program. I know that you've put a lot of time into that and I think a lot of folks in Connecticut are grateful for your work on that.

SAL LUCIANO: Thank you, Senator.

SEN. LESSER (9TH): Thank you. Next up, Joe Brennan, followed by Zina Bennett and I've heard rumor that this might be one of the last times Joe

is required to subject himself to the Insurance and Real Estate Committee, but --

JOE BRENNAN: I was really hoping I already had my last time doing this, but Senator Lesser, members of the Committee, thank you. My name is Joe Brennan. I'm president and CEO of CBIA. I know you've talked a lot about and I'm hearing 346. I know you heard a lot about this today. I'm not going to -- We do have written testimony. I just want to make a couple points and I'd be happy to answer any questions you have. First of all, and I mean this sincerely, I want to thank you for continuing this discussion. I remember being here a year ago talking about it and, you know, highlighting the importance of it because, you know, I would argue that I probably talk to more small businesses in the course of a year than anybody else in this room, given the fact that the vast majority of our members are small businesses and healthcare comes up all the time, just as you and others, you know, when you're knocking on doors, you know. I hear it every day, too.

And what we want to do is find something that works and just for a lot of reasons that you've heard and some others I may bring up, I don't know that this is the solution. There are so many components to healthcare in the U.S., different than other states. You know, I think in some ways, people are a little spoiled. You know, utilization is high here. People are just used to over the years being able to go to the doctor and in Connecticut, I think it's exacerbated by the fact we just have high costs overall here, so to operate a hospital here or to operate a doctor's practice or to operate an insurance company or pharmaceutical company, all the

-- just so many costs for energy and labor and other things just build up, so just to say this one thing is going to our solution, you know, I just don't think that's right.

So I do -- I was encouraged listening earlier about some of the cost containment measures in Massachusetts. I read the *The Globe* every day and I've been following healthcare for years up there and they have made a lot of progress, so I would suggest more going down that route and trying to find some things so we can really get to the underlying cost of healthcare and delivery of healthcare because just adding a public option doesn't do that. It will create cost shifts, it will create other problems. As I said last year when I was here, you know, we heard a lot of the same encouraging things about the MEHIP program years ago, if we opened up MEHIP to the small business community, that would solve a lot of problems. We did that, hardly anybody went there, and then when the ACA got past and we created exchanges, the same thing with the SHOP exchange, and now, you know, we're told that they need more money to do more marketing because nobody's going to the SHOP exchange.

Just the fact that it's going to be a government program doesn't necessarily mean that people are going to come and it doesn't necessarily mean that it's going to solve their problems. Susan talked about the level playing field. I mean, that's a big issue. I didn't want to go here, but I'll go here anyway because it may be my last testimony. Some people alluded earlier that, you know, we don't like competition, you know, because we have, you know, a health plan. You know, we're an association like

AARP and the Bar Association and a lot of other ones. We've tried to provide benefits to our members and one of the benefits that we've been able to develop over time is a health plan for them, but it's a member benefit and we supported legislation back in the '90s that basically put us out of business because we thought the legislation was a good idea and I've always said if we can't compete with the state, then we shouldn't be in business at all. So it's not that we don't want competition, we just want a level playing field and we want solutions that actually will solve a problem and not exacerbate problems.

Just one other comment on the industry, you know, a very small percentage of our members are insurance companies, but they're very large employers and there's no question that it's an important industry in the state of Connecticut and I don't want to say the sky is falling that if this bill passes, you know, we won't have any insurance jobs here. That's not the case, but the fact is every single day, my job is try to create a globally competitive business climate here in Connecticut and we've got real challenges, you know, and despite a lot of criticism we may get about being negative, you know, I'm one of the biggest cheerleaders for Connecticut. I think we have tremendous opportunities here and a tremendous state, but from a competitive standpoint, we do have challenges, and I just think if we go forward and be one -- in the insurance capital of the world, say, you know, the insurance industry can't get it done and the state has to get involved, I just think that's going to make it even harder for us to a successful state as a whole, not just for insurance.

I had one other point and I'm getting old and I forgot it, but I just think the bottom line here is that we've got to continue the discussion going. I would love to explore some of the cost containment measures that were discussed earlier. I don't want this to be, you know, a big -- just rhetoric back and forth. We all have a problem we're trying to solve. We've got the brightest minds in the world in this area -- in this state for this issue. There's no reason why we can't, you know, find other solutions. It's not about competition. It probably is, and this is the final thing I'll say, there probably is a real ideological divide here. You know, the state wants to get into retirement plans, there's all kinds of problems with that retirement security board. As I said, you know, when they opened up MEHIP and SHOP, it just philosophically, when we've got great industry here in Connecticut, I don't know -- I think I would rather have the state work cooperatively with us, how we can make everything better, but not necessarily compete.

It's not about CBIA's plan, that's irrelevant in the big picture. It's really about industry as a whole and working with the state cooperatively and not feel like you have to compete with the -- with the public sector. We need the private sector to thrive. One of the biggest problems we have in Connecticut that affects all these problems that you'll hear throughout this session is the lack of growth. If we had growth, we'd have so much more revenue, we'd have surpluses that we couldn't imagine if we had the growth that mirrored the rest of the country over the last decade. We haven't had that growth. It creates so many problems. So from the big picture standpoint, I think this is going to

inhibit our growth instead of enhance it. And I get all the arguments about small businesses, you know, not being able to start or an entrepreneur not being able to start a small business because of the cost of healthcare, but as I talk to those hundreds and hundreds and hundreds of companies all year about healthcare, nobody says to me the problem is I can't buy into the state plan. The problem is we have too many mandates or too much cost shift because the state doesn't meet its obligations around Medicaid. Those are the things that I hear. I don't hear the problem is I can't buy into the state plan. And I know I went over my time and I apologize for that and I appreciate your patience and would happy to answer any questions.

