CHAIRPERSONS: Senator Matthew Lesser,
Representative Kerry Wood

SENATORS: Anwar, Cabrera, Hwang, Lesser,
Maroney

REPRESENTATIVES: Comey, Dathan, Delnicki,
Farrar, Luxenberg, Meskers,
Nuccio, Pavalock-D'Amato,
Perillo, Riley, Rochelle, Wood

REP. WOOD (29TH): Good afternoon, everybody. Sorry for the delay. My name is Kerry Wood, I'm the Chair of the Insurance and Real Estate Committee, and welcome to our public hearing on March 9th. Any remarks from my Co-Chair? Any remarks from Ranking?

REP. PAVALOCK-D'AMATO (77TH): Just wanna thank everybody for being here today and looking forward to the testimony on these Bills. Thank you, Madam Chair.

REP. WOOD (29TH): Thank you.

SENATOR HWANG (28TH): Thank you, Madam Chair. I am eager to hear the testimonies. I recognize this, we've just seen even today that the challenges with the technology and Zoom, that I would implore that we as a Committee and as a leadership worked extra hard to ensure that transparency and early information, related to Committee meetings of critical importance, public hearing releases of Bills are made in a diligent and timely manner for all people to be acquainted with such important issues, particularly in this day and age with the technology challenges.

So I would ask the indulgence of the Chairs that when we have an opportunity to get information for people to be engaged as soon as possible, and not at the last minute. And I thank you very much, Madam Chair, for your efforts and your due diligence and

quick response in this always, appreciate it. Thank you, ma'am.

REP. WOOD (29TH): Thank you, Senator Hwang. We're gonna get started and our first speaker is-- the first three are actually speaking together, which is Jonny Dach, Vicki Veltri and Lou Bucari, and followed by Senator Kelly. We'll start with the first one, welcome.

JONNY DACH: Thank you, Representative. Can everyone hear me?

REP. WOOD (29TH): Yes, we can hear you.

JONNY DACH: Perfect. All right, thank you so much to the esteemed Members of the Insurance Committee. Good afternoon and thanks for having me. I'm Jonny Dach, I'm Governor Lamont’s Policy Director, and I really appreciate this opportunity to convey the Governor's support for his proposal to address high and rising health care costs here in Connecticut. As I don't need to tell the Members of this Committee, health care is a human right that far too many Connecticut residents struggle to afford.

Nearly 5% of our constituents, our friends and neighbors are uninsured. And even those with insurance struggle to afford premiums or have to forego care because of high deductibles. And so, it’s the Administration's belief, and I believe the Committee's belief, that we have to do something to address health care costs, and one significant cost is prescription drugs.

Prescription drugs, according to information submitted in written testimony by CID account for nearly 25% of premium in Connecticut's fully insured market, and the cost of those drugs has consistently seen annual price increases north of 10%.

And those excessive increases in Connecticut track national data that you can find in my and Vicki

Veltri's written testimony. And, of course, more importantly, they track the experience of far too many Connecticut families, who are some of the 3 in 10 Americans who say that high cost of prescription drugs have prevented them from taking a drug as prescribed.

So what would this Bill do? In Part, it limits annual prescription drug price increases to inflation, +2%. That's good for consumers. It may save the money at the pharmacy counter; it will certainly save the money on premiums by bringing healthcare cost growth under control. And it's also good for employers, who pay two thirds of employees' premiums. And as Governor Lamont as well from his time in small business, often struggle to keep up with those premium increases year after year after year.

We can help those consumers and those businesses without undermining research and development opportunities at our all-important pharmaceutical companies. Companies should know the R&D costs when they first price a drug. And they should price those drugs at a level that allows them to recoup those costs and sustainably fund further investment, not at a level that they will later need to surprise consumers by jacking up.

This Bill is about unjustified price increases, which I hope that Connecticut-based companies aren't pursuing. And indeed, Aleksion, in its written testimony said that, the Bill as drafted, although they opposed it, would not impact them today.

And I encourage the Committee as those manufacturers come before you to ask them, whether they're increasing drugs on the scale of 4 or 5% in prices a year? And if so, why? And if not, what the problem with this limit would be? Because we think that limiting price increases to a reasonable level isn't A Democratic or Republican idea, but one that's enjoyed bipartisan support in the region.

This is very similar to a Bill that Governor Baker has introduced, and that Governor Lamont and Governor Baker have discussed, as well as in Washington, where it's been the repeated subject of Bills from Senator Grassley and Senator Wyden.

The other Sections to the Bill are similar to a Committee proposal, they create a covered Connecticut program to expand access to quality, affordable care, and Vicki will describe that program and how we might spend it to benefit our residents in a little more detail, and then she, Lou and I will all be available to answer questions.

Before Vicki does just a very quick word on how that program will be funded, again, it’s similar to the Committee's proposal and to language that passed the House on a bipartisan basis two years ago.

This year, the federal government Sunset Health Insurance provider fee that was created by the ACA, that fee raised hundreds of millions of dollars from Connecticut health plans, and we're proposing to reinstate a smaller version of it, tailored to address insurers’ concerns about interstate tax competition.

It asks the companies for significantly less than they're saving as a result of that Sunset Tax, and for significantly less than they're paying to other states that have already reinstated the Federal Fee. New Jersey, for instance, passed a version of this assessment last year.

They have less than three times our population, but they're asking for more than four times as much money from a much smaller segment of the market. And finally, our assessment on the insurance companies will be offset by new revenues that come in from penalties levied on drug providers, manufacturers that violate the new price limits.

So, I think our proposal in this Section of the Bill, like the Committee's, is a reasonable way to sustainably fund health care access for those most in need. And I'll turn it over to Vicki to describe a little bit of what that would look like. Thank you, again, for the opportunity to be here today and discuss these issues with you.

VICKI VELTRI: All right. Thank you, Jonny for the handoff. Good afternoon, Senator Lesser, Representative Wood, Senator Hwang and Representative Pavalock-D'Amato, and Members of the Insurance and Real Estate Committee.

It's nice to see you all, I haven't testified in front of this Committee in a little bit, but I'm glad to be back. I appreciate the opportunity to testify today, like Jonny, in support of the Governor's Bill, 6447, to create the covered Connecticut program and expand access to affordable health care.

Jonny described to you the prescription drug part of this Bill, I wanna talk to you a little bit about the Cover Connecticut account-- Cover Connecticut program, very similar as Jonny said, to what the Legislature had proposed. Few differences in that, this program would give OHS the opportunity to work with the Insurance Department, with the Department of Social Services, with the Insurance Department, with Access Health and frankly, other stakeholders to design a plan to mitigate the impact of high health care costs on insurance premiums.

And we would like to ask the Committee on cost sharing, because what we're seeing, in addition to premium increases that are really affecting the affordability of health care for the consumers of the state of Connecticut is also deductible levels that are becoming unaffordable for consumers. And the ability to target potential subsidies to address cost sharing is a really critical aspect to this

Bill. We did not include that in our language, we intended to, so we would need a fix to do that.

Importantly, this plan also includes some flexibility. So rather than specifically addressing targeting those subsidies, certain areas, as the Committee's Bill does, ours gives us a little bit of flexibility among several areas.

It includes the flexibility to design subsidies to assist in Medicaid coverage, subsidies for folks on the exchange, the ability to potentially pursue a Section 1332 waiver with the possibility of reinsurance and gives us the opportunity to look at other ways to promote access to health care in a meaningful way.

We think this is a reasonable approach to target immediate gap in affordability of coverage. There are other longer term strategies, which you know about, the Governor's second quarter number five on benchmarking, which is in the process of being implemented and was supported by Legislators on a bipartisan basis. We think that's critical to the long-term class growth that we're seeing in the state of Connecticut. But this Bill really takes aim at an immediate need, and we think the account is important.

The other thing I would just say on the prescription drugs, Jonny said that is an ongoing issue, our office continues to take calls, even though I'm not the healthcare advocate anymore, I get calls on prescription drug pricing, and it is a daily problem for our consumers.

So while we are very grateful for the work that our pharmaceutical companies have done to give us a COVID vaccine, there are still outstanding issues regarding drug pricing that needs to be addressed.

And importantly, I will say that despite the use of PBMs, Pharmaceutical Benefit Managers, and other

tools to try to bring down pricing, we're still seeing prices in the United States two times that of international pricing. So we really need to address this. And it's an immediate need for people.

So with that, I guess I would just turn it, I guess, to Lou, who's going to speak next from DRS. Oh, no? No, Jonny? I'm sorry.

JONNY DACH: I'm not trying to muzzle Lou, but I think he's here for questions if the Committee has any for DRS.

VICKI VELTRI: Questions? Okay. So with that, I guess, we will turn it over for questions. And I apologize for that Lou, but glad you're here for questions.

REP. WOOD (29TH): Oaky. And I'd asked the Committee Members to just raise their hands for questions. I was wondering, Vicki, if you could tell us why prescription drug pricing is so much higher here in Connecticut than other states? I have looked at a few of the numbers and since you've been doing some data collection, what is the reason for Connecticut residents paying such a higher cost?

VICKI VELTRI: Well, as you know, drug pricing is the most complicated system in the world. It includes multiple players. It includes the manufacturers who set prices, it includes the PBMs, which negotiate between the drug manufacturers and carriers, includes wholesalers, includes the pharmacies and includes consumers on the other end of the equation.

I would say, you know, there are several reasons for drug prices to go up on, maybe, the advent of newer medications. But in general—

JONNY DACH: Vicki, you muted yourself.

REP. WOOD (29TH): Yeah, Vicki, you’re muted.

VICKI VELTRI: Muted myself. It's very hard to find a clear rationale for some of the price increases we're seeing. I mean, that's the short answer, we really don't have a good handle on what we're seeing in terms of price increases and why they may be more than in other states, except for maybe, not as good negotiating to bring them down. So that's kind of where we are.

REP. WOOD (29TH): Yeah, I appreciate that. When you were drafting this language, did you consult with the Pharmaceutical Industry here in Connecticut on feedback on this? And the reason I ask is because, you know, I'm also on the Commerce Committee, and we have done on all these programs over the years to grow our Pharmaceutical and Biotech sector, and that we're really proud of all of that growth and the innovation that's happening here in Connecticut.

We're in a pandemic and we're, again, just very proud of everything that's going on with that Sector, and then to cap their profits, which-- I mean, I think there's a way to do it, but I feel like the caps that you put in place are extremely broad. And I was just wondering if there was any interaction with that industry on how this language was written.

VICKI VELTRI: Well—

JONNY DACH: Well, I could—

VICKI VELTRI: Go ahead, Johnny, go ahead.

JONNY DACH: We talked to them the week before we took it public, we did not consult with them ahead of time. In some respects, it's because it was relatively late information. Governor Baker and Governor Lamont we're talking about what would be in the Bill.

We're obviously happy to continue that conversation going forward with the stakeholders, with the Members of the Committee, and to hear what ideas over the course of this public hearing they may be able to put forward.

But if you told me that you had an industry in Connecticut that was selling something that people had to buy, and they could increase their prices in real terms year over year over year at 2%, I would say, "Where do I sign up to invest my money?" So, I don't think this is an unreasonable limit to impose on companies. And I think it's a limit that will help our consumers and will help our economy on a much broader basis.

VICKI VELTRI: I will say, just to supplement Jonny's comment quickly is that, we have spoken to the pharmaceutical companies in context of the possible benchmark. So the-- we will be collecting data from carriers, reports on the pharmaceutical spending of the manufacturers, and we have had a pretty collaborative relationship on that score.

JONNY DACH: And I should say one last piece which is, we do have meetings on the calendar with them going forward, Representative, to exchange views on this Bill.

REP. WOOD (29TH): Good. I wanted to just go back to the Covered Connecticut Program. And reading through the Bill, I felt that it gave-- you know, being a Member of the Insurance and Real Estate Committee and working with, you know, state agencies and departments, I felt like it gave Vicki this kind of-- Like I was wondering what the oversight is on the Covered Connecticut.

I realized that you would come before the Insurance and Real Estate Committee with a report, but there's really not much we could do besides listen to your report. What kind of oversight is there? Board of directors? Who's managing your team, Vicki? And when

you're not there, you know, who is-- you know, who are you accountable to?

VICKI VELTRI: Well, I'm accountable to the Governor, as an appointed official. So, the Governor, I report to the Governor, as any Commissioner does in state government. As does the Insurance Commissioner, as does the Social Services Commissioner, and as you know, Access Health has a Board of Directors.

So there is accountability through that stream, I believe, because Access Health has to implement this, right? There is the Board of Directors will also be looking at this. And we will, as you said, be bringing a report back to the Committee to review the plan.

But, I mean, I think the concept of consulting with the other agencies is absolutely critical to designing a plan that meets the need as the best plan possible. And, as I said, I think in my remarks, I don't think we're limited to engaging only those folks.

So, it's not necessarily my style to limit my input to just the Commissioners, and while the Commissioners are probably-- are much more steeped in this work than most lay people are, every single day of the week, I think there will have to be some sort of stakeholder engagement to assure that the plan meets the needs of residents.

REP. WOOD (29TH): Great, thank you. I'll open up to questions from my colleague. Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair, and through you to the folks from the Executive Branch of Government, a few questions. And I'm gonna be quiet 'cause I'm trying not to wake a constituent who's right here.

One, just about the prescription drug part of the proposal. I know that in 2020, Vicki, I think your office for the first time listed prescription drug price data for up to 10 cost drivers. How would this proposal intersect with that data? Is that something that-- those two things tie together in any respect?

VICKI VELTRI: Well, so that's a good question. And I wanna know if that's the real baby, 'cause the baby's being too good. But in any case—

SENATOR LESSER (9TH): Don't tempt your faith.

VICKI VELTRI: So, the Bill that passed in 2018, which is PUBLIC ACT 1841, requires manufacturers to report to OHS on pipeline drugs, and then we are to collect data on certain drugs that-- whose prices increase between a certain amount. And I think it's 20% to a certain percentage.

We are seeing in that drug reporting, some pretty substantial increases in drug prices that aren't captured in the letter of that Bill with the data that we collect. So, what that Bill allows us to do is go investigate a drug whose prices increased by a certain level if it's an outpatient drug, right?

But that limits us to investigating like the resources or the rationale behind one drug a year by one manufacturer. Well, that's nice, and that was a Bill, as you know, that was hammered out over a long period of time in 2018. It doesn't get to the breadth of drugs, prices that are increasing over time.

And so there are many more drugs that are increasing at, let's say, what this Bill has, which is a really reasonable level, CPI +2%, that we would never see in that Bill. But that those are still substantial price increases for people in the state of Connecticut.

CPI, which is the Consumer Price Index, is the normal price of-- you know, you have to pick up a basket of services that you're tracking with the Consumer Price Index, but it's substantially inflation +2. And the Bill we look at is much higher increases. So we're missing a whole slew of drugs underneath what that Bill requires if we don't capture drugs that are rising at the rate of inflation +2.

SENATOR LESSER (9TH): I guess, through you, Madam Chair, the data that you've collected suggests that a lot of drugs, or at least the drugs that are in this list, are growing at prices, or inflation rates, well above CPI +2. I'm looking at Cialis, which had a unit cost that seemed to decrease according to your data by 53.67% between 69—19, Auvi-Qs, which is an anaphylactic drug that—or device, increased by 60%. On fee, which is anticonvulsant, increased by 70.99%. So those are-- those seem to-- I don't know what those are for a year on year--

VICKI VELTRI: Yeah.

SENATOR LESSER (9TH): It seems like there may be drugs that are increasing much faster than CPI.

VICKI VELTRI: Yeah. There are drugs increasing at much higher than the rate that's in the Governor's Bill, and just to be clear with the Committee, the prices that are listed on our site, just for clarity, because I wanna be fair to the manufacturers, we're listing unit costs there, we're not listing WAC, which is the Wholesale Acquisition Cost.

So there might be some slight differences there. And we will have a report up in the next month or so for last year's drug spending. And that report will also be the basis for some of the reporting for the benchmark work. So there is a tie between that Bill and the benchmark.

And then, I guess, my question on this, obviously, I think the elephant in the room is making sure that we have a steady supply of prescription drugs for the Connecticut marketplace. I don't know what the status of the Massachusetts Legislation is. I know that there's a section of this Bill that's attempting to prevent drug manufacturers from removing their products from the marketplace. But can you speak to that concern? That a drug manufacturer responses Legislation may choose to remove a drug from the Connecticut market.

JONNY DACH: Yeah, I can try. Vicki can correct my mistakes as well, as always, of course. You know, that Section is in there, that Section will do some work to prevent market exit. It is borrowed from model proposals put forward by the National Academy for State Health Policy that are substantially more aggressive in terms of the restraints they would put on drug prices.

One of those Nash-P Model Bills, for instance, which has been introduced and heard in states around the country this year, would cap prescription drug prices at Canadian prices, which are probably something like 40% of their American prices. So, I don't want the fact that that Section is in there to lead the Committee into thinking that we have real concerns about market exit as a result of these caps.

You know, the companies are selling drugs at this price for a profit in Connecticut today, they will be able to increase those prices and probably their profits in real terms by 2%, in nominal terms, by something close to 4%, were this Bill to pass, and I would be very, very, very surprised if that final Section of the Bill ever had to be used to maintain supply here in Connecticut.

The Bill does guard against, you know, if there’s sort of an exogamous shock that truly limits supply,

there's a National Drug Shortage List that the federal government maintains and drugs on that list would be exempt from this limit on their annual price increases.

SENATOR LESSER (9TH): Thank you for that answer. I guess, I also have questions about the Covered Connecticut portion of the Bill that are similar to my Co-Chairs.

It does give an extraordinary amount of flexibility to the Executive Branch, in terms of how to implement the spending under that and so one question was about what we can do as part of a 1332? Because my understanding is-- forgive me. So my understanding is that a 1332 needed prescriptive language from the Legislature, but Vicki, I don't know if in particular you had any knowledge about that.

VICKI VELTRI: As we've crafted and passed Legislation that Section 1332 usually would be authorized. So if we had a plan, we'd have-- I'd have to come back to you. The language that we've proposed in previous Bills would have an authorization from the Legislature. I'm not-- you know, I didn't anticipate if we came back with a plan with a 1332, we would probably seek to have that authority clearly granted.

JONNY DACH: And I, you know, I'll say on that matter, in general, we're obviously very happy to work with the Committee to structure our flexibility in your oversight in a way that's comfortable to you and to your colleagues.

One of the reasons behind the streamlined approach taken in our Bill is that, unlike the Committee Bill, we were trying to turn on these supports for plan year 2022, nine months from now, anticipating that there will be significant amount of pain still in the COVID-induced recession and recession economy and then we would like to deliver aid to people in a

timely fashion that might not allow us to come back before you all next session with a plan before it needs to sort of go live during open enrollment. But again, we should work together on language that everyone feels comfortable with.

SENATOR LESSER (9TH): I'm gonna be answering some constituent concerns for the time being, but I will have some more questions in a little bit. I'll turn it back to you, Madam Chair.

REP. WOOD (29TH): Thank you, Senator Lesser. Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. It's hard to follow up. The baby looks adorable, Senator Lesser. Thank you, Mr. Dach, and thank you, Vicki, and Mr. Bucari. Thank you very much. And my appreciation to the Governor, for taking the initiative on this very important matter.

I think, Mr. Dach, you're absolutely right, I do believe that health insurance and health care is a human right. And I really appreciated you articulating that Republicans and Democrats in the country and within our state fully support the idea of containing costs and managing. The differences is how we go about it, right?

So, let me go right to the Cover Connecticut Account. So obviously, I have great confidence in Ms. Veltri’s ability and her history of service, really on the grassroots level. She has done the work on the grassroots level, so I've great confidence in that.

How is that funded? Where's that revenue coming from? Is it a tax or an assessment? And who is going to be-- assess those values, or taxed on those values?

JONNY DACH: Sure. So there are two possible sources for revenue for the Covered Connecticut Program,

combined, so that Vicki and the other stakeholders, which she consults can make a plan with some certainty. The statute guarantees that they will add up to $50 million.

One source is an essentially reinstated state-level version of a federal assessment on health insurance plans that was created in the ACA and sunset for the final time at the beginning of this year. That equated to somewhere between a 2 or 3% assessment on Health Insurance Plans.

The state version that we're proposing is structured a little differently from that federal assessment to avoid concerns that carriers had about retaliatory taxes from other states. We worked with them both in 2019 and again, this year through CID and their tax departments to do everything we could to address that concern that this would lead to unexpected taxes from other states. I believe we have addressed that concern and left an escape hatch, if we've missed something, but you're Of course welcome to ask the carriers about that later today.

So, it would be an assessment on Health Insurance Companies in the state, an assessment, again, at a level, as I said in my introduction, that is much less than they were paying under the federal tax and much less than other states that have reinstated the Federal Tax are asking of health insurance companies in that state.

The second revenue stream is-- our hope, obviously, is that pharmaceutical companies, as we understand most in Connecticut already do, are complying with the new limit on year over year price increases on their products. But to the extent they exceed the inflation, +2% limit, there will be a penalty assessed at 80% of the difference.

So if their price this year was 100, inflation +2% would have taken it to 104, and they decided to charge 110, the penalty would be equal to 80% just

have that difference between 104 and 110. And that money would go into the Covered Connecticut Account and be used for the purposes described in the Bill of defraying the high cost of health care to the people of Connecticut.

SENATOR HWANG (28TH): Well thank you very, very much. Now, in regards to the second component of pharmaceutical companies and put in this, this is an addition to, obviously, the first part of the component in regards to prescription drug cost management, correct?

JONNY DACH: Thank you for the clarifying question. So the two sources together will add up to $50 million a year. So should the pharmaceutical companies pay $10 million in penalties for unjustified price increases, the amount expected of the health insurance companies will go down from 50 to 40 million to make up that shortfall.

Again, our hope is really to change behavior in the pharmaceutical companies, not collect revenues. Although, I will note that because the insurance companies and their premiums cover those pharmaceutical costs that we're hoping to bring under control, you know, they should see decreased costs on the pharmaceutical side of the house that more than outpace the contributions they would be expected to make to the fund.

SENATOR HWANG (28TH): Thank you. And just for me in clarification, my question was, the revenue side asked for the pharmaceutical companies if their prices exceed a certain percentage that you cited, but my question is, would they also have a separate obligation on their business in regards to the underlying proposal on health prescription drug reductions? Is it two separate or are they combined into one?

JONNY DACH: Ask it one more time. I'm sorry, Senator.

SENATOR HWANG (28TH): No, no, what I mean is, the first part in regards, as you eloquently said about drug costs of maintaining it, and reducing it, and asking the pharmaceutical companies to be a partner in this, in lowering prescription drug cost. That is one big component of this Bill. Is that in addition to the expectation that they would be contributing to the revenue side, two separate expectations of their involvement in the contributions to this proposal?

JONNY DACH: No, thank you. Thank you for clarifying. No, I would say the expectation of the pharmaceutical companies is that where they would limit their year over year price increases to operate within the, I think, still generous limits imposed by this Bill.

I would note that the Grassley Wyden Bill, bipartisan Bill in Washington, DC, over its iterations has proposed a simple inflation Cap on your over your price increases. So the 2% on top of inflation, included in the Governor Lamont and Governor Baker proposals is more generous to the companies in that respect than some of the proposals we've seen, at least, in the Medicare context in Washington. And if companies kept within those limits, they would have no other contributions to make to the Covered Connecticut Fund.

SENATOR HWANG (28TH): And obviously, you're well versed in that area and the devils in the details, obviously. And that being said, there are unintended consequences of a domino effect. So, again, case in point, the potential $50 million assessment or attacks, however, you wanna do it on insurance premiums, that would have unsettled, but we're gonna reinstitute a portion of a kind of a derivative of it. What if this gets put into place? Do you not think that the insurance companies would offset that cost burden onto commercial products?

JONNY DACH: No.

SENATOR HWANG (28TH): And businesses would struggle?

JONNY DACH: Yeah. Thanks for the question. I think the anxiety is that they might pass that cost increase on to their consumers. There's nothing in the Bill that would require them to do so, but it's a possibility that we should, you know, acknowledge forthrightly, that this would mean cost on companies that are being passed on to costs on consumers.

We think those costs are small. We think they're small in comparison to those asked for by other states and by the federal government. And we think that they will raise at minimal impact on other companies or consumers, a substantial enough sum of money that would allow OHS, in consultation with other stakeholders and with the Members of this Committee to drive dollars towards where they could make a very significant difference, over and above the difference we're hoping to see out of the plan that's passed in Washington this week.

SENATOR HWANG (28TH): And I appreciate that. And I'm extremely concerned about any additional burden that we have to our businesses in the state of Connecticut as they struggle to overcome the economic free-fall of the COVID pandemic.

To pivot also to the drugs, I think you raised the concern that there are certain drugs that are protected on a federal shortage, but let's just use hypothetically, and I do want to give a shout out to our biotech and pharmaceutical companies, because it is Pfizer, which was through their incredible medical ingenuity and innovation and success that were able to get one of the three vaccines that have been approved on COVID, to kind of address the issue of the COVID pandemic.

So, look, our pharmaceutical companies do tremendous good, and the incredible level of R&D that's necessary to create the science, and the ultimate successes is incredible. I wanna make note and be on the record to comment on that. But when you talk about us setting up a prescription drug system in Connecticut, now, when we looked originally, as this began, of looking at Canadian structure of costs Caps and all that, we had an immediate rebuke from the Canadian government that said, "You know, don't encroach on our supply and take away and impact what we do."

What do you say to the challenges that if the state of Connecticut does it, or even state of Massachusetts does it in a combination, what do you say if another state says, "You know what? We'll pay fair market rate, give us a drug that's not on a health shortage list that we want because it's the next great thing," but it may be kind of an optional or selective choice. Are we looking to control the free market between states of prescription drug costs versus supply and demand?

JONNY DACH: Yeah, thanks for the question. I remember the same calls from the Canadian government last year. I suspect that that coupled with some of the difficulties around physical re-importation of drugs is why other states around the country like Washington, as I referenced, have moved this year from proposals that would import Canadian physical drugs to proposals that would import Canadian prices.

That's obviously not this proposal so I won't talk about it at particular length, but we did work with the Office of the Comptroller to look at the impact that that would have in Connecticut. In other words, the difference that the state, which ensures a number of lives is paying between Canadian prices and US prices. And we found, just by looking at the top 50 drugs that, the Comptroller's office purchases, that if you took those down to their

Canadian price, the state would save $32 million a year, it would it would pull $32 million out of just state drugs spent, more than 10%.

Sort of a shocking illustration of what Vicki alluded to earlier, which is the extent to which the United States and US consumers and employers are overpaying for drugs, relative even to other developed countries in the world, and perhaps subsidizing those research and development costs or direct consumer advertising and marketing and detailing by the drug companies here in Connecticut.

I'm really not anxious that if we told a company that was selling a drug for $100 on December 31st, that on January 1st, they could raise it to 104, but not 110, that they would say, "Okay, we're gonna take our business elsewhere." Among other things, they're selling it at that price, or something far below that price and at a profit in every other country in the world.

SENATOR HWANG (28TH): My concern is, if X state says, "I'll pay you 150," and I wanna get that drug for my constituents in the state and my free market, or my existing market is not constrained by government regulations, that they may choose to go there before they come to the state of Connecticut. But neither here, it's not been proven, it's not been validated, and I think the biggest challenge we have with trying to look at finding solutions for healthcare, believe me, it's an issue that's longer than you and I have been in public service, and it will continue to be. If we had the magic solution, everybody in this world would look to do that. It's a complex ecosystem.

But I really appreciate your approach and your diligence and having someone like Ms. Veltri who has the experience and had done the work to be able to articulate some of those ideas. So, Ms. Veltri, just one question.

In regards to the previous question about the amount of control and on the impact that you would have in managing the Cover Connecticut Account with the Monetary Funds that you're allocated. One of the things that was very important that you noted was the fact that accountability and transparency is critical, and that you, in managing this account, would report to the Department of Insurance. Is that regulated under statute or is that just something that you would be looking to do because the nature of your public service experience?

VICKI VELTRI: I'm sorry, I'm looking around because you keep changing spots on my zoom screen, so I apologize if my eyes are moving. But actually, I report to the Governor. And so, the Insurance Department is a fellow agency, right? Like DSS. So obviously, all of us need to be on the same page, which itself is-- drives some accountability, right? Because whatever plan we come up with affects insurance plans, it may affect Medicaid, right? It may affect the exchange.

So, that level of joint analysis and accountability, I think, is really strong, plus we, obviously, report to a Governor. And we, in any plan would come back to the Committee. So I feel like there's a strong level of accountability there, plus the ability to engage other people in the work, right? We have that ability, and we will use it as we have done with the benchmark.

So, we've been very transparent in that process by engaging parties from across different healthcare sectors, especially when it affects them. And I think we have to do that here, too. So I feel confident that we'll have a good accountability mechanism for them.

SENATOR HWANG (28TH): Thank you, and I appreciate that, but the point would be that there is no statutory requirement for reporting and transparency. Yes, your report to the Governor, but

the Governor is not required to disclose the transactional and cost and the real transparency that's necessary that we require on statue.

I think that was one of the biggest questions we have with any plan, because currently in the state of Connecticut, any insurance product that is sold and used are required to report and to follow the regulation of the Department of Insurance. The possibility is, there is no statutory requirement that this account utilizing premiums or assessments or taxes, and impact on prescription drug cost from the public would have the transparency and accountability requirement of statue. Your well intentions--

VICKI VELTRI: We could work with your Committee on that. I think as Jonny had said earlier, we're happy to work with the Committee to make the Committee comfortable, I think, with accountability on the account, I think that we can do that. And so, obviously, I have no problem working with the Committee on that.

SENATOR HWANG (28TH): And I appreciate your quick response, which consistent with your incredible work ability with Legislators and the public, so I look forward to working with you on that for greater transparency and accountability. And I thank you both for your time. And, Mr. Bucari, I don't have any revenue questions yet, and I wish everybody a wonderful day and stay safe. And thank you very much for your time, my appreciation to Governor for his initiative and leadership on this.

VICKI VELTRI: Thank you.

REP. WOOD (29TH): Thank you, Representative Meskers.

REP. MESKERS (150TH): Thank you very much. So I'd like to go my first question is to Mr. Dach. So, in

the current market, are you able to import drugs from Canada?

JONNY DACH: No.

REP. MESKERS (150TH): Are you able to import drugs from Switzerland?

JONNY DACH: No.

REP. MESKERS (150TH): Are you able to import drugs from the United Kingdom?

JONNY DACH: No.

REP. MESKERS (150TH): So, are we living in a free market for pharmaceuticals?

JONNY DACH: We're not very tightly regulated.

REP. MESKERS (150TH): Okay. And the regulations are resulting in prices that are at least 50% in excess for most of the OECD countries, I understand it.

JONNY DACH: That's right, sir.

REP. MESKERS (150TH): So when we stand in front of our pharmaceutical industry, which I support, and if done tremendous work, we have to recognize that their pricing model is a profitability model based on US consumers, versus their consumers around the rest of the world and it's an advertising model, and a profitability model where we fund all the research, but we bear all the costs? And you could argue that if they're selling a cost in Canada, we're funding the selling of that cost or that they're making a profit in Canada and the prices there are not so bad.

I'm interested that you-- the first thing you mentioned in the industry was that, they're now looking at not importing the physical drugs from Canada, but looking at potentially using some model

based on the drugs for-- Canadian drug prices as part of a fractional amount for modeling how pharmaceuticals should be priced in the United States. That is fair assessment.

JONNY DACH: That's right. There are Bills like that pending in other states and I'd be happy to follow up with you directly or with the Committee to provide that information. Again, not the proposal before us today, but something that your colleagues in other states are taking a hard look at.

REP. MESKERS (150TH): Okay. I think that's important that we as a Committee understand that, I believe, the United States produces about 28% of its drugs and imports about 72%. And they're imported in manufactured all over the world and sold at price points based on barriers to entry.

So I'm just-- when we talk about a free market in pharmaceuticals, I can buy a car made in Brazil or Korea, but I can't buy an Aspirin manufactured or sold in Toronto, there seems to be a problem there. So, I appreciate that because-- and it's around about conversation in that, we sit on the Insurance Committee, now the Insurance Committee and the insurance industry is the one we love to hate. But the insurance industry represents 8 to 10 to 12 cents on the dollar of our cost structure in the medical industry for in-health insurance, where 80 to 90% of that is the either pharmaceuticals or the hospital industry.

So until we get a grasp on that, we're going to be looked at ever spiraling costs of 7-10% a year. The compounding rate is leading us to high deductibles, high insurance rates. So, we're faced now, looking in this coming week on a public option and on the Governor's Bill. So I wanna applaud you on the Governor's Bill in that, you look to be taking the first stab at a Cap, if you will, or cost containment on pharmaceutical prices, which will ease the burden on the Insurance Industry and

ultimately, to the individual who goes to purchase his insurance policy. So I really appreciate that this seems to be dealing there with insurance-- with the cost to pharmaceuticals.

Is there anything explicit within the constraints of 644 that you're doing in relation to hospital costs?

JONNY DACH: There's not.

REP. MESKERS (150TH): Okay.

JONNY DACH: Although, I agree with you that they along with pharmaceuticals are one of the significant drivers of ever increasing, unsustainably increasing cost of care in the market.

REP. MESKERS (150TH): Right. But basically, so you've taken one of the three legs-- Well, two legs of the horse, you basically are giving the insurance companies coverage in that you're trying to curtail the cost that they're passing on to us or pharmaceuticals. So the next leg in that equation should be something done on the hospital side to do something on the cost in the hospital for it to-- for hospitalization healthcare costs, which I believe also run about-- Well, I believe the overall health care bill is about twice what it is in Canada, with fairly similar outcomes, if I'm not mistaken.