SEN. LESSER (9TH): Well, thank you, Joe. I appreciate your testimony and, you know, the -- you make a lot of good points. I would agree with you that I hope this is -- Well, I would ask -- My hope is that this isn't an ideological fight, like I don't have any interest in engaging in pointless ideological fights because those aren't easily resolvable and I think the reason the bill before us is really focused on segments of the healthcare market and isn't -- you know, doesn't have large employers, for example, in there because there isn't market failure there. There are places where the market is working. I believe in competition, I believe in markets, I think the other folks on this committee of both parties do, but the -- there are places where the market has not worked and, you know, maybe that's entirely because of mandates and government intervention, I don't know, but I think we're trying to respond to what we're hearing, which is what I think you're probably hearing as well,

which is a real frustration of small and mid-sized businesses trying to figure out how to be competitive and they see healthcare costs as one of the things that inhibiting.

JOE BRENNAN: Yeah, I just want to comment, Senator, and I appreciate that. When you say the market failure, you know, we're -- the market is kind of constructed for us, right, by federal and state laws and regulations and if, not that this will happen in my lifetime, but, you know, if we could maybe loosen up some of those regulations and have more innovation and more flexibility, then the market might operate better. Maybe if we had fewer mandates, and I know that's a touchy subject in this building, it might operate better. Maybe if, you know, the state could meet its Medicaid obligations to a larger degree; that could remove some of that cost shift which would lower the costs on small businesses. That could help the market function better. So I agree, it's on both sides. It's just not the market itself, the private market. That private market has got all kinds of constraints on it that don't let it flourish the way I think it otherwise could.

SEN. LESSER (9TH): Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good evening. I'm just curious, I have no clue what the answer is, when they -- we heard some testimony earlier that people had been collaborative, had been getting everybody's idea on how we could move forward with this, has -- you represent how many different businesses in Connecticut?

JOE BRENNAN: Around 5,000.

REP. VAIL (52ND): Around 5,000, have you been brought into those discussions?

JOE BRENNAN: I'm sorry, I'm not sure which discussions you're referring to.

REP. VAIL (52ND): Discussions about moving forward with, you know, this bill in particular, some of these other bills on how to address our healthcare issues. We heard testimony that this would be good for small business. I know you have -- obviously you represent a lot of those businesses. Have you been at the table to help try to find some common ground on this issue?

JOE BRENNAN: I'll do my best to answer that. Certainly I haven't personally -- Our folks are in the building all the time and have conversations with the people around this table all the time, but do we have any official role in constructing something like this, no.

REP. VAIL (52ND): Okay. Thanks.

JOE BRENNAN: I mean, just to add, I have sat down with Comptroller Lembo numerous times. You know, we have great discussions about this. Again, it's not antagonist, it just may be differences of opinion, but as far as official role, no.

SEN. LESSER (9TH): Thank you. Just out of curiosity, have you had a chance to survey your membership on this proposal?

JOE BRENNAN: On this bill?

SEN. LESSER (9TH): Yes.

JOE BRENNAN: No. I would -- Like I said, I talk to current members all the time and we talk about all

these things and like I said, their attention is on other things that are driving the costs up.

SEN. LESSER (9TH): Other comments or questions from the Committee? If not, thank you very much.

JOE BRENNAN: Thank you.

SEN. LESSER (9TH): And best of luck in your future endeavors.

JOE BRENNAN: That wasn't supposed to leak yesterday. I'm going to be around for a while.

SEN. LESSER (9TH): Okay.

JOE BRENNAN: You're not going to get rid of me that easy.

SEN. LESSER (9TH): Next up, Zina Bennett followed by Melissa Biggs.

ZINA BENNETT: Good afternoon, Senator Lesser, and members of Insurance and Real Estate Committee. My name is Zina Bennett and I'm a certified nursing assistant at St. Joseph's Manor in Trumbull, Connecticut. I am also a proud 1199 delegate because through the union I have been able to have a voice in the workplace and at the capitol. I am here today to testify in support of S.B. 346. I currently live in Bridgeport with my two sons. I became a CNA because I believe in preserving the quality of life as best as I can. I value the work that I do and every day I try to make life for my residents as easy as it can be. My oldest son is only 12 years old and suffers from chronic asthma and some very complex GI problems. My son's asthma medication alone is \$65 dollars as a copay.

As for myself, I have been diagnosed with seizure disorder in the past two years. My seizure medicine is \$70 dollars for a 30-day supply. I cannot afford that much for medicines on the salary that I'm making and yet both my son and I need these medications to survive. My employer, Genesis Healthcare, recently switched their healthcare plan overnight so that almost all Yale-New Haven providers are now out-of-network. This change affects the health of my children and myself because all of the doctors and specialists that we need to see we can't see under this current insurance. Most of the doctors and specialists are in the area are Yale-New Haven and my sons and I have to find new doctors and specialists that are cheaper inside the network.

I absolutely cannot afford to pay that out-of-pocket. There's no way that I can afford that. If I could leverage a larger insurance pool or join the state employee's health plan, I would be able to afford the life-saving medication that I and my child need. If Connecticut has a public option, I would be able to afford to see any doctor of my choice. I also could have a very low copay and affordable health coverage. This plan will provide the engines of our state economy, workers, families, small businesses, and nonprofits, access to high quality and high value healthcare that will ensure that my family is not jeopardized if I or a family member falls ill. Please support S.B. 346. Thank you for your time.

SEN. LESSER (9TH): Thank you very much for your testimony. Just a few questions, so you've talked about the cost of the seizure medication and the asthma medication, have you had to -- has there ever

been a point where you've had to take less than your doctor said you should take or your child take less? Have you ever had to ration access to those medications?

ZINA BENNETT: Yes, I've had to not be on my medication in order for me to be able to pay for my son's medication because as a mom, I put my kids first and in the process of me doing that, it has backfired on me a little bit and I've had more seizures than I should be having, and then when I'm out of work, I lose money.

SEN. LESSER (9TH): Yes, that's perverse logic, right, where we, you know, make it -- We were just having the same conversation about insulin and Type I diabetes last week and now on this issue. When you save a little on the front end, then it costs you a lot more on the back end and that's sort of the way our healthcare system sometimes is constructed. I think that's what we're looking at trying to fix today. You talked about -- I'm curious about the story you talked about with your new healthcare network. That's not really what the bill is focused on, but that's one of the many things that we're talking about is that issue of network adequacy, of having to go outside, not being able to go see, in your case, a doctor in the Yale system. How far do you have to go, like where are those specialists? What kind of burden is that? Maybe you could just tell us a little bit more about that.

ZINA BENNETT: As far as the doctors that I do see or the doctors that I would have to change over to?