JONNY DACH: That's right. And, you know, we-- I am sure there are Bills pending in the Legislature that would address that, they are not coming from us. Vicki Veltri, you know, is working, pursuant to Executive Order 5, to better understand cost growth in health care in the state of Connecticut, make it more transparent, make the people who are increasing their rates more accountable.

And there are Bills pending before this Committee on Thursday that would codify some of that work, I think we've been very pleased with the progress

we've seen over the last 14 months since Vicki began, at least in helping us understand the problem and in hoping that sunlight will be a good disinfectant for those cost increases, as indeed it has been in Massachusetts, which is about a decade ahead of us on this kind of cost containment benchmarking, and has seen significant decreases in year over year price increases and partly, we believe, as a result.

REP. MESKERS (150TH): So, I guess, Vicki, where I'm not confused, I'm trying to figure out the-- so the roughly $50 million assessment, which is coming, hopefully, at some point from pharmaceuticals and some from the insurance industry and so blend, that ultimately is an assessment or tax, but that's replacing a $300 million assessment from the federal government roughly, is what you were saying, right? So basically, their cost structure is down to 50. And I'm assuming in the short term, given the delays in medical expenditures in their Billing procedures, their MLRs will be down around 85-80. And so, as they smooth that out, there should be excess reserves and abilities to defray that cost. Is that a fair assessment?

VICKI VELTRI: That's, that's our belief as well.

REP. MESKERS (150TH): Okay. I'm interested, I thank Senator Hwang on the issue in relation to disclosure. I think the accountability for any-- whether it's from the executive or any office of the government into how those assessments are effectively deployed is crucial. Ultimately, I think, in improving the coverage, reducing deductibles, I think the goals are all laudatory. So I'm anxious to see those happen. So I appreciate that.

And, you know, I do worship at the research side of the pharmaceutical industry, but I do appreciate the fact that I think drugs that have been designed and invented 30 years ago, I think putting a price Cap

on the cost to limit the growth there, I think is more than a reasonable response. I think that's it for me. Thank you.

VICKI VELTRI: Thank you.

REP. WOOD (29TH): Representative Nuccio.

REP. NUCCIO (53RD): Thank you, Madam Chair. Good afternoon.

VICKI VELTRI: Good afternoon.

REP. NUCCIO (53RD): Ms. Veltri, and Mr. Dach. I've never met you before, so it's my first time. Hi, how are you? Are you doing?

VICKI VELTRI: Good. How are you?

REP. NUCCIO (53RD): Good. Thank you for coming in explaining this. I wanna start out too, to say that I too, as Representative Meskers just stated, would like to commend the Governor on this Bill, it's very in contrast to the Public Option Bill. This Bill, actually, it begins to address the cost of health care and it doesn't mask that cost with the program that I'm not sure would actually be able to accomplish what it says it does.

But I'm very interested in the portion of this Bill regarding the pharmaceutical costs, and I definitely welcome those conversations. I think that so far, what I'm seeing here, depending on how the language ends up, could be beneficial to at least change the behavior, which I think is the first step in trying to control the astronomical costs of healthcare. But my concern is really in relation to the covered CT portion. If you could humor me a little bit here, Mr. Dach, you've mentioned that the retirement of the high fee or the hit tax, depending on who you talk to, you mentioned it as being a save for insurance companies, and I wanted to weigh in on that.

All of the ACA fees, all of them, including the high fee, are passed through assessments. So if you look at standard contracts in insurance, all fees and taxes are part of the cost to the employer. It's a standard practice, really pretty much with any industry, I don't know any industry that doesn't pass on a tax or an assessment to cost of goods.

So the insurance companies aren't or haven't saved anything with the removal of the high fee. What you saw here in the state of Connecticut is that rates were actually decreased, because that was not passed through to anybody any longer, and if you add that back in at any rate, you are going to see a direct increase in the cost of health care. And that's based off of standard contracting and anything else that comes along with a tax or an assessment for an industry.

Now, I wholeheartedly give you that the estimate of what the high fee was to-- before to this 50 million is significantly lower, but it will be a direct pressure on the cost of health care. So, I guess, my first question is, a 1332 waiver, I'm assuming you're gonna utilize the Connecticut HRA ACT since that was never truly repealed, or would you be utilizing new language for this 1332 waiver? Would it be the language in this Bill here? 'Because there wasn't a lot of language in this Bill directly regarding the implementation and parameters of the 1332 waiver?

JONNY DACH: My thought is, you know, there are—Oh, I'm sorry, Vicki, go ahead.

VICKI VELTRI: Well, I was just gonna say that there isn't a direct-- there isn't a lot of language about a potential 1332 bit, I think, because we haven't decided because the language of the plan gives potential options for the 50 million, only one of which might be a section 1332.

And the 1332 would probably if it were pursued would be with a reinsurance, a potential reinsurance program.

REP. NUCCIO (53RD): Right.

VICKI VELTRI: And if that should happen, then we would, you know, look to existing mechanisms or figure out the best path forward pursing the 1332.

REP. NUCCIO (53RD): So probably the HRA? 'Cause that language is still alive and well. It hasn't been implemented in a while, but the language was never repealed from the Legislation. So, besides the 1332, what would be the other forms of funding that 50 million? So we've got the drug piece of it, the 80% on anything over the CPI +2% possibility of a 1332 which would then lead into an HRA, like a reinsurance thing. So what are the other aspects that may fund that 50 million?

JONNY DACH: So the 50 million itself, in terms of state dollars, will come exclusively from either the reinstated shrunken hit or the pharmaceutical assessment. One of our goals is we put together the plan, will be to leverage the most federal dollars possible with that 50 million.

And so, you could do that through reinsurance, you could do that through targeted, very targeted expansions in Medicaid eligibility that would bring in the FMap from the federal government for those expansions, and you can do it by getting more people to sign up for the exchange, which even under the expanded premium subsidies that will be available temporarily from the federal government, people may decide not to do because they can't afford the costs of care even once they have that insurance, right?

If you're someone with, you know, 250% of the FPL, you're probably making $45,000 a year as a family in Connecticut, and you're looking at a, I don't know, 5, 6, 7000 dollar deductible. That's a deductible

that might lead you to think, "You know what? You even paying this subsidized premium is not worth it to me." If we can come in with further premium support, or if the Committee is kind enough to amend the Bill and JFS language with cost-sharing reductions and we can encourage some members of the Connecticut population who are currently uninsured to sign up for an exchange plan, we will bring in significant amounts of federal dollars.

You know, for every person, the sticker price on an annual basis, on an exchange plan is about $7500. If the Federal APTC, you know, reduces that to $1,000 for someone and they still think that's too much, if we can take it from 1000 to 500, we're putting out $500 of state money and we're bringing in, you know, $6500 worth of federal match in APTC dollars that would otherwise have gone unclaimed by anyone in Connecticut.

So that was that was a roundabout way of saying $50 million from the two sources identified in the Bill, but with the full intent of not only helping as many people as we can, but bringing in as much federal money from a variety of sources to provide that help.

REP. NUCCIO (53RD): Okay. So that actually leads me to a couple of my other questions. Not to dance around too much, to try to stay on the waiver here. Are there any other options for the state that would not include increasing the tax, which are direct pressures on the cost of insurance? So, besides that, besides the assessment?

JONNY DACH: I don't think there are other mechanisms for the state to provide targeted support for the exchange population. Our general fund, as people know, is sustainably strapped. But there are certainly other proposals to try to meaningfully bring the cost of care under control, right? You see one example of that in the pharmaceutical portions of this Bill, I don't wanna pretend that's a silver

bullet. There's a group of researchers at Yale who recently launched something. What's it called Vicki? The 1% Project?

VICKI VELTRI: 1% Project, yes, the 1% Project.

JONNY DACH: The idea being that, you know, if we're waiting for the silver bullet on healthcare, we're are really waiting a long time. We instead need to start picking bikes out of the underlying problem. This Bill proposes one, there are others that I'm sure have occurred to the Committee, and are pending before and we'd welcome a conversation, of course, about those as well.

VICKI VELTRI: Right. And I think it's an important point that Jonny's making to keep making to all Legislators and the Public, which is, you know, we are asking for an assessment here to get more people covered, to get people access to care, which hopefully, actually, itself drives some prices down. Because without being covered, you know, there's pent up demand, there's all sorts of things that can happen to people when they don't have coverage.

But this these are hard discussions about the underlying drivers of healthcare costs. And there's constantly a balancing project that has to go on between, you do want innovation, on the other hand, there were driver. We want our hospitals to do well, but they are a driver. You know, we do have to acknowledge that these are hard discussions, I think that we're going to have to continue to have if we want coverage to be affordable.

REP. NUCCIO (53RD): I wholeheartedly agree.

VICKI VELTRI: That everybody plays a part.

REP. NUCCIO (53RD): Yeah, I wholeheartedly agree on that. I asked specifically, because I know there are states that have been granted 1332 waivers that have not implemented assessments that have looked for

ways, other ways to fund it, and then pulled down a substantial amount of matching grants. And I know Alaska is definitely one of them and there are a couple others also that have done the same thing. So I was wondering if Connecticut was looking at trying to employ some of the procedures that other states have done that have not put a direct pressure back on the cost of insurance.

So I don't know if that's a conversation that we can have or more research that can be done to see if there are other options, but I just wanted to mention that it's out there. And staying with the Covered Connecticut, so if I understand this correctly, the Covered Connecticut dollars are going to be for granting subsidies for insurance, correct?

VICKI VELTRI: That's one option. Yeah, that's one potential option. The Bill as worded gives some flexibility, but that's, that's one substantial option, is to target insurance premiums or cost-sharing.

REP. NUCCIO (53RD): So we're looking at premiums or cost-sharing?

VICKI VELTRI: Yeah. I mean, the Bill as drafted, I think I may have said earlier, I hope I did, we do need a correction to this Bill should move forward that we would like cost-sharing to be included as one of the options to target subsidies. Because as Jonny said, you can afford a premium, but if your deductibles are running in the $7,000 range, you may not go get care. And that is what we're seeing more and more of, is people complaining about cost-sharing.

REP. NUCCIO (53RD): Absolutely. So, I guess, that gets me then to probably one of my last question, one or two of my last question. So, with the new Federal Rescue Package, there are significant dollars in here.

It’s the largest investment in ACA in over a decade, significant dollars investing in the ACA, which include large subsidies, including – increasing availability to people who were previously cut off in regard to the benefit cliff, increasing the percentage of the FPL to 400 plus lowering the age that you're able to get subsidies and the biggest one that I think is really big is maxing out the cost of insurance to a max of 8.5% of income.

So there's also been a lot of signaling at the federal level that there's interest in even more funding for the ACA coming and expansion. So if we're going to be receiving this couple of aspects, I guess, if we're going to be receiving this slew of money that we're getting right now from the federal government for COVID, and all the other subsidies, $50 million compared to the billions of dollars that we're getting, seems to be kind of a drop in the bucket.

Is there any way that we could -- if we're going to be receiving this, this money, look for ways to kind of use that or any other option as a match, because enacting the Connecticut -- the Cover Connecticut -- Covered Connecticut, I'm sorry, funding along with all these other things that are coming in right now through the ACA and then throwing an assessment on top of that, you're going to see increase in the cost of care to anybody who's not on that exchange, plus, we're going to be getting money from the federal government to make subsidies more available, increasing the FPL.

It almost seems like we should kind of pause on this piece to see what happens at the federal level before we intentionally increase the cost of health care here in the state of Connecticut. And I just wanted to point out if we do get a 1332 waiver, and we employ the HRA language that we have. That current HRA language is a premium based assessment. And that means it's only against fully insured insurers. So the fully insured market in the state

of Connecticut is about 30% of the entire insured market.

And it's also the more costly method of insurance from a fully insured perspective. So we would be adding to a significantly smaller populace than the full insured populace using a reinsurance method.

So I think we need to be very careful about where we're looking to get this money to fund the Covered Connecticut and I'm just wondering how much of this is at like actually going to be duplicate -- holy moly! I can't speak. Double -- it's going to be duplicative to what we're getting at the federal level with what's going to be coming down from the rescue package.

So have you guys really looked into the rescue package and what that is going to do for us here at a state level from a coverage perspective?

JONNY DACH: So we've looked into it, you know, we only really got the final text hasn't even passed the house yet. And hopefully will tomorrow.

REP. NUCCIO (53RD): Today or tomorrow. Yeah.

JONNY DACH: -- Desk, I know, our colleagues at the Department of Labor who have to implement provisions that would otherwise expire over the weekend are extremely eager to see the President's signature on that piece of legislation.

We've looked into it. I thought your summary of it earlier was quite well said. And we knew it was coming. And that's why we wrote this Bill to provide OHS and the other stakeholders, you know, enough flexibility to accommodate the eventual federal reality as a result of that Bill and to accommodate the federal reality once the provisions of that Bill sunset, as they're supposed to do as currently written.

You know, as Vicki said, I do think we would need JFS language to allow the plan that OHS puts together for the Committee and others considerations to include the possibility of spending on augmenting the CSR as well as the APTC because the federal proposals as I've read them do not address that cost sharing piece, which really starts to phase out very quickly at the 200% FPL level, and it's entirely gone by 250. When we know that a lot of people still can't afford their deductibles.

Just you know. Quickly, I guess on your last point, I do think it's important that we try as we collect money, to collect it not just from the fully insured segments of the market, but instead, you know, true to the Obama administration. I mean, true to the Lamont administration, sort of general broad base low rate philosophy.

You know, we've written this assessment, we wrote the assessment to the House passed in 2019 to apply to some TPAs, as well, with an effort of minimizing the impact on everyone that it affects and with an idea of minimizing the impact on sections of the market that are most vulnerable, and so attracts the Committee Bill's language in most respects it actually -- our language exempts the small group market, from the assessment because we have particular concerns about the health of that market and that small employer community.

REP. NUCCIO (53RD): So the language that you have is going to exempt the small group market go against the large group, and it's going to go against both fully insured and self-administered through -- and stop loss through a TPA.

JONNY DACH: That's right.

REP. NUCCIO (53RD): Okay, so you're going to be looking more at a per member per month and not a percent of premium.

JONNY DACH: That's right. And the per member, per month --

REP. NUCCIO (53RD): Per member per year, actually, is what Connecticut does.

JONNY DACH: It’s a per member per year.

REP. NUCCIO (53RD): Y'all like to give us the per member per year, and we're got to break it down on a per member per month.

JONNY DACH: You know, the way the formula works -- I won't bore everyone, it's in the Bill, but $50 million target. We know what we got that year from any penalties paid by the pharmaceutical companies that don't comply with the limit, we deduct that from the 50. And we essentially divide the rest evenly among all the lives that the companies report to CID that they're covering.

And then on a per capita, rather than a premium dollar basis, we assess them their share of that 50 million. That per life basis is advantageous on the interstate retaliatory tax issue that I referenced earlier. And, you know, in a couple other respects.

REP. NUCCIO (53RD): So just from a historical perspective, I know that 4.5 million from Malloy’s budget is now 11.7 million. So you mentioned the 50 million, what's the stability of that $50 million, especially if we actually incent correct behavior and the pharmaceuticals and they start to lower that price, you're going to be shifting even more of that cost over to the insured from the pharmaceuticals.

But more importantly, what do you see the growth of that market being because 50 million in subsidies right now, if we follow prior Connecticut assessments it has the potential to be $130 million in four years.

JONNY DACH: Yeah, you know, if the Committee wants to -- it's a fair question. $50 million is enough for us to do a substantial amount of work, you know, I have not run the numbers under the new federal act. But right now, the total premiums paid by everyone under 200% of the FPL, on the exchange is about 20 or $21 million.

So for $20 million, you could zero out premium payments, by everyone currently on the exchange and hopefully entice many more people at that income level who were dismayed by the premiums, are dismayed by the CSR on to the exchange.

So I think we would be able to do significant things for the people of Connecticut within that $50 million limit. We would not have to increase it if the Committee wanted to signal an appropriate rate of increase, should there be one in the legislation, you know, one option would be to tie that 50 million to something like health care cost growth or overall inflation so that it keeps up with without sort of mission creep. But again, certainly a conversation we're happy to have.

REP. NUCCIO (53RD): You just said that to the very wrong person. I would love to see if you're going to standardize language in there to limit the amount of growth. So it's actually more reasonable number, that's something that I'd be very interested to see that kind of language.

So then the last question that I had, I guess, that maybe we didn't really get into is in regard to the drug portion of this, which again, I understand the need for and I'm supportive of. I think that this is definitely an area like 26 plus percent of healthcare cost is as pharmaceutical drugs.

Have you talked to the industry? And how long do you think it would take them? Or would they be amendable to living under the regulations that we put in place here? Is this something that you see them doing or

them addressing prices rather quickly? An 80% tax on that increased amount is a substantial amount of money.

So I'm just kind of trying to get an idea of where the legislation was thinking is on how quickly they think this would actually help reform the cost of health care?

JONNY DACH: Yeah, you know, the 80% is significant as you said, but I just want to highlight for everyone, it's 80% only on the amount above the limit, right? So it wouldn't claw back. They're sort of fairly earned charges or profits.

The industry has concerns. I think those concerns are reflected in written testimony pending before the Committee. I'm sure you'll hear about it from their representatives today. I am curious. I have meetings with at least one of those companies tomorrow, others later this week. The Governor himself will be available to their CEOs for conversation.

You know, I do not have a good sense and this is one of the things we'll be raising in those conversations. Are there Connecticut companies that are currently staying afloat only because they're increasing profits by 10% a year or increasing charges by 10%? I don't think so.

You know, as I referenced, we saw in the Alexion testimony that they say for their five or six drugs currently on the market, they're living within these caps, or at least that's how I read their testimony. I shouldn't speak for them.

REP. NUCCIO (53RD): Okay, thank you very much. Thank you for humoring me and putting up with my long winded questions. I appreciate both of your answers.

REP. WOOD (29TH): Senator Lesser, did you have another question?

SENATOR LESSER (9TH): Yes, I satisfied some of my constituent concerns. So I've got -- with the Chair's indulgence ask questions for a second time.

So first of all, I really appreciated the back and forth and particularly Representative Nuccio's questions about how this proposal would fit in with the American Rescue Plan set to be voted on today.

And as I see it, they're complimentary proposals in terms of the subsidy portion where any additional assistance that we could provide, folks. So I thought that was a helpful point.

You know, I do know that this proposal is being compared with some of the other healthcare proposals before the Committee. And so I think there's some question about what's in this versus other things.

Obviously, if the prescription drug proposal in this is successful, that would potentially drive down prescription drug costs for the marketplaces overall. But is there anything specifically in the Bill, about the small group market?

JONNY DACH: The only thing in the Bill that's specifically targeted to the small group market is the exemption from the reinstated assessment that I just referenced in our conversation a minute ago. The limit on pharmaceutical price increases would of course, benefit them the way it benefits everyone in the market, but nothing specific.

SENATOR LESSER (9TH): And while the Covered Connecticut's language, I think could allow the administration to expand Medicaid, it shows there's nothing in the Bill that explicitly expands Medicaid coverage. Is that -- is that correct?

JONNY DACH: That's correct.

SENATOR LESSER (9TH): And then there's nothing in the Bill about access-- for access for folks, who are you now eligible to purchase coverage presently, on the exchange.

JONNY DACH: There's nothing in the Bill specifically about that population or any other sort of Medicaid or exchange in eligible populations. Although there is a general invitation to OHS to work with DSS and other stakeholders to look at ways in which the Medicaid eligibility rules can be expanded to expand access to care in Connecticut.

SENATOR LESSER (9TH): So back to the prescription drug portion question about the wholesale acquisition price. To the extent that the Bill is successful at limiting the growth of that is there any sort of guarantee that that savings gets passed on to consumers as opposed to captured by pharmacy benefit managers or insurers is there -- where does that price go?

And then the other sort of flip side of that is that one concern I heard from the industry was that they might respond by raising initial costs prices. Do you have any response to that?

JONNY DACH: First of all I'll take the first part first, with your permission, you know, the insurance companies' job is to negotiate the best possible rates for Connecticut consumers. And if wholesale acquisition cost increases are limited, I would expect the insurance companies to negotiate lower rate increases and to pass those benefits on to Connecticut consumers.

And if the Committee is concerned that they won't do so, you know, minimum MLRs is the way to make sure that insurance companies are passing any savings on to their customers and our constituents.

As Vicki said earlier, it's a hopelessly confusing value chain. You know, even for people like us who spend a lot of time thinking about it, and trying to understand it. It appears almost to have been developed explicitly to defeat policymakers' efforts to bring costs under control.

But I do believe that limiting the wholesale acquisition costs are starting at the top will lead to reduce costs throughout the value chain and ultimately reduce prices to consumers.

Again, they may not see those at the pharmacy counter in terms of their out of pocket payments, but they will see them in premium savings. And that will provide them more money to meet challenging out of pocket contributions or allow insurance companies to offer, you know, better cost sharing on their side.

As to whether companies will choose to sort of have a higher launch price and anticipation of eventual limits on their cost growth, it's a good question. It's a good concern to have. In some ways I think if the 10 million lives in the Connecticut, in New Jersey markets limit year over year cost increases, you know, they can't set a launch price different for Connecticut and Massachusetts than they are for the rest of the country.

I'm not sure to what extent we will fully drive their pricing decisions at launch. But, you know, I think there are other constraints on those launch prices. And if they are going to increase them to cover their R&D costs, I think the responsible, intellectually honest thing to do is to set those prices upfront at a level that lets them recoup their costs rather than sort of luring customers in at lower rates and then increasing them later.

As we all know, it is hard to get, and rightly hard to get patients who have accommodated themselves to one drug to change. Even if the price of that drug

changes people's behavior becomes relatively inelastic.

SENATOR LESSER (9TH): I mean, is there anything that would prevent – I'm just trying to figure out. I don't I don't know what cost limitations in it -- price limitations in any in any state? You may know more than I do. But is there any -- you know, because of we have an interstate commerce in this country. Is there anything that would sort of restrict or disallow transshipment? Or in trying to figure out, you know, can somebody buy Connecticut drugs and then sell them in California? How is this going to [inaudible]?

JONNY DACH: Yeah, you know, I wish we had sort of McKesson or in the distributor companies here to testify today on that question. The limit applies to drugs intended for eventual sale in Connecticut for final sale to consumers in Connecticut. I don't think that people will be buying shipping containers full of drugs here at the wholesale level, and then shipping them through the Panama Canal, or even across the New York border.

SENATOR LESSER (9TH): And then one last question. There is open ended language about what we talked about earlier about the 1332 waiver that they're permissive of. I note that Massachusetts and Vermont have state based subsidy programs that they've been able to leverage additional federal funding through the use of an 1115 Medicaid Innovation Waiver. Does administration have a position on the possible inclusion of 1115 waiver to enhance hospital subsidies?

JONNY DACH: Vicki.

VICTORIA VELTRI: Thank you. Okay, sorry. I was deferring to you. I think it's a possibility. 1115 waivers under the Social Security Act, it's normally done by the Medicaid agency to fill -- offer some flexibilities. It has budget neutrality associated

with it. So whatever you propose, you have to do a new federally neutral budget with, so you'd have to consider those calculations.

1332 is deficit neutral, slightly different concept equally confusing to most people, but is a federal deficit neutral mechanism. 1115s have been used widely across the United States for very different purposes.

Massachusetts, 1115 predated the ACA, as you know, and it's been renewed because the mass Romneycare preexisted Obamacare, and Massachusetts was offering subsidies under that 1115 and they continue to do so. Vermont is using a different sort of mechanism for a statewide Accountable Care Organization, but they are using a 1115 construct and it is possible. So it's an option, I would just say, but an equally complicated option to just be clear.

SENATOR LESSER (9TH): Thank you. Madam Chair that's actually all the questions I have for right now. One thing hopefully we resolve this coming before us, and I'll turn it back to you.

REP. WOOD (29TH): Great. Senator Hwang.

SENATOR HWANG (28TH): Actually Madam Chair, I appreciate the indulgence but for the second time, I'm happy to wait after Representative Farrar. Thank you, Madam Chair.

REP. WOOD (29TH): Thank you. Representative Farrar.

REP. FARRAR (20TH): Thank you, Senator Hwang and Madam Chair, just actually a quick question, following up on a few of the questions that Representative Nuccio had, and how do you both -- I had to jump on a little late so you might have covered this earlier on.

But in the proposal and this goal of this $50 million target, I believe Mr. Dach you mentioned

that the way it be structured is you would build in what this pharmaceuticals, you know, pharmaceutical contribution would be and then after that kind of assess what the insurance company role would be. Do you all have numbers that you're anticipating in thinking about how this would roll out? I'm just trying to wrap my head around how this would be structured and within the 50 million right now, what each player -- what each source would really be contributing at a startup phase?

JONNY DACH: My anticipation or at least my hope is that pharmaceutical manufacturers would follow the law. And they would limit their annual price increases in Connecticut, totaling inflation plus 2% -- about 4% in real terms, and that would mean that the entirety of the $50 million assessment, 30 million in the first year 50 million thereafter, would fall on Connecticut insurance companies and ultimately, to revenue to his point probably be passed on, although not necessarily passed on to Connecticut's insurance consumers.

We think that the reduction in cost increases on the pharmaceutical side of the house, even if the pharmaceutical companies aren't paying directly into that $50 million fund, will more than offset any increase in consumer prices associated with that $50 million assessment, keeping it not only well below the level that it's been historically in this and other states, but below sort of what trend would have been but for this Bill as a package.

REP. FARRAR (20TH): Thank you for clarifying that. And certainly, as you said, the goal here is to, you know, incentivize this behavior. I certainly hope it does that trick.

From the standpoint, though, of what we're looking at right now, in the market, you've noted that that's really not the case. So are you all anticipating, again, kind of certain amount of funds from having to, you know, address these real cost

increases amongst the pharmaceutical companies or you're anticipating they change their behavior before implementation?

JONNY DACH: We're anticipating they change their behavior, especially if Connecticut and Massachusetts are able, as we hope to act together. Perhaps with our other southern New England friends in Rhode Island and start, you know, setting a meaningful expectation for these companies of what really their consumers and our constituents can bear year after year.

REP. FARRAR (20TH): Great, thanks for giving me that sense of how you all kind of view this and working with other states as well. Thanks. Thanks, Madam Chair.

REP. WOOD (29TH): Thank you. Senator Hwang. Did you have a –

SENATOR HWANG (28TH): Yes, thank you, Madam Chair. I just wanted to respect that protocol. And I appreciate the opportunity to speak for the second time. And part of the reason for the second time is I really wanted to listen to my colleagues, and greatly appreciated Mr. Dach's and Ms. Veltri's answers.

So let me take that through from an analysis standpoint of the Senate Republicans had proposed Senate Bill 1006. I'm not sure if we're gonna get a public hearing out on that. But as I'm listening to you, I see a tremendous amount of similarity and the same frame of mind and thinking, particularly one of the components of reinsurance.

And one of the questions I wanted to ask is, has the administration considered with the potential granting of federal funds that in utilizing the 1332 exchange and potential federal health care money and Medicare, etcetera, that we could offset the assessment and tax on premiums?

That is it a possibility that we could use allocated federal funds, and offsetting that cost to be able to create the reinsurance product? I know you cited it in your Bill and in your testimony, but didn't go into deep discussions about that. I think reinsurance may be a very viable product at this time to be able to offset some of the costs considerations we're trying to address. Any thoughts on those -- on that question?

JONNY DACH: Yeah, you know, the administration supports reinsurance. We had a Governor's Bill last year that included reinsurance. The landscape has changed with the shift in federal administrations and with the passage of the recent Bill, you know, what we want to do is buy ourselves the time, not for you to hear from just me and Vicki. But to hear from Vicki and the relevant agencies and experts on a soup to nuts plan for how this $50 million, 30 in the first year, could be best put to use for the people of Connecticut and put to use in a way that maximizes federal dollars in that effort.

So reinsurance, we know from the weekly report that AHCT has commissioned and you've probably seen, brings in roughly one federal dollar for every dollar we spend as the state. That's not bad. That's about what we get in Medicaid. There may be opportunities through more targeted premium supports or cost sharing reductions to bring in not one to one federal dollars, but a substantially higher federal match, and to target that match and the state dollars at the population most in need.

So we're you know, we're really open to whatever story, the numbers tell us in terms of how we can best serve our constituents.

SENATOR HWANG (28TH): I am so appreciative and grateful for the open mindedness and the offer of collaboration. It is indeed welcome for us to get the best product at hand. I think the second

component that we share a lot of similarity with Senate Bill 1006, is the fact of addressing the cost of prescription drugs.

I think the administration proposed some very different ideas than the preexisting idea of Canada's pricing. And I'm very much receptive to engaging in that conversation. But I want to reiterate that for the Senate Republicans, and the House Republicans, the idea is looking at prescription drugs has another significant cost factor.

And I wanted to compliment the Governor and yourself for that kind of perspective. The third issue that that we looked at was benchmarking, and that shared a lot of similarities in regards to -- and I want to share that I've had some conversations with Ms. Jean Ahn, who was the Chief Strategic Officer, I believe, in some capacity with Baystate Medical Center now with Nuvance.

And she saw firsthand the more recent utilization of benchmark and we have great talent in our state to be able to utilize and make a best benchmarking based upon lessons learned. Do you have any particular thoughts in regards to how the legislative branch can help policies to the administration in crafting a benchmarking program that will be truly effective in managing costs and being able to be able to have some data points? You or Vicki.

VICKI VELTRI: Were you referring to me? Because I think I can play in on this one. Okay.

SENATOR HWANG (28TH): It was a setup for you Vicki.

VICKI VELTRI: That was a nice setup. Thank you very much. We have been working -- I want to thank this Committee, the Public Health Committee, you know, we've had a really good relationship on the benchmark work. It's even pre Executive Order. There

were a lot of conversations going on about implementing a benchmark program in Connecticut.

And, you know, we did start with the Executive Order, in part because we had a Bill last year, we had a Bill the year before it was late in session, we had a Bill last year the session died, as we all know. And we proceeded to work on and we think like the other states, that this is a really important thing to do.

The transparency efforts are really critical to exposing the underlying costs that are driving health, you know, health premiums and cost sharing that people are paying. Right? That data is slowly coming out. We think that we will have to codify the benchmark. And I'm sorry, I will say in advance that I'm not gonna be able to testify Thursday in person, but we are submitting testimony on it, we will have to codify that work.

I think what's slightly different than when we initially proposed the Bill is that we're actually working, right? So we're learning things as we go on how to best codify it. So we're in the first year of actual implementation of that benchmark.

So we were kind of proposing that we come back next session with an ironed out Bill, that's consensus that isn't going to be highly dramatic, because lots of these kinks have been worked out. And we invite people to stay engaged in it. We do meet monthly with our legislative partners, the Chairs and the Ranking Members and the Vice-Chairs, we've been meeting every month, or trying to with almost everybody on it.

But the key there is going to be when you see the data, right, that we will be showing what action are we going to take together to address what we're seeing in these data? And those are going to be very difficult conversations. Just being honest, like we're having today, right?

SENATOR HWANG (28TH): No. It absolutely and we have the talent pool. And as I said earlier, your demonstrated experience and grassroots effort is critical for us to be able to utilize that's as a cat go behind your back.

VICKI VELTRI: Yes, I'm sorry.

SENATOR HWANG (28TH): That's okay. That's okay. We had a baby –

VICKI VELTRI: Usually one makes an appearance sometimes.

SENATOR HWANG (28TH): Now, the fourth part of Senate Bill 1006 we talked about it's really important is the fact of transparency and accountability. And I think I don't want to repeat myself, or have you repeat yourself, that is absolutely paramount for any system to truly be effective and sustainable.

So I appreciate both of your time. And I just want to reiterate that the Senate Republican, are looking to create a better way working with the administration to finding solutions. And I want to applaud the administration and all its staff members for being open and collaborating and working with all of our various partners.

I think ultimately, the best way we can contain costs and be able to manage a system moving forward is to address an entire ecosystem. But to do it in a collaborative way with existing structure. The idea of creating something brand new, maybe something that may be great and ideal, but the reality comes into a brutal confrontation that sometimes these challenges like I said earlier, if we could solve health care cost containment, we would have done it 30 years ago.

But nevertheless, I really appreciate all of your time and effort and my ability to be able to share that at least for me, as a Senate Republican that 1006 reflects a lot of the values and be able to collaborate work together. So thank you, Madam Chair for the opportunity. And thank you all for your work again, and your indulgence and time. Thank you, Ma'am.

REP. WOOD (29TH): Thank you so much for coming and spending this time with us and we appreciate it and look forward to continuing to work together.

JONNY DACH: Thank you for having us and likewise, we're always available.

REP. WOOD (29TH): Next, I have Senator Kelly, but I believe he may have left due to time constraints. I wanted to just see if he's available. I don't see him. Next, we have Representative Q. Phipps. Is he available? There he is.

REP. PHIPPS (100TH): So good afternoon, everyone. Thank you for this opportunity to speak to you about this important Bill, I think it’s Bill No. 6587. The Bill regarding EpiPens and epinephrine.

This is a very important Bill for numerous reasons, I think it's-- I would feel remiss without talking about what's happened over the weekend, where one of our own coordinates, one of our own staffers had a recent allergic reaction that put them in the hospital and very sick.

And we are always, those of us with severe food allergies or allergies to insect bites and so on and so forth, are always this important in life saving medicine away from death.

And that was always really apparent, I don't actually remember my first interaction with my severe tree nut allergy, but it’s something that my mom remembers very, very clearly.