SEN. LESSER (9TH): The doctors that you have to change over to.

ZINA BENNETT: The doctors that I have to change over to, I've looked at some of them, but again, in my situation and my son's situation, Yale was the best, so anybody under the Yale or Bridgeport Hospital is what's best for us. One of the hospitals that under -- that is in network is St. Vincent's and unfortunately I've had a past issue which my life was not in good hands at that time, so I had to make the choice to Bridgeport Hospital, so that's why it's so important for me to be able to have the option of where me and my kids go because in the state of Connecticut, Yale for me, Yale is the best for us.

SEN. LESSER (9TH): Thank you. Are there questions from members of the Committee? Yes, Representative Hughes.

REP. HUGHES (135TH): So thank you, thank you, Mr. Chairman, and for your testimony. So how much time do you end up spending to try to navigate finding the alternative who is in the network plan, you know, when those barriers exist for you and your child?

ZINA BENNETT: Well, recently -- See, what happened was when they changed the insurance, when they did open enrollment, they said that there would be small changes. They did not explain in depth how bad the changes were going to be. They didn't say oh, we chose a whole other plan, so when we initially went on line after open enrollment to search and make sure our doctors were still in-network, on line it says our doctors are still in-network. It wasn't until I took my son to the doctor's office and pulled out the card and she seen the color of the card and she said we don't take that.

REP. HUGHES (135TH): So what you describe is what a lot of the clients work also in Bridgeport describe is that the actual implementation, that's where the barriers are and so then it's up to the responsibility of the patient, often the sick patient, to then find the recourse, to find the next, you know, the next avenue open and to go after it. You take on the administrative burden instead of the change in health plans.

ZINA BENNETT: Right, and the bad thing is we are switching over doctors, especially when you're leaving your doctors to go to new doctors, a lot of the tests that have already been done, everything has to be redone all over again. So my son, his blood work has to be drawn again, he has to get pricked again, so it's draining and it can be a nightmare and there's a lot of frustration because when you're paying a certain amount of money into your insurance every -- now it's every week, before it was biweekly, I'm paying for nothing because I can't -- I don't have access to who I need to have access to, so it feels like I'm going backwards instead of moving forward.

REP. HUGHES (135TH): Thank you. I appreciate that.

SEN. LESSER (9TH): Thank you, Representative. Other questions or comments from the Committee? If not, thank you for being here.

ZINA BENNETT: Thank you.

SEN. LESSER (9TH): Next up, Melissa Biggs followed by Steve Karp.

MELISSA BIGGS: Good afternoon, members of the Insurance Committee, or good evening as it is now. I appreciate the opportunity to speak to you today.

I'm speaking on behalf of America's Health Insurance Plans, AHIP. AHIP is a national association whose members provide coverage and health related services that improve and protect the health and financial security of our consumers, families, businesses, communities, and the nation. I apologize, our regional director was not able to attend today, but I promise I can him available to anyone in the Committee who would like to speak to him after. I'm here to talk about our concerns regarding S.B. 346, AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTHCARE IN CONNECTICUT. Proposals as the Connecticut Health Plan proposal outlined in S.B. 346 have the potential of being very disruptive to Connecticut's current healthcare system. The proposal is anti-competitive, the Connecticut Health Plan and small employer buy-in would have a distinct advantage over traditional qualified health plans. That would be in direct competition with it because it would likely force providers to accept below market rates or unfairly subsidize only this coverage with taxpayer dollars.

We believe that a robust and competitive market aids in keeping healthcare costs contained. Providers may be forced under this plan may be forced to raise rates in contracts with other products to cover their losses from participating in the Connecticut Health Plan. As proposed, the Connecticut Health Plan would need to force providers to accept a below market rate. We are concerned that this would lead to participating providers raising their rates for the other insurance products, which would further destabilize the commercial market. Patient access may be adversely affected. Rural hospitals and providers serving rural communities may not be able

to sustain large blocks of business at the low commercial market levels of reimbursement.

Connecticut residents living in more rural communities may be faced with increased difficulties due to access care that they need as a result. We believe that there are policy solutions that exist that to build upon the backs of both private and public specters that we can improve affordability and coverage for all Connecticut residents. We share the same goals as this committee in ensuring that people have access to quality and affordable healthcare. We are prepared to come to the table with proven policy options to address this issue. We are in the support of the following proposals; improving market and outreach for those available -- already eligible for Medicaid, implementing safe base premium assistance programs and reinsurance programs, and taking steps to lower costs for everyone, including promoting list prices, transparency, competition, and value in prescription drug pricing and eliminating taxes and fees that would harm consumers and increase premiums. Thank you for your time today and your patience at this hearing. I would be happy to try and answer any questions you may have, but I would be happier to refer you to someone at AHIP who can provide you with a more thorough answer.

SEN. LESSER (9TH): Thank you, Melissa. I don't recall ever having someone say please don't ask me questions.

MELISSA BIGGS: I didn't say that specifically.

SEN. LESSER (9TH): You didn't say that, no, but I can read between the lines. Are there questions from members of the Committee, despite that?

MELISSA BIGGS: Fantastic.

SEN. LESSER (9TH): If not, you got off easy. Thank you. Next up, Steve Karp followed by Kathy Flaherty. Oh, I don't see Steve. Kathy? After Kathy, we'll hear from Tom Burr.

KATHY FLAHERTY: Good evening, Senator Lesser, and members of the Insurance and Real Estate Committee. My name is Kathy Flaherty. I'm the executive director of Connecticut Legal Rights Project, co-chair of the Keep the Promise Coalition, and also here on behalf of the Cross Disability Lifespan Alliance. I just want to put on the record that I have also submitted written testimony in support of S.B. 320 and S.B. 324, but I'm here tonight talking about the public option bill and I am the executive director of a nonprofit. We have 13 employees. only four of our employees are covered through the plan we offer at work because our plan is so bad that if people have the opportunity to get coverage elsewhere through a spouse or a family member, they take it.