And in fifth grade there, I won a math award named after a student who died from a nut allergy, only to graduate from Bryan University and there was another award for a young student that was very involved in the university level and also died from the same thing, allergy to tree nuts, ingesting it and not making it with this life saving medication.

And I was really lucky my mom worked for the state of Connecticut for many years. So we've always had really good insurance. And when I started working for Bank of America, who was making literally a billion dollars a quarter at the time, I had the best insurance plan that they had, but the insurance was-- the prescription cost was $400 for an EpiPen, which is something that at the time I couldn't afford, because of the many other bills between student loans and housing, and so on and so forth. I couldn't afford it even as this company made almost kinda billion dollars a quarter.

And that inequity was always clear to me that every time I ate at a Thai restaurant, or any restaurant for that matter, I was always putting my life in danger, and that was-- it's always been scary, it's always been really, really scary.

So when I think about where we are at today, after making this life saving change last year in terms of diabetes medicine and insulin and making sure that everyone had access to this life saving medicine, where people should not have to choose between food on the table and medicine, or their housing payment and medicine, or energy and medicine.

We in the state of Connecticut have already made a commitment saying that we need to make sure that we protect one another, and that people should not have to make those hard choices. And this is what this Bill is really about, the ability to be able to afford to protect yourself, to protect a loved one.

And also as an educator, I think we forget of how many of these lifesaving medicines you need. If you're a young child, you would need one at school, you need went to grandma and grandpa's house, you need one at home, you need one at the school program.

That right there was going to cost you hundreds, if not thousands of dollars at the current rates in which the prescriptions would cost. So I would encourage you all to support this Bill to make sure that every young child will have this protection, that every family will not have to make the choice between protecting themselves or protecting a loved one, and providing basic care.

So I would highly, highly encourage you to support this Bill, to pass this and make sure that everyone in the state of Connecticut can be protected and have this life saving medicine.

REP. WOOD (29TH): Thank you, Representative Phipps. Questions from Representative Comey.

REP. COMEY (102ND): Hi. Thank you. Good to see you, Representative Phipps. And I think, you know, we actually share that employee and I was-- it was a pretty severe reaction that happened over the weekend, and the story goes, when I dug a little deeper, that she didn't realize because she had had-- she's a new employee, relatively new and didn't understand that unlike her past insurance policies and her past plans under her parents and things, that the EpiPen would be covered.

We're very fortunate with our state insurance that an auto injector is covered. But she was not aware that the insurance-- she thought it would still cost her over $500 to get that prescription filled and that is why she did not first fill that prescription.

I think, you know, we're sort of talking about the same thing when we're talking about the price of the medications, in fact. Senator Lesser mentioned the Auvi-Q as one of the highest raising-- the highest rising prices, and in fact, here in Connecticut, the-- Connecticut is fifth highest among states in the nation for food allergy diagnosis and anaphylaxis events.

And when you mentioned that you had to have-- that you heard that you had to have-- I have a child with food allergies, to be completely upfront is that I have at grandparents, at school, on him at all times, and then, you know, with mom and dad. So we have to have several, like sometimes a half a dozen Pens with us. And it's just, you know, insurance only covers a portion of that.

But I think what's most important is that it is lifesaving. This is a lifesaving medication that will help in the situation where someone gets a bee sting and has anaphylaxis, or someone eats a food that they're-- didn't know that they were allergic to, or they did know that they were allergic to. And this is such an important Bill for those that don't have the greatest of insurance.

So, I thank you for bringing it to my attention and I'm not sure that I actually have a specific question. I mean, there's some great testimony that was uploaded by a colleague of mine, Patricia Donovan, who has done some great work on this. So, thank you for allowing me to thank you for bringing this forward.

REP. PHIPPS (100TH): And I thank you for bringing up that point about having the multiple EpiPens in all the different locations instead for one. At the current minimum wage, that can be over 30 hours of work, for someone to be able to just buy the one, an entire week's worth of work to buy one medication. And you still would need one for school, for home, for grandma and grandpas, for after school, and many

other places that you may need one for a child alone. So it could be incredibly, incredibly expensive for a family.

REP. WOOD (29TH): Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And thank you, Representative Phipps, for your testimony today, and I do wish the best to your staff member, I hope she's okay.

And like many other folks on this Committee, I have personal experience here. I had anaphylactic reaction at the Capitol a couple years ago and this is something that is important to me.

You know, the thing that we have to sort of weigh in making sure that these devices are available to folks is also the fact that the companies that manufacture them, and Representative Comey just mentioned this a minute ago, have been increasing the prices at an astronomical rate, I think, preying on the fact that families are desperate, people wanna make sure that their kids are protected.

The Bill as drafted just speaks to the out-of-pocket costs that the fully insured person in Connecticut, who does not have a high deductible plan would pay. It does not, as I read it, restrict the cost driver the manufacturer puts on it by raising the price. You know, in the case of Auvi-Q by something like 60% over a three year period.

In the Insulin Bill that we looked at in the fall, we attempted to get around that by piggybacking on prices available to community health centers. Is that something that you would suggest this Committee take a close look at as we tried to not just address the out-of-pocket cost, but also the underlying cost?

REP. PHIPPS (100TH): Senator Lesser, that's a great question. And when I put in a similar Bill to this

idea, I suggested that we already have model Legislation, the model Legislation being the Insulin Bill that we've just passed. And I think in many ways, just switching out the word, "Insulin" for EpiPens or Epinephrine is the way in which this current Bill should be written.

I think we wanna reinvent the wheel twice. Let's follow the best practice that we've already created.

SENATOR LESSER (9TH): Thank you. Thank you, Madam Chair.

REP. WOOD (29TH): Representative Meskers.

REP. MESKERS (150TH): Yeah. Representative Phipps, thank you for the testimony. I think, you know, we sit here we argue about health care, we argue about cost, we argue about structure, and it's so helpful to have someone, a colleague come up and talk about their experiences. You know, Senator Lesser, thank you for the commentary.

Of course, unfortunately-- Well, fortunately, Senator Lesser, it was a couple of years ago, so the immediacy of you of your experience is less. So, hearing the needs and realizing that our decisions weigh on, or our decisions have outcomes and effects on people's lives is so important. So I really thank you for the testimony and thank you for stepping up for that.

REP. PHIPPS (100TH): And thank-- I forgot one part about the story that I meant to share about this, like how life changing it is to have this medicine, have access to it. I remember when I first started working for my most current employer, when I got an insurance plan where I can afford the medicine, I took a picture on Instagram with it.

With me holding my EpiPen, just being so proud that I would never have to worry again about being in danger at eating out or accidentally ingesting this.

I took a picture of it, I made sure I documented it on social media 'cause it was that important, it was that big of a change that I could finally afford this.

And also when I was a banker, I had been an Executive Director, someone that should have been able to have the privilege to not have to worry about medicine, but here I was, six years ago, holding an EpiPen in my hand on Instagram because it was that important to me to let folks know that I could have one and that I was safe again.

REP. MESKERS (150TH): And that takes us back to our commentary on the Bill as well. And 6447 when we start telling you about the-- you know, without attacking pharmaceuticals, if we relentlessly raise the price of base medicines, that whose formula has been virtually unchanged for 50 years, we price people out of the market, whether it's insulin, or EpiPens, we price people out of the market, or-- and as Americans, we bear a cost that, for some reason, they don't have to bear in Toronto, where they don't have to bear in Switzerland, or in London-- Geneva, I guess, I used a city everywhere else. But it's not fair that we should build a pricing model on the back American citizens.

I'm not arguing about the profit motive of the pharmaceutical industry, I just don't wanna be-- I don't think the target should be on the back of Americans to fund the entire research of that industry.

So I salute what they do, I just wish that, you know, the Canadians pay their fair share instead of the Connecticut residents. So thanks for your testimony.

REP. PHIPPS (100TH): Thank you, Representative.

REP. WOOD (29TH): Representative Nuccio, followed by Senator Hwang.

REP. NUCCIO (53RD): Thank you, Madam Chair. Good afternoon, Representative Phipps, how are you?

REP. PHIPPS (100TH): I'm doing great. Good afternoon.

REP. NUCCIO (53RD): Good afternoon. So, I too have a story like that, with yours and not for myself though, but my husband had a severe reaction to a bee sting, never had in his life, and it didn't happen until he was in his late 30s.

And it required an ambulance trip and shots of more epinephrine and then shots to bring his heart rate down, and it was extremely terrifying and horrible. And I remember when we went to get our first EpiPen for him, which by the way back then you could buy one, and you didn't have to buy two, and it was $25 copay. And over the years, it turned into, like you said, it was a $400 copay and you had to buy two.

And we just didn't get it, we couldn't get it, you know, there was no way that we could afford it. So we had outdated ones and just said, "You know, it's not too cloudy, hopefully, it will work." You know, so it's-- this is definitely a real matter.

My question was gonna be, though, I didn't know if you happen to hear any of the testimony for the prior Bill that we were talking about regarding the pharmaceutical portion of it.

REP. PHIPPS (100TH): No, I did not hear that, I was in another hearing myself, and preparing for the Aging one little later this evening-- or afternoon, excuse me.

REP. NUCCIO (53RD): I know what that's like. So, in that Bill they were talking about being able to tax pharmaceutical companies that increased their prices over a certain amount of the CPI +2%.

And my only problem with Bills like this one and the Insulin Bill is that, it truly does not do anything to affect the cost of the health care piece of it, it doesn't do anything to affect the cost of the product.

So, I'm interested in seeing if there's a way that we could try to find some language to work around that, because the other portion of this is same thing with the Insulin Bill, the state of Connecticut's market is only 30% fully insured. So those Bills only truly affect certain people that have insurance and the majority of people have ASO plans and they don't see any relief, actually, the cost gets shifted from the fully insured portion on to the ASO insured.

So, it's unfortunate, I think we need to try to find a way to work around the cost of these products and trying to get, as Representative Meskers said, I guess, we need to raise our voices more, that we can't continue to be the stepping stone of research for the rest of the country.

So, I just wanted to say thank you for bringing your story because I totally identify with it, lived it, and still kind of live with it. I still haven't even gotten a new EpiPen yet, and need multiples. But I'm just concerned that we find language that we can try to help everybody with.

And I'd be definitely interested to talk to you and work with you in any way to try to find language that we can accomplish that.

REP. PHIPPS (100TH): Totally. And I'm a fairly new Legislator myself, and I think the difficult parts about this work is that we know that we can't help everyone, which is why you just say my favorite word is, and, right? That it’s not a work of or, just a work of and.

And that it can be true that we can help the folks like we have in the former Insulin Bill and that this one should be modeled after, and we can still work on the cost of medicine, and we can work on the outrageous costs that pharmaceutical companies use for things like marketing and bonuses, and so on and so forth.

Actually, brother was a pharmaceutical Rep themselves, so I have seen one of my own family members benefit from that kind of compensation and work. So that's not the critique, I think the real question at hand for we as Legislators to answer is, is it okay for us to lose our neighbors for a fairly inexpensive drug that has been, as Representative Meskers has mentioned, fairly unchanged for the last 50-80 +years when it was designed? And, like, how many people do we want to lose for, once again, a fairly commonplace medicine? My answer would be none. That's what my answer would be.

REP. NUCCIO (53RD): I'm with you. I too, I think it's predatory. There are certain drugs, I think, that it's just predatory pricing because it's needed. So, thank you again, for bringing it forward and, you know, I gladly talk to you anytime about trying to expand it somehow.

REP. PHIPPS (100TH): Awesome. Great question. Thank you so much, Representative.

REP. WOOD (29TH): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Representative Phipps, thank you so much for sharing your thoughts and your story.

And what really struck me is the joy that you talked about taking the photo of your Epi, because that's what healthcare is so powerful, because it's life and death, it's an essential part of what we need to protect ourselves. So, I completely agree with you on that.

And I wanna thank Representative Comey for her supporting comment. And I want to acknowledge Tricia Donovan, who has been a tremendous advocate. And it is predatory pricing, and this is beyond the poll, this is exactly why the pharmaceutical industry sometimes gets a bad rap.

Because the important work that they do are essential, the innovation, lifesaving efforts, all acknowledged. But when you see something like the EpiPen evolve in pricing, that has no basis, or rhyme and reason, it really is predatory political.

And I actually am familiar with the history of this, where a federal statute was enacted to favor certain players in that entity. So I really wanna thank you for pointing that out, and also speaking on behalf of so many others, parents and individuals impacted by food allergies.

I have a son who's 21 years old and since the day he has been born, we've had to buy the EpiPen. And the fact we have seen the prices increase from $55 to now nearly $600 is unconscionable. Right? And the fact it is not a product that has an infinite life cycle, it has an expiration date over a period of time.

And what's important for people to know is the fact that, if you are a parent of a child with allergies, you need to have one at home, but you also need to purchase another one to be based in the school in which they're at.

And when you have to front the dollars, when there are no appropriate insurance coverage, and I think that's what's important when we talked about earlier, that we need to control and manage health care insurance costs, because this is an example.

The fact that people with health insurance coverage can get this EpiPen and pay the copay at a small

dollar amount, they can get that as a lifesaving product for their loved ones. For those people that don't have insurance, the out-of-pocket expenses that you describe so effectively, Representative Phipps, is exactly why we need health insurance reform, but one that's sustainable.

So I, you know-- we're doing a lot of talk and telling you that we appreciate you bringing this to the forefront and along with so many others that are telling the story, because this EpiPen experience, I talked about it all the time, this is outrageous price increases, and it's got to be contained.

So, I fully support your advocacy and I wanna thank you for testifying.

REP. PHIPPS (100TH): Thank you, Senator.

REP. WOOD (29TH): Representative Comey, do you have another question?

REP. COMEY (102ND): Yeah. I'm just grateful. Actually, Senator Hwang said a lot of what we were gonna say. I mean, the epinephrine itself is just $2, it's the device. And I just wanted to clarify, when I mentioned Auvi-Q, Auvi-Q, is an incredible product. It is a speaking auto injector. It is wonderful, it is small, it is friendly for Kids, my kid just gave it to himself over the summer for the first time, it's not threatening, it's not a huge needle like the EpiPen.

So there is some incredible work being done to make products better, and I didn't want to sort of call them out, but as we remember with the Myelin EpiGate is actually what it was called, where the prices sprung 400-- rose 400% while it was the only product on the market, so that's another reason, Representative Phipps, that I'm so grateful for you to be able to bring this forward and to be with you--work with you on that. Thank you.

REP. WOOD (29TH): Great. Thank you, Representative Phipps, for coming in.

REP. PHIPPS (100TH): Thank you so much, and appreciate the commendations.

REP. WOOD (29TH): So, I just was informed by our Clerk that we have past the first hour of our Committee meeting and how the speakers are going to be called going forward. The first hour is reserved for Legislators and Agency people and we then rotate in the public.

So, we do have-- so I'm just going to read off the next four speakers so that people can prepare, because if you are looking at the speaker lift-- speaker list, we're gonna have to rotate.

So, the next person is Neil Roberts, followed by Representative Turco, followed by Paige Mahaney, followed by Representative Pat Dillon. And with that, let's hear from Neil Roberts.

NEIL ROBERTS: Hi, everyone. Thanks for having me. Can everyone hear me? Okay.

REP. WOOD (29TH): Yeah, we can hear you.

NEIL ROBERTS: My name is Neil Roberts, I'm from Burlington, Connecticut, and I'm the Executive Vice-President for the Schuster Group, an employee benefits agency here in Connecticut.

I've worked in the healthcare industry for the last 18 years and advised over 200 clients in the state, both private and publicly funded clients, of all different funding and sizes.

In addition to working in the sector, like you, I'm also a consumer of health care and a purchaser of health insurance. I do think that one thing we can all agree on from hearing these testimonies that we

all want affordable and accessible health care coverage for ourselves and our families.

However, when I read the Bill, House Bill 6447, I don't really see a solution. The Bill simply shifts cost to the payers and consumers of the products and those underlying costs don't change.

So here's some facts about healthcare economics that I think are vital for consideration. And an underlying provider expenses and participant utilization are the key drivers of the cost of health care. Nothing in that Bill addresses that.

The Bill only increases costs to one group of the constituents to subsidize costs for another, and the Bill simply mandates will find the option. The AFFORDABLE CARE ACT should prove to be a sufficient lessons learned; I think for that approach.

The Bill ignores the fact that most payers in the state have embraced and are implementing true-value based health care products that reduce costs and increase the quality of outcomes. Good public policy would promote competition through deregulation and embrace true move to value healthcare in a free market.

I think that the state really has three levers to achieve the goals that they're looking to do in this Bill. Fee for service to pay health providers more in line Medicaid, taxes raised to subsidized coverage and assessments directed to insurance companies and therefore to the consumer. None of these will achieve affordability. All of them are bad for the economy.

The state's mechanism for forcing the provider to accept lower costs will immediately cause a provider to shift the cost to the commercial insurer, thereby increasing costs to the employers.

The Bill also exempts itself and some of the rules regulations, assessments, and taxes. And so, you know, thereby permitting the body to be free from the burden of the cost that it's imposing on the legitimate participants in the healthcare marketplace.

The state thinks that it has to assert some purchase power here. And when I look at the state, you know, run plans currently, you know, ironically, the state of Connecticut employee health plan is the most expensive, one of the most expensive health plans in the state, and the partnership plan is relatively insolvent.

You know, as a taxpayer, you know, I have really large concerns with this negligence. You know, when you look at the history of these government-run programs, and their performance and increasing cost, and we're here, you know, trying to expand it.

So, you know, in Connecticut, we have economies of scale, we have six payers in the state. And, you know, they employ tens of thousands of people, and I just feel like that this is a real cost shift. You know, we're affecting one group of constituents to subsidize another, and I think that discourages competition in the market.

So, thank you for your consideration.

REP. WOOD (29TH): Thank you, Neil. Do we have questions for Neil? Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Mr. Roberts, thank you very, very much. And you offer a context as we talked a lot about the health insurance solutions, but I think you represent a viewpoint that don't always get heard in the debate, which is you as a benefits counselor on the grassroots of helping consumers get the information.

And I think one of the concerns I have with the Governor's Bill is the assessment or tax on the various insurance products and the fact that it potentially will be redistributed to business policies. Maybe I'm just being a little bit kind of sensitive to redistribution of costs, but what is your experience on that type of a program?

The cost is gonna go somewhere, right? And also, where do you see this kinda program as it impacts the consumer and getting information as you provide so much of it to people on a very complicated and complex issue?

NEIL ROBERTS: Yeah, thanks for the question. So I'm an underwriter by background, so, you know, when I consult with the groups, it's mostly on a fiscal basis. So we're always managing a budget, and so costs are-- you know, it's helping employers manage their biggest asset, which is their people.

And, you know, I think this Bill, you know, really ignores, you know, the pressures that the commercial market and the private sector is facing with healthcare. I mean, they're in the same boat as, you know, the public sector as well with the rising costs, and in some view, the unsustainable rise, which I agree with of some of the components of healthcare.

So, you know, from my perspective, I think that, you know, again, it's just it's a bully in, you know, increase of costs in one area to then-- you know, if you push on the balloon, it's got to come out somewhere else. And I just-- you know, I don't think the Bill really addresses what the true problem of cost is with health care.

I've heard a lot about the pharmacy side which I, you know, I'm not here speaking towards today, but that is a probably a good start and trying to understand how that happens. But, you know, in general, I don't believe in price ceilings, I do

think that a competitive market kinda solves itself in some regards.

And we do have economies of scale in the state of Connecticut, we have six carriers that are at parity with each other with from a network perspective, and they're competing for a small slice of the state for membership. And, you know, I would prefer a look to deregulate some areas where, you know, they're forced to pass through many of the assessments and taxes that this body is considering.

SENATOR HWANG (28TH): Yeah. And my second question is, you work with insurers, and in at times they have a well-deserved bad rap. Because they're always the people saying no, and all the rationales as why people aren't able to get care and coverage. But in your experience, working with not just the six carriers that you talked about, but also with Medicare programs and government and entity programs. Who would you still rather be able to do business with from a consumer, as well as a product availability standpoint?

Because one of the things I've learned is we have Medicare, Medicaid products. But we also have a supplement of Part B, Part C, Part D; part F, to supplement what is provided.

So the idea of a government program isn't always having its promise. Would that be a fair statement?

NEIL ROBERTS: Yes. Yeah, absolutely, you know, and I agree, there's, it's not a one -- healthcare, it's definitely not a one size fits all. I mean, you know, it's even within my own family, you know, I look at my health care needs versus, you know, maybe my sisters or my parents, and, you know, really everyone has different health care needs.

And so, you know, employers are really tasked with that I work specifically with mostly larger group employers. And so, you know, there are options in

the market, you know, aside from just the six payers on a fully insured basis that, you know, employers need to get creative, and I think they have, and they've had they've been forced to.

But again, I think, you know, some of the creativity and innovation that's come out of, you know, that market and some of the cost containment ideas that are available to employers are not born from government policy.

They're born from, you know, private sector, developing these products to gain a market share.

SENATOR HWANG (28TH): And I think my last question would be from the standpoint of regulatory. Every single one of the products are reviewed by the Department of Insurance and meeting compliance, right? And would you say, how many years have you been in the business?

NEIL ROBERTS: 18.

SENATOR HWANG (28TH): 18, so you have seen prior to the Affordable Care Act, forever and its challenges to be. One of the benefits for me has always been that preexisting conditions are now required to be covered.

Is that not a critical, essential element of health insurance coverage right now, that there is no going back, and it is an essential, human right on that?

NEIL ROBERTS: Yes, I agree to that.

SENATOR HWANG (28TH): Right, and --

NEIL ROBERTS: Under preexisting condition alone. Yes.

SENATOR HWANG (28TH): Right. And any possible consideration that would create an adverse selection in an insurance product is something that is

tantamount to going back significantly. Would that be fair to say?

NEIL ROBERTS: Yes.

SENATOR HWANG (28TH): Thank you. Thank you, Madam Chair. I appreciate your time. And thank you for your service as a liaison and interaction for many people that are experiencing challenges in health insurance and giving them answers, and feedback and collaborating with them. Thank you very much. Thank you, Madam Chair.

REP. COMEY (102ND): Thank you, Senator. I'm just going to jump in or Representative Wood. Representative Nuccio.

REP. NUCCIO (53RD): Thank you, Madam Chair. I'm sorry, Sir, did you say you were an underwriter or an actuary?

NEIL ROBERTS: Underwriter by training.

REP. NUCCIO (53RD): That's okay. I really appreciate an underwriter in a conversation like this. So you brought up -- well, first of all, to Senator Hwang's point, I actually think the state of Connecticut, I could be wrong, but I'm 99.9% sure that preexisting conditions were covered in the state of Connecticut prior to ACA.

We already had legislation that said that we could not discriminate against preexisting conditions. So you're right, it does go back a very long time. But that wasn't my question for you. So you brought up a very good point, the state's plan is often touted as you know, a more efficient, not efficient, but a less expensive plan.

But part of that is, in fact, due to the fact that the very first thing, most of these, actually all of these legislations have done as exempt themselves from it.

So all of these assessments and premium fees, and all these other things that get passed on to regular insurers are not applicable to government plans. The first thing we do is exempt themselves.

So thank you for bringing that up, because I think that is a, it's a very important piece of all of this, to understand. And with all of these pieces of legislation, like you said, it's going to shift costs from one to the other. You know, if you talk to providers or anything, anybody else if Medicare pays 80 cents on $1, they're recovering those 20 cents on another populace.

So thank you for bringing that up. Would you say the drug portion of this Bill though, are you in favor of the drug piece of the legislation?

NEIL ROBERTS: You know, my own personal principles to that is I still you know, I'm -- I understand that Drugs save lives. And that, you know, we want access for people, we want it to be at an affordable rate.

And I do think there's a place for, you know, some of these programs, but, you know, I also see the private sector side and there can be competition, you know, and that's what we've developed. And instead, my agencies, you know, you don't, you're not forced to work with one PBM. You're not forced to work within the confines of one option.

And so, there are many products out there that can solve for that through competition. So, you know, I don't believe in price fixing. I just think that it affects supply and demand in the market. And I would prefer it to be a freer competition.

REP. NUCCIO (53RD): Thank you. Thank you for your input. And thank you, Madam Chair.

REP. COMEY (102ND): Thank you, Representative. Any other questions for Mr. Roberts? Okay, seeing none, thank you so much for coming.

NEIL ROBERTS: Thank you for having me.

REP. COMEY (102ND): Next, on the list, we have Representative Turco. Welcome to the Insurance and Real Estate Committee.

REP. TURCO (27TH): Thank you very much for having me. Senator Lesser and Representative Wood, Senator Hwang and Representative Pavalock-D'Amato, and all of my colleagues. Really great to see you and I thank you for this opportunity.

I'm here to testify on Senate Bill 1004. This is AN ACT CONCERNING DENTAL AND VISION INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN.

And I know some of you, I've seen Representative Dathan here, and, of course, Senator Lesser and many of you are familiar with this Bill. It's been in front of the committee before I strongly supported it the last two years that I was on the Insurance and Real Estate Committee.

But I know some of you were new to the Committee, so let me just tell you why I think this is a very important Bill, and I'm hoping that you'll pass it out of the Committee and we can get it all the way through to the House and the Senate and the Governor's desk this year.

This Bill helps young people in every single one of the communities we represent in the entire state. It's working towards helping expand access to affordable and vital dental and vision services to young people who cannot get these benefits from an employer.

Now, State Representative Michelle Koch is going to share with you, if she testifies today, I know you have a lot of other people that are going to testify, some personal stories, stories about young people, either after graduating high school, after graduating college, or going out into the workforce didn't get a job that offered them dental benefits, vision benefits, and some of the life threatening illnesses that resulted because of that.

They weren't able to afford chronic treatments that they needed; they weren't able to get preventative oral health care that they needed. You put that off for many years, it will catch up to you.

Not having proper oral care can result in heart disease, it makes it's necessary for treating diabetes and other conditioners. I see we have, you know, Senator and Dr. Anwar here, who can educate us on how important oral health care specifically is a vision too.

So we have an opportunity with passing this Bill that will allow individuals young people to stay if they're able to on their parent's insurance policies until the age of 26. This already happens with medical health insurance, as you know, in Connecticut, we passed this in 2008. And then a couple years later, the Affordable Health Care Act did this for the entire nation.

If you're graduated from school, you can -- if you're under your parents' health insurance, you can stay until you're 26. And then hopefully at that time, you can get your own insurance through an employer. But dental and vision for some reason weren't included. And they should have been because they are healthcare as well. And there's dire consequences if somebody is not getting the care they need in those areas.

So I've submitted written testimony goes into some more detail. I know you have a lot of people

testifying today that will tell you a personal story about why this is important.

I've spoken to many constituents of mine and knowing 10 young people without dental insurance that this will help. And I promise you, it's going to help every single person, it's gonna help individuals in every single one of your communities, and it actually will help save lives.

And how often can we really say that a push to that green button a yes vote is actually saving lives of our constituents. So I open it to any questions. And thanks again for this opportunity.

REP. WOOD (141ST): Great, thank you any questions? Thank you, Representative Turco.

REP. TURCO (27TH): Thank you. Have a great day.

REP. WOOD (141ST): I made an error. So I'd like to apologize that I skipped over john Burkhart from Pfizer is John available? So John Burkhart is next followed by Representative Dillon. Okay, we'll come back to John. Representative Dillon.

REP. DILLON (92ND): Thank you, Madam Chair. I was waiting. And thank you, Chairman and Ranking Members and esteemed Members to the Committee. I'm Representative Pat Dillon from the 92nd district in New Haven. I'm here to testify in support of raised Bill, Senate 1008.

You may have gotten my testimony today. We were on Environment yesterday for 12 hours, so I was challenged today. But this is terribly important. Because as time went on, during this pandemic, it became clear that at least in the United States, there was a disproportionate toll being taken on communities of color.

And I think as public policy makers, it's really incumbent on us to unpack that and to figure out how

it happened. One of the things that I learned when I was researching this summer was that this little device a pulse oximeter, which some of you may know or not know. And I'll hold it up. Which is very common and available, whether it's approved by the FDA or not, because it's so common, was very often being used to, to discern the acuity of, of the condition of the patient. And sometimes decisions were being made on that, medical decisions.

As long as 2005, it was clear that, with a pulse oximeter, the measurement is less often accurate, if your skin is brown, and that really has nothing to do with anyone's bad intent.

It's simply the science of it, the light pulses through your skin. And, unfortunately, nothing was done about it. This is most important when it comes to insurance coverage, which is why it comes here. I'm not seeking to regulate the device because a lot of that really went out the door, especially when the FDA law changed in 1997.

You can get this on Amazon and it may not even be a good quality device. What we're concerned about is Medicare decides whether or not you're -- how sick you are based on your blood oxygen. And 90 is very often the cutoff.

Unfortunately, if this device tells you 90 it's really an estimate. And that may mean that you're deprived of home oxygen, because many private insurers copy Medicare, because it's easier.

It seemed to me as a state legislator, there's, there are limited things we can do. But one thing we could do is to say that you cannot deny care to an individual of a service that would be otherwise covered.

Unless -- based solely on the reading from the over the counter device, the pulse oximeter, that doesn't mean that everyone has to have arterial blood.

It doesn't mean, it doesn't this way, it doesn't really tell any doctor what to do or any hospital. It does say though, that if you get a blood oxygen 90, it may very well be 86, and you may deserve care that you're being denied if there's a rigid algorithm.

So that's what the language does. And I need to say the after I consulted with some people, I was really advised by a lot, a number of people not to do legislation.

And the reason is there was so much skepticism about vaccines, that people were afraid that we would scare people. And as the pandemic wear on, it seemed to me, and especially in December, when an article in the New England Journal of Medicine, which I linked in my testimony, demonstrated that African American patients, in a very large study were three times more likely to get an inaccurate reading. It seemed to me that we were at risk of denying people of badly needed care.

I can't claim that that net resulted in their death, but that's not the only outcome. They could end up with, with severe illness going forward, or some kind of heart damage.

These can provide tremendous comfort to you. They were comfort to my family during my father in law's illness we were able to get a reading from him every day, and we had an idea of what was going on.

So that I don't want to disparage the devices. But we need to, we need to make sure that we don't overstate their importance, and that we understand their limitations.

If you have any questions, I'll be happy to answer them. And thank you very much for having me.

REP. COMEY (102ND): Thank you, Representative Dillon, Senator Lesser.

SENATOR LESSER (9TH): Thank you Madam Chair and thank you, Representative Dillon, we're, as you stated in the middle of a health equity crisis, in the middle of a healthcare crisis.

And this is a small important issue that you raised. And so I want to thank you for that. Just had a question about some of the testimony we received from the hospital association. They recommended one looping in the Department of Consumer Protection, which regulates pharmacies and pharmacists.

And then also suggested as well, making sure that the Bill doesn't just apply to insured to people but all patients in the state. Is that -- are those suggestions that you would use friendly changes?

REP. DILLON (92ND): Well, as I mentioned, Senator, really since 1997, when the FDA statue became more of a marketing statute than a safety statute, there's been more direct marketing to patients, that's when you started seeing prescription drug ads on television.

And there were a whole lot of complex changes in the law, partly a consequence of that, and partly because they're easier to manufacture. When it comes to regulating these devices, I think the horses out of the barn, and we can very well as a matter of courtesy include the consumer protection, people in Connecticut, but it's unlikely they'll be able to do very much.

I mean, if -- when I was worried at the end of March about what was happening in New York, I got one of these devices on the -- I ordered one from Amazon, I didn't get it until May, because there was such demand that was almost as bad as the mask.

But I wouldn't have known necessarily, I couldn't buy something, whether it was FDA approved or not. And that was really why I took the course of making sure that no one is to denied care, and also trying to provide information to providers.

So I did not do that. I was more concerned about preserving life and reducing debility, but if the Chairs in the Committee want to do that, I that isn't necessarily something that's essential to me. It's just that I didn't think it was needed.

SENATOR LESSER (9TH): Thank you.

REP. WOOD (141ST): Any other questions? Great, Thank you, Representative Dillon. Okay, do we have the John Burkhardt come on?

JOHN BURKHARDT: Hi, can you hear me?

REP. WOOD (141ST): Yes. Thank you, John.

JOHN BURKHARDT: Thank you. I had a little technical difficulty earlier so apologies for that. Co-Chairs Lesser and Wood Ranking Members, Hwang, Pavalock-D'Amato, and all the Members of the Committee, thank you for inviting me today.

My name is John Burkhardt. I'm head of the site for rottens R&D, in Pfizer in Connecticut. Pfizer is proud to call Groton home to research for 62 years, and is currently Pfizer's largest R&D center anywhere in the world.

More than 2700 R&D professionals work at this site, as well as the New Haven Clinical Research Unit. Every medicine or therapeutic that Pfizer develops, comes through our ground facility at some point, and many were discovered right here.

This past year has been like nothing we have seen in our lifetimes. When the COVID pandemic struck, Pfizer colleagues immediately went to work.

We formed research and manufacturing teams and created distribution partnerships, collaborated to help solve this unprecedented public health crisis. Since receiving emergency use authorization from the FDA, Pfizer has shipped the US more than 50 million doses of the Pfizer Biontech vaccine. And we're on track to deliver well over 300 million doses by the end of July. In Connecticut, we'd have shipped 1.4 million doses.

I'm proud of the role of Pfizer and thousands of our colleagues in Gratins, for continuing to play and bringing our COVID-19 vaccine to the world. Currently, our Groton site manufacturers a critical liquid component used in vaccine production, and we have contributed to over 113 million doses.

With that introduction, I'm here to respectfully oppose House Bill 6447, AN ACT CREATING THE COVERED CONNECTICUT PROGRAM TO EXPAND ACCESS TO AFFORDABLE HEALTH CARE.