I -- My husband is self-employed. We have the health plan. It is a high deductible health plan and it's -- we don't have the ability to self-insure, so it puts the cost on our employees, including myself, so on a purely selfish but also on behalf of my employees and all the other people in this state that deserve good healthcare, I hope you can figure a way to get this bill across the finish line. It actually impacts our ability to hire. It is a challenge for us to hire anybody who really truly can't afford to work for legal services. I have had employees be unable to get the medical care

they need. If they cannot address their own health issues, they don't perform their jobs as well.

We designed a system that ties healthcare to employment. I don't think anybody who redesigned the system from scratch would ever do that, but that's what we're stuck with and if there are ways to help people work around that, I fully support that and I'm here in support of the bill and I just hope you guys can figure out how to make it happen. Thank you.

SEN. LESSER (9TH): Thank you. I just have a question, why, given sort of the structure of what you're talking about, one of the things that I know some small employers are doing is under the new rules providing a subsidy to folks who purchase healthcare through the exchange. Why is that not the direction that you go?

KATHY FLAHERTY: Well, I guess it's a possibility and people have looked into it, but I guess the way the numbers work on the exchange for the particular people who are at our office, we tend to have an older workforce and, you know, I think especially since, you know, there are certain things where they can rate by age, it jacks up our prices, so I have no doubt that that's part of our -- the challenge that we're facing because what we do is if anybody is able to get their healthcare cheaper than what it costs us to have them on their plan and they want to do it, then they do that and we pay them the difference, so, or not the whole difference. We pay for -- You know, we have some people who are married retired state employees, so it's a very small portion because it doesn't cost that much, so.

SEN. LESSER (9TH): Thank you. Questions from members of the Committee? If not, thank you.

KATHY FLAHERTY: Thanks.

SEN. LESSER (9TH): Next up, Tom Burr followed by Bill Morico. Good evening. Please press the button. Kathy, why did you turn it off? You're killing me.

TOM BURR: Good afternoon, actually evening, I guess, Senator Lesser and representatives of the Insurance and Real Estate Committee. My name is Thomas Burr. I'm the community and affiliate relations manager for the Connecticut state office of the National Alliance of Mental Illness, otherwise known as NAMI Connecticut. NAMI Connecticut is in support of Senate Bill 346, AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTHCARE IN CONNECTICUT. I should add that NAMI is the largest mental health organization dedicated to building better lives for all people affected by mental conditions. NAMI Connecticut and its local affiliates provide support groups, education programs, and advocacy for people with mental health conditions and their family members and loved ones.

The continued and unsustainable rise in healthcare costs, including premiums, deductibles, copays, and co-insurance has become an unbearable burden, not only for me and my family, but my coworkers as well. For example, my wife and I get health insurance from our respective employers, but with the astronomically high deductibles, we simply cannot afford to get sick or injured. You have my written testimony that includes some really great information provided by the United Healthcare Foundation.

You also have written testimony from my executive director, Lisa Winjim, who submitted testimony on this bill, so I would encourage you to read that and just in the sake of time, I just want to add we've also submitted testimony on S.B. 320 and 321, the step therapy and burden of proof bills, and would encourage you to read Lisa's testimony on that as well and we support both of those bills and also appreciate the Committee taking the time to address all these issues which currently have a huge impact on the mental health community and since the dinger hasn't gone off yet, I should add, and this is just Tom Burr talking, not NAMI Connecticut, as someone who has been on this earth now in my sixth decade and has been employed since the early 1980s, it astounds me the de-evolution of the health insurance industry.

In all due deference to any industry reps who are still in the room here, guys, I'm an engineer by training and if something is broken, you fix it, you re-engineer it, or you replace it and this system is broken as it certainly is in the area -- this bill, 346, addresses. It's broken and it needs to be fixed or replaced and I'm glad you're taking the steps tonight to do this because honestly, you know, with not only 346, but 320 and 321, I mean, step therapy and burden of proof, these are all things that the insurance industry does to prevent people from getting the care that they need. You know, you're not adding value and you're costing us an awful lot of money and again, from a purely pragmatic engineering standpoint, if you're not providing value, get out of the way. So with that, I yield the balance of my time to the floor. Thank you.

SEN. LESSER (9TH): I'm not sure it works that way, but oh, to the floor, yes, I guess that works, but thank you for your testimony and for being here. Questions or comments from the Committee? Representative Hughes.

REP. HUGHES (135TH): Thank you for saying what I was trying not to say all afternoon, but --

TOM BURR: Well, sometimes you just have to call it, do you know what I mean?

REP. HUGHES (135TH): The disrupting of the market that is not working so clearly needs to be disrupted or replaced or fixed and I got to agree. I feel like the insurance industry has had ample chance to do that and has not, so we are trying to do it. It's not in the way that others would have it, maybe tried, but we've got to do something and so this is not the first try or the second or the third, but it's worth doing something different and seeing how we can improve for everybody. There might be some blips along the way, but I think the public has never been more ready than right now.

TOM BURR: Absolutely. I mean, this is a conversation I have all the time with my peers and friends and family. It's not working for anyone, it really isn't, and it's time. something's got to give, so thank you.

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

REP. VAIL (52ND): Thank you. Yeah, I see it a little bit different than you do. I see it when the government starts getting involved, that's when things start going wrong and since they get their hands so deep in this and mandates, instead of

letting doctors take care of patients. I certainly see a problem with the insurance industry, too, but they are backed up against a wall because they're constantly on the defense because we're constantly going after them to solve problems that they don't even create, so that's the problem. Big government solutions to me never work, so I just wanted to throw that in there.

TOM BURR: And I appreciate that and I used to think that way, too. Then I started learning about Medicare and how well run that is and now there is a role for the insurance industry in the Medicare industry and Medicare Advantage Plans and again, as someone who is not 65 yet, but is looking at it in the rearview mirror or looking at it coming up to me, I've been trained on the Choices Counselor Program, which walks you through the whole program and it's very complicated, but it seems to work pretty well for people. I don't get a lot of people who are over 65 that are on it that complain a lot about it and again, the Medicare Advantage Plans is a nice place for the industry to still have a role there, so I would disagree that the government necessarily creates a mess. Certainly with the Medicare Program, the numbers that I see and the efficiencies that it runs at is to be commended. They certainly take a lot less off the top than the typical insurance company does.

REP. VAIL (52ND): Well, we put in to the Medicare system our whole lives while we're working, so there's money there in front of us before we get there, so that's why it's funded the way it is. Medicare Advantage then takes that money that would be allotted to you for your insurance on Medicare and then you come off Medicare and go on the

Medicare Advantage Plan and they take that premium and they're able to do a lot with that, but that money goes in as you pay every year. You can't -- You're talking about something with an immediate influx of money. That money has been invested over time, that's why that works, and it's done with the insurance industry and that's why that works instead of putting them up against the wall. Believe me, it sounds a lot of times like I'm an advocate for the insurance industry. I am not, okay, I'm an advocate for people and sometimes when we target the insurance industry, they just -- they're just going to pass it on to other rate payers and I don't see these as good solutions, so I certainly understand where you're coming from. I just wanted to state my opinion.

TOM BURR: No, I appreciate that and I was really not talking about the premium aspect of Medicare, but more the administrative costs, but I appreciate your comments on that. Thank you.

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

TOM BURR: Thank you.

SEN. LESSER (9TH): Next up, we have Bill Morico followed by Dominic Cotton. Is Bill here? I don't see Dominic here either. Roger? Roger Senserrich, followed by Bruno Venero. Please press the button.

ROGER SENSERRICH: Good evening, Senator Lesser, members of the Insurance Committee. First of all, sorry for my voice, I had the flu last week. I'm not contagious anymore, but my voice is still a little bit taken. I'm here to testify in support of

S.B. 346. My name is Roger Senserrich. I am the communications director at the Working Families in Connecticut. We're a statewide organization that seeks to have a Connecticut economy that works for everyone, not just a wealthy few, and we are supporting this bill because we think that despite the significant progress that Connecticut and the nation has done on health insurance coverage since the Affordable Care Act was introduced a few years ago, there is still a lot of things that need to change for everyone in the state to have access to affordable healthcare.

The uninsured rate in the state, it's around 5 percent, it's really low, but we still see huge disparities in race for this. For adults, for nonelderly adults, African Americans see an uninsured rate of close to three times of whites, it's close to four times for Hispanics, and we see huge disparities as well by income, the lower income. You have to have not just insurance, but good insurance as well and even by the type of company you work. If you're working in a small business, you are much less likely to have good insurance and insurance that you're going to have -- Well, if you have insurance through the employer and the insurance that you are likely to have is probably going to be worse.

Besides health insurance coverage itself, the one thing that this legislation will help to solve is the problem of being underinsured. People have a lot on their plate, health insurance consumers in the state, since the Affordable Care Act was introduced. Premiums have been steadily rising, out-of-pocket expenses for families even with good insurance plans from their job, have been steadily

rising to the point that it's around 11 percent of the yearly income on average, health expenses out-of-pocket plus what they pay for premiums, a portion of their premiums. So introducing the Connecticut Plan, having -- giving more options to people in the state to have more access to better plans, different plans, and actually have a plan that is driven to cost controls, but not cost control in the sense of denying coverage, but actually having a level of administrative costs, having health decision-making process, not whatever the bonus the CEOs of the insurance companies need to get, that order, gather behind government agencies makes a lot of sense. So we fully support this bill. We think it's actually going to be a good improvement to how healthcare in this state gets delivered and I will happy to take any questions.

SEN. LESSER (9TH): Thank you, Roger, for your testimony. Are there questions from the Committee? Representative Hughes.

REP. HUGHES (135TH): Yes, thank you for your testimony and waiting all day. So one thing we haven't heard a lot about is the underinsured and just from your experience, what does that look like in Connecticut?

ROGER SENSERRICH: So it looks like you might have a health insurance policy that covers -- in theory has a big network of providers, in theory has all these benefits that it needs to hit, but you have \$3,000 or \$4,000 or \$6,000 dollar deductible per family, meaning that you might be spending \$15,000, \$12,000 dollars a year in premiums and still have to pay \$6,000 dollars a year in healthcare expenses. Someone has mentioned the statistics about the

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amount of savings that Americans used to have. Most people don't have more than \$1,000 dollars in savings, meaning that they have a sudden medical emergency, they are out -- they have to burden through that. They have to significantly cut expenses somewhere else or get into premium plans, even if they have health insurance. We had a catastrophe three years ago, if you remember that, and just in terms of hospital bills, it was really good insurance. We ended up spending \$10,000 dollars. We had planned for that. We were able to save for that, it wasn't an unexpected expense, but any sort of hospitalization that comes out of left field and be completely not your fault, you get hit by a bus on your way to work, that means that you can get a family savings completely wiped out. You are actually losing income as well, it can get you into real trouble. And besides responding to emergencies, this means that a lot of people that need treatment, that need to go to the doctor, will put it back.

You're not going to get that need check because you know that it's going to a doctor bill. You have a bronze plan or a plan that you have to pay dollars out of pocket, like a specialist where there might be another fee or dollars out of pocket, and you don't know if that's going to end up with more delays. It's a bit like people that don't go to their mechanic because they know that the mechanic is going to ask them to change the brakes or get a new transmission belt or something like that. The difference is that it's not a car, it's your own health, and it can snowball into something much worse.

REP. HUGHES (135TH): One thing that I was thinking of as you're talking is most people don't consider themselves underinsured. They don't frame it -- I know when we listen to the Medicare -- I mean Insulin for All, they didn't know that there were some times, some young people, in terms of rationing. They just knew that they couldn't afford that, so they were putting it off and trying to make it last and going without, like another mother we heard, and so this is normalized that this is just what most do, most working families do, and they -- we don't normalize --

ROGER SENSERRICH: And this is not normal. It's not normal that you -- if you have the flu, you don't think about going to the doctor just in case it gets worse. We have a pandemic that's going on in this country and there is a big uncertainty how much does it cost to be tested. Just on that alone, the potential impact of these, it's going to be much worse in the United States than anywhere else, mainly because a lot of people are going to think twice before going to the doctor. And the one thing about underinsurance, as well, is a lot of people think they have good insurance and they only realize that that insurance has big gaping holes once they have to interact with the healthcare system. So I mean, I had a relative that needed a knee replacement. They thought they had good insurance. They ended up paying I think close to \$15,000 dollars in out-of-pocket expenses at the end of the day. They were convinced that they were protected, they were convinced that they were not going to be spending that much money. They were so -- And the health insurance company then supposedly determined the claim benefit that they had. They didn't know

that they were underinsured until they had to interact with healthcare system.