Well, we can all agree that the title of the Bill is something to which we aspire. This Legislation assumes incorrectly that there is disproportionate spending on prescription drugs.

It wrongly asserts that innovative manufacturers should be penalized and naively assumed that biopharmaceutical manufacturers determine the price that a patient pays at the pharmacy.

Here in Connecticut, standing on hospitals and physicians accounts for 60% of healthcare spending. Whereas drugs only account for 15%, administrative fees and insurance company products account for over 1/5 of healthcare spending.

This Legislation singles out the biopharmaceutical manufacturers, who are delivering lifesaving innovations and ignores inefficiencies in the drug supply chain. Excuse me, my phone rang.

REP. WOOD (141ST): John, you've completed your three minutes, if you could just wrap it up, that'd be great.

JOHN BURKHARDT: Okay. The middlemen scrape off 42 cents on every dollar spent for prescription drugs in the US. And it feels patience by not lowering the price.

The price setting diminishes incentive for us to invest in R&D, penalizes us for these efforts. Pfizer stands ready to work with the Legislature to develop solutions that help patients better afford their medicine.

I'm asking you to reject the price controls and address the systemic problems. Thank you for the work that you do. And thank you for inviting me here today.

REP. WOOD (141ST): Thanks, John. When you say middlemen, who are you referring to? Are you referring to PBMs, or you are referring to what?

JOHN BURKHARDT: Yes, thank you. It's to me it's a murky middle that involves probably all of the above insurance companies and pharmacy benefit managers, or PBMs.

REP. WOOD (141ST): And so you believe that dealing with the middlemen would drastically reduce cost?

JOHN BURKHARDT: Oh, could you say that again?

REP. WOOD (141ST): Do you believe that dealing with the middlemen, you know, whatever entities that may be would help reduce cost?

JOHN BURKHARDT: Oh, I believe its complex. And that list price of drug is a small part of the overall picture. And that something that's more holistic about looking at pricing and looking about what

patients pay at the pharmacy counter, it would be a more productive way to go.

REP. COMEY (102ND): Thank you, Senator Lesser.

SENATOR LESSER (9TH): Thank you Madam Chair, and I guess I can't have-- gentleman from, in charge of research at Pfizer in front of the Committee without saying, first of all, I think all of us want to thank your company for its work in helping us get through the biggest healthcare crisis we've ever had to deal with. So thank you for, for that work.

One of the things that I'm struck by though is that, obviously, we have been the beneficiary of huge amounts of pharmaceutical innovation.

But that the places in the pharmacy market where you've seen huge increases in drug spender not necessarily aligned with innovation.

Are there other steps that we could take to; you know, more closely align innovation and market rewards? You know, I know that other countries have different approaches, or their steps that Connecticut, or the US can take that with more closely aligned innovation?

JOHN BURKHARDT: Yeah, that's a great question. And I have benefit and, and pride in working for a company that's, you know, highly innovative. So over 80%, of all of these products that we have in development would be no first in class, they would be the first drug to hit that target, and bring transformational care to patients.

So, you know, we're very much interested in tying benefit to patients and innovation, to pricing, that might be, you know, the patient pays for what they're getting. And part of -- a big part of that pay is for the innovation that R&D has, has created. And the interesting examples, with the EpiPen, for example, you know, are in stark contrast to that.

SENATOR LESSER (9TH): Right? So what do we do about that? Because the EpiPen has been the same for 30 years, and the price keeps going up, where your company is being is investing in, in new vaccines, new treatments, obviously, we want to reward that R&D.

But to my mind, I look at it the EpiPen I see a market value, right? The market is not responding in a way that, you know, either because of regulatory barriers or something the market is not responding in prices. [cross-talk] How do we fix them?

JOHN BURKHARDT: I think it's a great point that there are various levels of innovation. And it illustrates the complexity about what you're dealing with. So, I think it gets back to really an interest to sort through that complexity, and look for real solutions.

You know, here's an example of that complexity. I don't know how it would play out in the Bill, is we are looking at a booster dose of the vaccine; we're looking at a new construct that would address the South African variants, as an example.

Is that a new product? Or is that the existing vaccine? Is it going to be easy to solve that problem of creating new variants is going to be very difficult?

It's, you know, we don't know the answers to some of those questions are very technical in nature. And there's complexity and biology, we don't know how those will play out.

So I wouldn't want to be, you know, hamstrung by a Legislation that's written for generics. But then it's applied to this very complex type of technical situation that I've tried to outline. We need to sort through that.

SENATOR LESSER (9TH): Okay, but you don't have a specific proposal for us to look at, right?

JOHN BURKHARDT: The R&D guys. I've got people in the company or, you know, perhaps working on that. So I'll make sure that they are aware.

SENATOR LESSER (9TH): I think I speak for everyone on the Committee, Democratic, Republican, what have you? We think we all want more money going into R&D, right, that is our edge as a country.

And I think my frustration and I suspect that's true of other folks on the Committee as well, is that in some cases, there's a lot of rent seeking and not the kind of R&D.

And so there are pockets of innovation you are at the center of one, no argument there. But we want more of that. And I think the question is how to add an element.

So I don't know if other folks from the regulatory side are coming up to you but we're still looking for potential options and we certainly appreciate your testimony.

JOHN BURKHARDT: Thank you; your questions illustrate that complexity, very well.

SENATOR LESSER (9TH): And I apologize, I will turn it over and back to the Chairwoman, but I understand that there were some manufacturing issues with EpiPens that were specific to some manufactured by Pfizer. Do you have any insight into that specific issue?

JOHN BURKHARDT: That's a good question. And I do not have insight into that.

REP. WOOD (141ST): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. Mr. Burkhardt, thank you so much for being here, and the fact that you we have a sight, you know, head for it and the R&D coming to testify in front of us, we are indeed very honored.

And obviously, it denotes the seriousness that your organization considers this proposal and impacting your ability to do business.

I think it's really important for us to take acknowledge and appreciate what you've said in regards that there are bad actors, that move away from the model of value to innovation and a fair market value for what you do.

I really appreciate you saying that because, in talking to the many scientists that I know, you have one mission, and that is to research and innovate, lifesaving solutions.

So I want to acknowledge that and not get lost in regards to some of the bad actors that that taint the pool.

That being said, I do want to ask, from a standpoint, what do you think would be an alternative solution to containing prescription drug cost, and what is Pfizer done in that regard? Because you're keenly aware, nearly 62 years in the state of Connecticut, and we want to make it another 62 years.

But what are some of the concerns that you have and thought processes as an organization to contain cost and deliver care? I'll give you a great example, right?

Your work right now in collaborating with state and federal authorities to deliver your COVID vaccine, there's tremendous demand, you could be price gouging on this, you're providing a fair share cost to an incredible community service. What solutions

can you share with us from the grassroots and the significant shareholders?

JOHN BURKHARDT: Sure, the kinds of things that, you know, that I'm hearing discussed, you know, it gets back, probably, it's key that there's value for the patients, and that patient pays for performance.

That the drug delivers, delivers the value, and, you know, that's what's being reimbursed, you know, back to us. We are entirely sensitive about prices that patients are paying at the pharmacy.

We are concerned about the nearly half of the cost, that the patient pays that that doesn't come to us. We discovered manufactured and developed the drug or the treatment, and then nearly half of the revenue is going to those who did not.

And so I think this gets back to a holistic, you know, approach to looking at where does the money go? How can we structure payment for patients, so that our drugs can get to them?

And I've been not pretending to think that that's an easy problem to solve. It certainly is not.

SENATOR HWANG (28TH): Listen, Mr. Burkhardt, you can find an incredible solution to the COVID vaccine, which to me is tantamount to putting a person in the moon in less than a year. But even you wouldn't want to dare to go into solving the health insurance cost basis. So you're very indeed, much smarter than all of us.

JOHN BURKHARDT: As a scientist, I would not.

SENATOR HWANG (28TH): Well, as I said to the Governor's staff and this is a long standing solution. And it's an entire ecosystem solution. I was simply offered to say this, the best thing I can leave you on this whole conversation and it is not lost on me the significance of having you testified

from your busy schedule, is that the offering by the Governor's office, to have their door open to you and to the leaders of your organization to engage in a conversation.

So the willingness to collaborate and talk about creating solutions is the positive thing that I can leave with you. The other thing I want to acknowledge is the fact that Mr. Ken Hisco, who is your head of Government Affairs, has been instrumental in being in touch with people.

Not only was Pfizer instrumental in being the first out with regards to a vaccine that will save many lives, but your work and collaborating with government entities in your rollout and distribution, you don't hear a lot about it, but your organization and all the various entities work so very closely, to make sure that the product is delivered to entities that need them.

So I wanted to send out kudos to you, your organization and Ken for their great work and communicating with all of us. Those are the things that don't get hurt. So thank you, Madam Chair. Thank you for the opportunity to give a big thanks to a Connecticut institution that's really saving lives. So thank you, Ma'am.

REP. WOOD (141ST): Thank you, Senator.

REP. WOOD (141ST): Representative Nuccio.

REP. NUCCIO (53RD): Thank you, Madam Chair. Good afternoon, Mr. Burkhardt. How are you?

JOHN BURKHARDT: Yeah, fine. Thank you.

REP. NUCCIO (53RD): Good. I would like to also reiterate what Senator Lesser and Senator Hwang said, and thank you for the work that you've done on the vaccine.

You brought up; you mentioned something that I wrote down immediately in regard to generics. Would you be -- do you think your company would be more amenable if this Legislation focused more in on the generic market and established drugs, while still giving you the latitude to be able to, to create a cost structure for R&D for newer drugs? Would that be more amenable to your company think?

JOHN BURKHARDT: You know, look, I probably shouldn't pick and choose parts of the legislation, you know, for that, particularly on behalf of others. But going back to some of the earlier commentary is keeping innovation in mind transformative treatment to patients; those are the things very much on our mind.

And this gets to that complexity that I think we were talking about earlier about pricing, co-pays, middlemen, etc. So I think there's something there, I'm not sure exactly what it is.

REP. NUCCIO (53RD): So, I find that I find that interesting, because the stuff that we talked about, and that we definitely focus in on is of course, you know, epinephrine, insulin, you know, drugs that have been around for a significant amount of time, where we've seen the cost structure increase.

And they're also drugs that are, you know, they're lifesaving life requiring drugs. So to see those drugs go up as much as they do, those are something that would fall into the generic realm. While innovation, you know, R&D in the pharmaceutical area is probably one of the most important R&DS that happens. So you don't want to stifle R&D.

So you mentioned that you're only seeing 40 something cents on the dollar at where you are. So -

JOHN BURKHARDT: We're saving, the 58%.

REP. NUCCIO (53RD): Oh, you're saving 58%? Okay. All right, and would you have, I know, you said you're not the finance end of this, but you know, we all talk around the water cooler.

So is there anybody -- is there anything that you could think of that would help to bring the costs in line? Are you suggesting that you guys should see more or that we should reduce the costs depending on the structure of who's getting what?

JOHN BURKHARDT: Yeah, I think it's just a convoluted structure between what we publish as a list price for a drug, and what the patient pays at the pharmacy.

There's a muddy middle there that, you know, I haven't studied in great detail, and you have uncertainty about it. And I think if we all studied up on that, and looked at that, with a view to benefit patients, that would be that would be really good.

REP. NUCCIO (53RD): Okay, great. Thank you very much for your, for your answers. I appreciate your time.

JOHN BURKHARDT: And you know, what, you know, one of one of those things that, that you'll hear people discuss is the rebate. So we're under pressure to increase those prices and then rebate to the PBMs increasingly large prices. You know, could that go to the patient? Wouldn't that be a winning day for a patient to receive the rebates that we are paying?

REP. NUCCIO (53RD): I agree, you know, the PBM market, there's definitely room in there, I think with in regard to rebate. So I encourage you to bring that if your company comes forward to speak to the Governor to bring that idea forward. Thank you for your time. I appreciate it.

JOHN BURKHARDT: Thank you.

REP. WOOD (141ST): Representative Meskers.

REP. MESKERS (150TH): Yeah, I want to thank you for your testimony. My sister is -- runs a mesothelioma foundation. The advances in cancer research, the advances in medicine are, need to be championed brown with a roundly and supported profoundly.

There's no question that I have a tremendous amount of respect for the research component of the pharmaceutical industry. You know, I think that the questions that we asked you tend to be those questions which are difficult beyond belief.

We start talking about pricing, and we can't figure out what the retail and wholesale price and profit margin is, because there's four different hands in the middle. And then we go to international drug pricing, and we find that there are material significant profoundly different prices for the same drug, which is manufactured in India or in China and sold in, you know, New York or London or Geneva or Rome, or Toronto.

And you -- and we all see the same stories about people driving across the border to get basic medicines, because they have trouble.

So I think the Bill represents our attempt to deal with one aspect of that pricing mechanism, which is the pricing of existing drugs, which suggests that, you know, those increases in prices will -- they'll have to be other revenue sources to fund research, you know, which come to us tax policy, which come from grants from the US Government, where a lot of that research is ultimately funded and owned.

And I, I just feel that we're at a breaking point, that you're, you're in front of us, because the industry insurance industry is at a breaking point.

We talk about a 7% compounding rate per year, or 8%, or 9%, on the insurance Bill, which is a combination of how hospitals and pharmacies, and with those kind of compounded rates, people are going to be spending more, you're gonna be spending 30, 40 and 50,000 a year for private insurance to cover their costs.

So until we figure the comprehensive cost containment, we're all in the same boat. And I'm sympathetic to the industry, and I'm sympathetic to the industry is concerned that they're being targeted.

But we've got two components, we've got basically three components, we've got the insurance industry, which everyone loves to hate, which is about 10% of the Bill. 90% of the Bill is split between pharmaceuticals and hospitals.

And those costs in the United States are approximately twice what they are in most of the OECD countries. So there will be pressure one way or the other for cost containment.

I think the governor's attempt is reasonable on the pharmaceuticals, I'm sure if I was, I wouldn't be standing here supporting if I was in the pharmaceutical industry, but I just don't see a way around it. I think it's a rational approach to try to improve things. But I thank you for your testimony.

REP. WOOD (141ST): Any other question? Thank you, Mr. Burkhardt for joining us. We really appreciate your time.

JOHN BURKHARDT: Thank you for having me.

REP. WOOD (141ST): Next is Representative Jillian Gilchrest. Is Representative Gilchrest here? Okay, we will go to Paige Mahaney.

COLLEEN BRUNETTI: Madam Chair.

REP. WOOD (141ST): Yep.

COLLEEN BRUNETTI: Hi, I'm Colleen Brunetti. I'm with Representative Gilchrest today. I don't know if she has control over the account from her end. But we were here in waiting.

REP. WOOD (141ST): Okay. You can go and you have three minutes. Thank you.

COLLEEN BRUNETTI: All right. Thank you very much. Good afternoon, everyone. I'm here to speak in support of Senate Bill number 1003 regarding co-pay accumulator models. Before I start, I just want to take a moment to thank Representative Gilchrest for her unwavering support to me over the last three years on this issue, to the Committee if you're hearing from the public today and to Senator Anwar for putting forth this Bill.

Thirteen years ago, I was diagnosed with a rare progressive and incurable lung disease called pulmonary arterial hypertension or PH for short.

Back then average survival rates gave me three to five years to live. Since day one, I've been under the care of excellent specialists at UConn Health Center.

I've beaten the odds by taking a variety of aggressive and very expensive medications. Up until four years ago, I was able to access the incredible cost of these medications using a variety of assistance programs, including manufacturer co-pay cards.

To give you an idea before insurance, my medications will easily fall in the $250,000 a year range. And that's before I see a doctor or get a test. All of that changed when my insurance company flipped to an accumulator model, while we were also on a high deductible plan.

Some of the medications I could want before it became one more out of reach. My personal out of pocket costs ballooned to $7,400, and more, all due in January for one co-pay of one month of one medication.

Because my overall yearly costs are so staggering, even if I had implemented that copay card and it wasn't applied to my high deductible. I was now on the hook for that money, no matter how you sliced it.

Insurance companies have found that only way to squeeze more money out of costly patients like myself. But from where I sit, it looks like they're double dipping. They now fully benefit from the co-pay card amount, plus my high deductible.
I'm no longer the beneficiary of the copay card program as intended and instead a huge and very wealthy company, is. To me this feels like a new way to discriminate against those with costly preexisting conditions.

It feels morally wrong to say the least, but it remains legal unless we change it. I'd like to look at some overall issues around co-pay accumulators to the public at large. I reviewed the current language on the Bill and I'm heartened by its broad nature.

I want to emphasize that some of the language and other states has referenced generics. And I want to encourage the Committee to continue not to do so. In the rare disease space generics really end up being truly cost saving for patients and when the PH world have seen several patients physically impacted for the worse when forced to make a switch.

In my four years working on this co-pay issue, I've often heard insurance companies, Pharmacy Benefits managers and manufacturers try to banter back and forth over high cost of drugs, ballooning health care costs, and finger pointing over who is

ultimately responsible for this part of our broken healthcare system.