REP. HUGHES (135TH): Thank you.

SEN. LESSER (9TH): Thank you, Representative. Other comments or questions from the Committee? I do have a question about one part of the bill. I think last year a lot of the conversation was about folks who are not eligible to purchase healthcare currently over the exchange, whether or not a publically available option would be a way to allow people who are prohibited because of immigration status or for some other reason from purchasing healthcare from the exchanges. Is that something that you would anticipate that we could address?

ROGER SENSERRICH: Yes. So our position is that these plans should be open to everyone and there is that saying that there is no -- there is no libertarianism in epidemics as well. Basically, it's a terrible idea to have -- Public health is a matter of everyone needs to be covered, everyone needs to be protected. Healthcare coverage during an epidemic is as good as whoever has the worst coverage in the aforementioned health emergency. So we are all in this together and knowing that the health impacts for a single person, of infectious illness or of a chronic condition or something like diabetes, and that being on the balance sheet of everyone and that affecting everyone, we think that access to health coverage and access to an insurance plan like that should not be determined by the place where you were born or your immigration status.

SEN. LESSER (9TH): Thank you very much. Any other comments or questions from members of the Committee? If not, thank you very much.

ROGER SENSERRICH: Thank you.

SEN. LESSER (9TH): Next up is Bruno. No Bruno. Stephanie Thomas has already testified. Angela Aguilar? After Angela, we'll have Pareesa Goodwin. No, you've got to press the button. Thank you.

ANGELA AGUILAR: Sorry. Good evening, dear members of the Insurance and Real Estate Joint Committee. My name is Angela Anguilar and I'm a graduate student at the UConn School of Social Work. I am testifying today in support of Senate Bill 346, AN ACT CONCERNING PUBLIC OPTION FOR HEALTHCARE IN CONNECTICUT. This bill would create a much needed public option for a high quality health plan with low cost premiums and no high deductibles. Healthcare is a necessity that we all need, but many cannot afford it due to high premiums. Even those of us who can afford some type of health coverage do not benefit, as the only options for us to purchase are high deductible plans. I believe we should all be entitled to quality healthcare regardless of income, class, or immigration status. As a social work student and intern, I have come in contact with individuals from all walks in life who do not have access to preventative care or worse, have put their health at risk by foregoing necessary medical treatment because of the high cost.

Today, the topic of healthcare remains a national debate, but truthfully, no one living in one of the wealthiest nations in the world should be without healthcare. Creating a public option that is inclusive and available to all Connecticut residents, regardless of immigration status, would improve public health and help reduce overall health care spending. By passing this legislation,

Connecticut would set the example for affordable healthcare reform and also help our small businesses and nonprofit. Again, I strongly support the passage of S.B. 346 and I hope that the Committee will vote favorably. Thank you for your time and giving me the opportunity to testify.

SEN. LESSER (9TH): Thank you. That was fast.

ANGELA AGUILAR: I've been here all day.

SEN. LESSER (9TH): No, you beat the buzzer by a mile, so congratulations on that. And you said you were a social worker student?

ANGELA AGUILAR: Yes, at UConn .

SEN. LESSER (9TH): Other comments or questions from members of the Committee? If not, thank you for being here all day. This is an important issue and, of course, we left it to the very end of our agenda, but thank you for your testimony.

ANGELA AGUILAR: Thank you. I was also a little nervous, so I tend to speak quickly when I'm nervous.

SEN. LESSER (9TH): Nothing to apologize for. Thank you so much for being here. Next up we have Pareesa Goodwin followed by Michelle McCabe.

PAREESA GOODWIN: Good evening. My name is Pareesa Charmchi-Goodwin. I am the executive director of the Connecticut Oral Health Initiative, COHI, as you like to call it, is a nonprofit and the only entity in the state with the sole mission of increasing access to quality, affordable oral health services for all Connecticut residents. I want to applaud the Committee for your effort to increase access to affordable quality health and dental coverage. I

am, of course, to speak particularly about the dental component and about the importance of always including dental into the conversation. As an oral health advocate, it's my hope that dental coverage will no longer be considered optional or a luxury item. Good oral health is essential to good overall health and wellbeing. It impacts our ability to eat, speak, work, pay attention in school, manage chronic diseases such as diabetes, and carry out a healthy pregnancy. Actually, gum disease during pregnancy is associated with low birth weight and a preterm birth.

So there are a lot of things that make it connected, right? We can't survive without our heads. We all have a mouth and we know that it is related to our health. So thank you for including dental in the conversation this year and having dental covered in the Senate Bill 346. I'm just going to keep it short and sweet because I know that you've been hearing a lot, so I welcome any opportunity to speak more about the bill, about particulars of how this would play out, about inclusion into the plan of oral health and I'm happy to talk about this now or to have follow-up questions if here are more details that we can get to as well. My background is in epidemiology and public health policy, so I live getting into the nitty-gritty, so if you want to follow up anytime, I welcome it and encourage it. My information is on the testimony as well and I submitted written.

SEN. LESSER (9TH): Thank you so much, Pareesa. I do have a bunch of questions, actually. It's perfect because you're the only person today to talk about the dental portion of the bill. So the bill right now has a like a -- I guess what could be a

Medicaid buy-in for a version of the plan currently offered -- the dental plan currently offered via the HUSKY program. Can you speak to -- You know, that's different from the rest of the bill which is not built in that way, can you talk about the program that's currently available under HUSKY and whether or not this is the right way to go or how to think about it?

PAREESA GOODWIN: Sure. I don't know that I can say definitively from the information that I have so far if doing a Medicaid dental buy-in separate is necessarily the way to go or if we couldn't do dental inclusion in the overall plan and make it the same. I don't know that one of those is right or wrong or better than the other, but what I can say is that we do have a robust HUSKY program in the state of Connecticut. We're very fortunate. It is comprehensive coverage. There are some things that I am wary of as an oral health advocate that I'm trying to get more information about, but it is good comprehensive coverage and from my understanding, if you talked to BeneCare, which is our dental ASO, who I saw did testimony in support, actually, of Senate Bill 346, which is interesting, so we have things like the insurer for the plan is on board with this, which is positive, I would say, if you were to talk to them and if you were to look at the American Dental Association's website, you'll see that they have a map of the network that we have in Connecticut showing that we do actually have pretty good coverage.

We have -- I would say we have an adequate network if you are going by those metrics. We have a fair amount of providers in the group, which is something that I know is of concern. Often times you're

thinking is it going to be an adequate network and I would say that it's important that we stay vigilant and make sure that our Medicaid network is adequate, but if it appears that it is, then I would say that sounds like a pretty good plan.

SEN. LESSER (9TH): Thank you. What are the -- I mean, I guess in the rest of the bill where we're responding to market failures or perceived market failures, the barriers for people that purchase healthcare through small insurers, is that -- And I guess what's the state of the dental insurance in place? My sense is that may not be the barrier, people getting adequate dental care, maybe it is, I don't know. What would you say?

PAREESA GOODWIN: I would say that dental insurance is structured very differently from health insurance. I would say that it makes -- it's more like an assistance program. It's almost more like having AAA, so in a way it's kind of like a robust coupon that can help you pay for things and really bring down the price, but it is not necessarily the insurer doesn't take on the same risk that a health insurer takes on and perhaps that is why dental insurance companies have not been here today saying that they have a problem with this bill to my knowledge because they are prepared to take on the risk that they are offering and they are probably happy to have some additional premium. I don't want to speak for them, but it could actually be something that is nice for them to have a bigger pool. It can be a win-win in that way.

SEN. LESSER (9TH): You know, you're right. I mean, one dental insurance company testified in support of this and we've been hearing about how much insurance

companies hate this bill all day, so it sort of stuck out at me that they testified in support.

PAREESA GOODWIN: Dental is quirky.

SEN. LESSER (9TH): Are there cost savings that would be -- that could be achieved by expanding the current HUSKY pool? Is that something that could potentially happen?

PAREESA GOODWIN: It could potentially happen, yeah. I would need more information to determine that to say absolutely yes, but I would assume that having a larger pool, if it is any significant number of people that would want to purchase that plan, I think that is always a good thing and generally that's a good thing for everyone to have more premium in there and to have more people on the plan and I think for the consumer, it would definitely be helpful. A lot of people are paying for dental out of pocket, three times as many people as don't have health insurance don't have any dental insurance and we know that nationally it is about 9 percent of Americans will self-report, but they, any given year, that they do not go to the dentist, even when they have a problem and they know that they need to, because of the cost, because of the out-of-pocket cost associated with it. So if there is a solid dental program that could help them with those out-of-pocket costs, that would definitely be good for the people of Connecticut.

SEN. LESSER (9TH): And I guess one of my regrets for the Affordable Care Act is that it didn't include dental coverage as an essential health benefit. That could have avoided this question. Questions from members of the Committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman, and thank you so much for your testimony. I met some of the dental hygienists last year and learned so much about how important dental health was. I mean, I always knew it was important, I learned a lot and about the number of cancers and all of these things are detected very, very early on by these preventative screenings. And so I really see a very strong investment -- return on investment. I think one of the concerns I do have about dental coverage is it's not eligible for, you know, the kids that up to 26, like the ACA, you know, you have -- you can stay on your parents' coverage, so that's a concern. So this is, I think, a good opportunity for young people to be able to get that coverage and get things. Has the industry done any ROI analysis on the -- what the sort of return on investment is for dollars spent in oral health and how it pays back and saves not just the pain and suffering from a disease, but also increased cost? If you could talk about that, I'd greatly appreciate it.

PAREESA GOODWIN: Absolutely, yes. Thank you for your question and I agree with you on the dental to 26. I'm hoping that we can solve that issue this session. That would delight me to no end and to a lot of young people that I've been talking with. Yes, there have been a few different studies on the return on investment for particularly preventative oral healthcare and a lot of these have actually been done by insurance companies trying to see if they can sell a dental product if it makes sense for them to -- imbedded into health and to make sure that people have those, how can they show people what they're paying for. It actually saves money

for the payers and, of course, for the consumers and often times for the employers.

So for the employers, they have seen in some cases 16 to 17 percent net savings from having dental insurance for their employees. You also see fewer missed days of work, so there's savings in that way as well, and then for families, in some pools you see for every one dollar that you spend on preventative dental, you save anywhere between \$8 dollars and \$50 dollars in restorative and emergency care. Emergency care can be quite expensive. And then you also see -- So that's particularly savings for emergency dental and dental restorative treatment, but you can also see savings in the medical that don't always get captures and attributed to dental because you're seeing it in the medical insurance savings, but you see that particularly for things like diabetes, sometimes with heart disease, sometimes with people who have had a history of stroke, and then also for people who are pregnant there can be savings in their medical as well that are associated with having good oral healthcare.

REP. DATHAN (142ND): Which in turn helps the unborn child, right?

PAREESA GOODWIN: Yeah, absolutely, and actually there is a connection -- there's an association between having gum disease and having tooth decay during pregnancy and then the child in early childhood will be more likely to have dental decay.

REP. DATHAN (142ND): That's also wonderful to hear. So thank you so much for your testimony. I appreciate how thorough you've been. Thank you, Mr. Chairman.

SEN. LESSER (9TH): Thank you, Representative. Representative Hughes, did you have a question? You don't have to, I just thought I saw your hand.

REP. HUGHES (135TH): I thought I did, but now I'm distracted. I think it was about -- Oh, yeah, I know what it was. Basically the denial of dental coverage is also plagued Medicare, which does not cover dental, and I feel like a really antiquated model of healthcare, oh, like teeth are cosmetic or, you know, really not that essential part and the Affordable Care Act is based on this very antiquated out -- you know, outdated understanding of the essential thing, which, you know, I've been railing for, you know, decades that all of these systems need to catch up with what is essential and, you know, Medicare was based on a very 1980s model, but, so just a comment.

PAREESA GOODWIN: Thank you.

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

PAREESA GOODWIN: Thank you so much.

SEN. LESSER (9TH): Michelle McCabe has gone home. Jack Carlson, is Jack here? Okay. Are there any other members of the public who wish to testify?

TARRA VOLPE: I'm completely out of breath. I just ran as fast as I could to get here. So I'm here in support of --

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

TARA VOLPE: Yes, I will do that now. My name is Tara Volpe. I live, vote, work in the beautiful state of Connecticut. So I'm here in support of Bill No. 346, AN ACT CONCERNING PUBLIC OPTION FOR HEALTHCARE IN CONNECTICUT. This bill is very important to me. My family and I pay -- We pay for our own healthcare. My -- I work for a nonprofit that does not offer healthcare and my husband works for a small business that also does not offer healthcare. Historically, I have worked in early childhood and in almost every single early childhood setting I have worked in, I was not offered health insurance, so I had to pay for it myself. We are a typical middle-class family.

Our health insurance costs -- Our monthly health insurance costs exceed our mortgage every month. Our health insurance costs absorb more than half of my personal salary and this creates a tremendous strain on my family. Our deductible is \$14,000 dollars and this is the best plan that we are able to provide for our family. This prevents my husband and I from going to the doctor because we need to make sure we can pay for our children to go to the doctor and so this bill, if it is passed, will -- it will just take an enormous burden off of us. We can't save any money right now. It's very hard for us. I mean, we're not destitute, but like I said, we can't -- we're not saving money and we would love to do that for our children's education.

In addition to that, a few months ago my 10-year-old daughter discovered a lump in her chest. She has -- Many of you may have seen her here before because she has some here to testify. In the end, she was perfectly okay, thank God, but the ridiculous conversations that my husband had to have to make

sure that she would be able to be seen by a doctor that we trusted was heartbreaking. It caused stress between my husband and I and it's just -- it just should not have happened that way. And so I know I'm not the only one that is dealing with these kinds of situations because of healthcare costs and again, both my husband and I, we are working and we are contributing and, you know, so for us, this bill is a life-changer, so that's it. Thank you so much.

SEN. LESSER (9TH): Thank you. Thank you for being here and I hope you catch your breath. So I heard you say over half of your income goes --

TARA VOLPE: My personal -- My salary, not my husband's, but my personal salary, more than half of my salary goes to our healthcare coverage every month and so upon taking this position, you know, this is a conversation that my husband and I had and we didn't -- You know, insurance is complicated and so we knew that we were going to get hit, but we didn't know just how hard, right? And so -- And then, you know, it's been hard. Like when I took the position that I took with the nonprofit that I work for, I thought this was the first job that I had since I returned to the workforce after having my children and I thought I was so excited and happy, not only for this position, but because I was finally going to take some of the stress off of my husband, and that has not been the outcome, so, it just hasn't and that's our situation.

SEN. LESSER (9TH): So you have a high-deductible health plan?

TARA VOLPE: Yes.

SEN. LESSER (9TH): And does it have an associated health savings account? Is that something that you get through the plan?

TARA VOLPE: I think so. My husband handles a lot of this, but I believe it does, but don't quote me on that. I'll have to find out specifically.

SEN. LESSER (9TH): Yeah, well, I think the reason is because the folks who are proponents of high-deductible health plans in the industry say that, you know, having a health savings account would relieve the stress of the plans, but it doesn't sound like that's the case in your family?

TARA VOLPE: No, it's not, absolutely not. I mean, it doesn't help us at all to my knowledge, so I just know that we are -- that we're getting hit really hard and we don't -- I mean, we live in a very like typical house. We have several bathrooms, three bedrooms, it's not, you know, isn't a massive home, but it's not a small home. Our healthcare costs should not exceed our mortgage.

SEN. LESSER (9TH): Are there questions from members of the Committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you so much, Tara, for your very poignant testimony today. I find it shocking that every hour of work that you do between January 1 and the end of July goes 100 percent to your healthcare. I mean, that is a shocking, shocking revelation and the fact that your health insurance and your healthcare costs are more than your mortgage and that says a lot and that's one of the reasons I'm fighting for this bill because it's people like you that I've heard from and then the stress that, you know, we have children who you want

to set them up for higher education and you don't want to limit their choices and it's -- and with college education so expensive, it's a really daunting thing and I feel for you and I'm so appreciative that you took time away from your family, away from your job to be here today to talk to this committee about what you're experiencing and in a hope that we can try to solve this astronomical problem. So thank you so much. That's all I have to say, but I appreciate it.

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

REP. HUGHES (135TH): Thank you so much, Tara. I heard your story over and over and over in my district and so I know multiply that by thousands and that's the kind of stress, but one thing you pointed out, when you took the job, there's the thing. You don't really know what those costs are going to be. You take it, you figure out what plan from year to year is -- seems like the most affordable. When I was telling folks that they had the opportunity to testify in my district, they said well, where can we compare the costs and I'm like that's the whole point. We can't now compare the cost, so there's such uncertainty with our current system and there would be some uncertainty with the state plan, too, like it's not just here's what it costs every month, because that's actuarially decided based on, you know, region and so forth, but we -- the whole point of doing this is to look at something that is not unknown when you make those hard choices and even if it's employer sponsored.

I was on the employer sponsored. That changed year to year, too, and then we moved from one carrier to

a whole different one. Okay, now we're going with Anthem, now we're going with -- you know, there is no certainty with that either.

TARA VOLPE: Yeah, and that's something -- Those are conversations that my husband have all the time. It's like navigating and what's the best strategy. I'm very lucky. I have the most wonderful husband on the planet. Like he's really good at, you know, understanding numbers and goes over everything, you know, with fine-tooth comb and what that triggers, though, often is, you know, like okay so what do we do this year. We have this conversation every year and it doesn't seem to ever help us and so, you know, I know -- I know there's a way to figure this out for the people of Connecticut who need it and I know that there's a lot of us that need it and so, you know, my hope is that there will be a solution to this this year because it creates -- it creates an unnecessary burden on people.

REP. HUGHES (135TH): Thank you.

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

TARA VOLPE: Thank you so much all of you.

SEN. LESSER (9TH): Thank you. Okay. Are there other members of the public who wish to testify at this hour? Okay. That does it for Senate Bill 346. We do not have anybody to sign up to testify on Senate Bill 347 or on House Bill 5018. Is there anybody who wishes to testify on anything else before this committee? Going once, going twice, if not, then this meeting -- public hearing of the

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March 5, 2020

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INSURANCE AND REAL ESTATE
COMMITTEE PUBLIC HEARING

12 P.M.

Insurance and Real Estate Committee is hereby
adjourned.