My response to this is that that conversation is misplaced on this issue. When that is the focus of these copay accumulator conversation, the patient remains the collateral damage.

If we want to address industry costs, I encourage them to do so elsewhere. Like in other Bills discuss today? The job here specific to co-pay cards is to protect and support the patient.

Should co-pay accumulator stay in play, there's a real fear that patients will be forced to ration their medications, abandon prescriptions, and ultimately increase higher risk and costs because they can no longer afford their medications.

There's an even higher risk of these issues for vulnerable and underserved populations who already have significant income and access challenges.

From my research, I know you'll find a great deal of public support to deal with copay accumulators. In conclusion, I want to thank you again for the opportunity to address you today and wholeheartedly encourage the passing of this Bill doing away with co-pay accumulators.

Connecticut has long taken a lead in proactive patient protections and we have had the opportunity to do so again now helping countless individuals and setting precedents for states around the country to follow. Thank you.

REP. GILCHREST (18TH): And I just want to say I'm sorry, I was late. Thank you to the committee for allowing Colleen and myself to testify.

REP. COMEY (102ND): Thank you, Representative Gilchrest, and thank you Colleen Brunetti, for your

story. Do we have any questions? Representative Farrar.

REP. FARRAR (20TH): Thank you, Chairwoman Comey. Colleen, thank you so much for being here today. I know that you and Representative Gilchrest have really led the way and with Senator Anwar's Bill.

I am hopeful that this year could be the year that we not only help you, but so many folks in your particular situation, which again, at the end of the day, you're just trying to get health care and stay alive. And that should be a simple approach.

I had one question because you referenced some other states and the language that was in our Bill. And I wanted to make sure to clear up why it was important. It sounded like to you that we do not include generics in this Bill, since that does show up in other states.

COLLEEN BRUNETTI: Sure, so we have some data for you here. See, so generic drugs, according to NORD, the National Organization for rare diseases account for nearly 90% of all prescriptions written.

But the manufacturer coupons incentivize brand name drugs at the fear that that is the case. The majority of co-pay assistance program are for drugs that have no generic equivalents.

So in the rare disease space, you often either have no treatment or only a couple or there are not generics. So allowing for generics doesn't necessarily help in that sense. And they go on to say that the 13% of branded drugs which generic equivalents products were available, accounted for only .05 of all prescription fields.

We've also seen time and time again, because there are generics for pulmonary hypertension drugs now that patients are they're not saving significant amount of money that would impact their overall

ability to pay or in fact, their costs have gone up substantially, because not on a copay accumulator model, the co-pay cards no longer exist with generics.

So it's a fairly nuanced issue. And we just have not found that relying on generics to cut costs for the rare disease space has been helpful.

REP. FARRAR (20TH): Thank you for sharing that, you know, from your own personal perspective. And then as you said, what's been seen nationwide, you know, and as someone you know, who is not in, you know, the circumstance that you're in at this moment, and it's just getting to know as some other Members on this Committee might about co-pay accumulators. How would a patient even come to know that these exist?

COLLEEN BRUNETTI: So it very much seems to depend on who your insurance carrier is. And what we know for certain is that it's not always very transparent. So if you called and said I'm shopping plans, X, Y, and Z, do they have a co-pay accumulator attached to them? It might not be called a co-pay accumulator.

I found three different companies with three vastly different names for them. So the rep may very well say no, we don't when, in fact, they have something that is the equivalent.

So it makes it very difficult for patients to make an informed decision and choose the most cost beneficial plan for them.

REP. FARRAR (20TH): Thank you for noting that because I think in navigating healthcare, you know, we, we often lose sight of sometimes not just how difficult it is to seek care, but sometimes, as you noted that things could be called very different things with different providers, and we could be really missing how this can play out in our own lives in regards to cost of care.

I just want to thank you Colleen again, for persisting in this Bill, not just for yourself, but so many others. And I really look forward to supporting it and encourage my colleagues to do the same. So thank you Chairwoman.

REP. COMEY (102ND): Thank you, Representative, Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And thank you for sharing your story and to Representative Gilchrist for being such an incredible advocate on this issue.

I do want to just also note, you mentioned that Senator Anwar introduced Legislation on this and that's true. But I also wanted to point out that Senator Looney who's the Senate President introduced this specific Bill as well.

So I just wanted to make sure that Senator Looney got some credit for that as well. But it's all good, it’s all good.

There were some comments that we got that from industry that said that co-pay accumulators were prohibited for prescription drug companies, obviously, there's a fight between drug companies and PBMs.

And an insurer -- and I didn't know if you had any anything for us to sort of get our heads around this, because we see patients like you who are obviously hurt by this practice.

And the always the fear, whenever you're talking about health policies, why is it that consumers are in the middle of these guys?

COLLEEN BRUNETTI: Well, we have perhaps the quietest voice at the table quite often. And it's, you know, it's difficult to get a patient who will

be able to come and do this, and speak to folks like yourselves, we don't have large lobbyists.

And the numbers are so staggering. That it I think that the reality of what it looks like for the average American family, or worse, the low income family is it's hard to catch unless you start to hear individual stories.

But to me as a patient, all I know is how this hurt my family and what it did to our budget. And I don't have a lot of sympathy for the finger pointing. Because as it gets batted back and forth, you know, we're not gonna, we're not gonna solve high and ballooning drug costs by addressing co-pay accumulators, we're going to help patients and help families by addressing co-pay accumulators.

And so I would like to see the conversation very compartmentalized, because yes, there's absolutely a place to talk about all of those things but the issue here is what is happening right now to Connecticut families.

SENATOR LESSER (9TH): Thank you for your testimony.

COLLEEN BRUNETTI: Thank you.

REP. COMEY (102ND): Thank you very much, any other questions? Well, thank you for coming to visit us and continue your good work advocating for this and other policies that will hopefully improve, improve the quality of care that you get and affordability. So thank you.

COLLEEN BRUNETTI: I appreciate the time.

REP. COMEY (102ND): Thank you. Senator Lesser, would you like me to continue on his chair?

SENATOR LESSER (9TH): You're doing a great job.

REP. COMEY (102ND): Okay, next up we have Paige Mahaney.

PAIGE MAHANEY: Yeah, hello. Hi, I'm here.

REP. COMEY (102ND): Okay.

PAIGE MAHANEY: Great to see you, so good afternoon Representatives, Wood and Pavalock-D'Amato, and senators Lesser and Hwang and Members of the Insurance and Real Estate Committee.

My name is Paige Mahaney and I'm head of research for the US for Boehringer Ingelheim, pharmaceuticals and I'm here to testify in opposition of Section 6 through 8 on House Bill 6447.

Boehringer Ingelheim, is a private company owned by the same family for more than 135 years, we discover and develop innovative medicines for humans and animals focusing on patients with the highest unmet medical needs.

BI established its US headquarters in Ridgefield, Connecticut in 1971. And it's the largest headquartered pharmaceutical company in Connecticut with more than 2000 employees in the state, and we are adding jobs in R&D over the next three years.

R&D is at the heart of our company. We reinvest the proximately 22% of our net sales back into research and development to ensure future innovation for patients.

This Bill will not help patients. I get it; patients are exhausted with the health insurance system. I hear it from my friends, I hear it from my family, but this Bill will not impact what a patient pays at the pharmacy counter. It oversimplifies an extremely complicated health care system.

For the vast majority of patients the cost of a drug is controlled by their insurance plan. So a price

cap on pharmaceutical companies will not reach the patient, because as you know, patients don't try to buy drugs from the pharmaceutical company they buy them from the pharmacy.

However, the unintended consequences of this proposal are significant and could really hurt patients because it could stifle future breakthrough therapies.

Therapies that are being developed today truly have the potential to transform patients' lives. However, R&D is costly and lengthy.

It takes more than 15 years and $2.5 Billion for one drug to be discovered and be launched. These types of Bills risk industry investments in new therapies for the patients who need them the most.

For example, Boehringer Ingelheim is pursuing research in schizophrenia, a patient population with very high unmet medical needs.

This population also faces very significant socio economic challenges. Incarceration rates are very high and many have a hard time finding jobs and staying employed.

In addition, many are in the Medicaid population. Medicaid has Penny pricing. This means that we make only pennies on medications sold in Medicaid. And in some cases, believe it or not, we actually pay Medicaid to ensure that our medicines are available to patients.

With Bills like these, we might be re -- we might be forced to reevaluate our investments and redirect them away from patients like those with schizophrenia who truly need them.

So in closing, I'm actually very proud of our lab scientists at BI, I cannot tell you how diligently they've worked, advancing their research, even at

the height of the pandemic in their labs. And they've also worked very hard to identify therapies for COVID-19.

It must be said that without the dedicated researchers in the pharmaceutical companies, both in Connecticut and my colleague from Pfizer spoke earlier.

And around the world, the future, our future in a world with COVID-19 would look very different. I want to thank you very much for your time, and I'm happy to answer any questions.

Thank you very much Ms. Mahaney, any questions? Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. You're doing a great job, great to see you Up there doing this as the Chair. Dr. Mahaney, thank you very, very much.

And I appreciate you acknowledging Pfizer and I know in the scientific arena, the competition is very real, but the respect for what you do as colleagues is even more sincere. So I appreciate you acknowledging.

But please tell us, you know, what are the things that you are doing as an entity as an organization in fighting COVID? Because it's not just Pfizer with the vaccine, but it's all of our pharmaceutical and biotech companies that are advocating and supporting in this united fight.

PAIGE MAHANEY: Yeah. So thank you very much, Senator Hwang, for that question. First of all, you know, I think back and I think it's really important, I think back when the pandemic first hit, and I don't know about you, but I was afraid to get -- afraid to go to the grocery store. I was afraid to open the boxes that came from Amazon that were

sitting outside because I was afraid that I might get COVID from the boxes.

But the scientists in our labs came into the lab every day, you know, risking, you know, their health in order to advance our therapies, ongoing research and oncology, ongoing research and immunology, and for COVID.

So we have an antibody, an inhaled antibody in the clinic to combat COVID. And we're also looking for antibodies that could combat the variants the South African variant, for example, the Brazilian variant, for example.

And in addition, we have therapies in the clinic to combat the acute respiratory distress syndrome associated with COVID as well.

So our tissue plasminogen activator, for example, is in phase two, to block the blood clot That you've probably heard about associated with COVID-19 and acute respiratory distress syndrome.

So we are working very hard, along with many of our colleagues around the industry to just help patients through this very difficult disease.

SENATOR HWANG (28TH): And my second question is you are a family owned business?

PAIGE MAHANEY: Yes.

SENATOR HWANG (28TH): The two families Boehringer and Ingelheim, German based so obviously as a multinational organization, and in Europe, there is pre-established kind of drug control systems and cost basis, as well as a unique health insurance kind of a Management Protocol. You have a foot in both systems.

I would very much welcome your perspective to see how we could learn from your German parents and

counterparts to be able to translate some of that prescription drug cost savings and state kind of collaboration to fixing this problem because we want to work with you, not simply blame you.

PAIGE MAHANEY: Thank you very much, I appreciate that. So I know that it's really tempting to compare our systems to compare the German system, for example, with the US system, but they're very, very different.

And I have to say also the same disclaimer as my advisor colleague; I'm also the research person, so I have been working in pharmaceutical research for 25 years. So I'm not as close to this questions as maybe some of my colleagues.

But still, I do know that the German system has a single payer, and they lack many of the what did my colleague call? It murky middle? Middlemen that we have in the US. So I think that that's one very, very important component, we have a much, much more complex system.

But the other thing that I think it's really important for everyone to understand is that the German system determines the value of drugs at the forefront for patients and many drugs that we have on the market in the US are simply not available in Germany.

And I think that this is very dangerous as we are entering more and more a world of personalized medicine, we are talking about in oncology now, but even beyond oncology, we want to match the right drug to the right patient.

And if you think about a disease, let's say just like the think about a disease like cancer, there's not one type of cancer, there are so many types of cancer, and we want to match the right drug for you.

So I think it's very important to understand that the German system determines which drugs can be available based on value to the patient, and just let me just put this into perspective.

My husband is on cholesterol medications, and these are not personalized. But my husband's on cholesterol medication, he had to go through many different standards in order to find the one that worked for him.

He finally found the one that lowered his cholesterol, and the insurance system that he was on, removed it from their formulary.

So as soon as -- he was only able to be on it for a month before it was removed from him, him being it being available to him. And this is kind of a system that we might want to think about in Germany, because they determine value that way.

SENATOR HWANG (28TH): That's a very insightful comparison, and it's important for us to get comparisons. That being said, there are tremendous lore, and I studied and understood that the public option or a state takeover or a one payer system, is alluring, and there are efficiencies, but at what cost to innovation.

And what has made the United States system so unique in the world, is the fact that our system, and maybe it is a factor to our cost. But we have the innovation and the desire to create the best, the fastest, and the pursuit of excellence in healthcare.

And that's why sometimes, when we talk about creating solutions and containing costs, we talked about it at least I talked about a lot that healthcare is deeply personal, that it doesn't fit in a theoretical analysis.

And so I appreciate that contrast, but because it's important to point out that when people make the promises that you will get the same level of care, the same providers, the same type of physicians, the reality may be the marketplace says no.

And that can't be a promise that we're making to over promise and draw people in because the reality of the marketplace has its effect.

So I appreciate that, and I'm gonna say it as a compliment, as I do with every research scientist, it must be obviously very, very important to BI, to have their chief scientist come and testify in front of a bunch of Legislators. It'd be like going to the dentist for me, I guess, in some cases.

So I really want to extend my appreciation, and also offer that in the governor's office testimony earlier, that they are receptive and open to a dialogue with all of our important businesses, and particularly from my colleagues in western Connecticut, Pfizer being one of the biggest employers and economic contributors there.

It should not be taken lightly, so thank you very much. And I appreciate your time. Thank you, Madam Chair.

REP. COMEY (102ND): Thank you very much. Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair, and thank you to the doctor for your testimony today, I appreciate the discussion.

One thing I missed in your initial testimony you did mention steps that have boring going behind might take to reallocate resources, if this Bill were to pass, it was some reference made to the Medicaid program. And I just wanted to see if you if you could sort of expand on what you said. We talk to that as a threat, I'm just running --

PAIGE MAHANEY: No, no, no, no.

SENATOR LESSER (9TH): -- what the book was we were talking about.

PAIGE MAHANEY: So I was just trying to use that as an example, and in for patients where the health economics such as skin patients with schizophrenia in the in the example that I used, there is that risk, is certainly not a threat, we're committed to psychiatric diseases and actually, bi is one of the few pharmaceutical companies has actually remained in in research and psychiatric diseases for the reasons that I described earlier.

So I just use as an example, you know, some of the solutions, I agree with my colleague from Pfizer as well, I think value based contracting is very attractive. Again, we want our drugs to work in the right patients, and we think that patients should pay for performance.

And I also very, very much agree with my colleague from Pfizer that, we have to provide very high rebates to some PB ends just to get our drugs on their formularies for those -- for patients to have access to them.

And those rebates are not passed through to the patient, they see none of those rebates, and if that can be changed, I think it could be a huge benefit to patients.

SENATOR LESSER (9TH): In 2011, Germany adopted, I hate to pursue my colleague Senator Hwang's line of questioning about the German system. But because he did raise, I have to I have to ask in Germany pass the pharmaceutical market restructuring act, and there is a name in German that I'm not going to even begin to attempt to pronounce.

AMNON is the acronym that allows manufacturers to freely set the prices of newly authorized drugs in their first year in the market. But then it does what you just suggested about the provider value based contracting through what's called the benefit assessment during this year, and that is the basis for price negotiations between manufacturers and representatives of the various nonprofit health insurers in Germany.

Is that something? Is that model something that that could work Here? There don't seem to be evidence of increases in launch prices, or I don't know if drugs have been pulled off the German market. But is that something that would be helpful is use suggesting me we should look at value based contracts?

PAIGE MAHANEY: So I am not 100% familiar with that case. But I do think that you have to be careful how benefit is assessed How is value assessed, and I believe in the in the German system value is assessed based by the government not based on the patient's value.

And we want the value based contracting paid for performance being based on we want the drug to work in the patient, not be assessed by the government, and that's very, very dangerous.

SENATOR LESSER (9TH): Because anyone who would obviously everybody wants a drug to work with the patient that that makes sense. But are you saying that the patient is going to be setting the prices? I'm not sure how, how do you -- how would value based pricing work?

PAIGE MAHANEY: Well, its overall performance of the of the drug across a patient population. I don't totally understand how it works. I'm sorry, Senator Lesser but again, I know in Germany, they have a comparator for the drug and that drug that comparator can be quite arbitrary.

So for example, for an arthritis drug that comparator can be physical therapy, not another drug on the on the market, and they could use that as a comparator to determine value. So I think it's very complicated, it seems on the surface like it's, attractive, but there are details there that really don't benefit the patient.

SENATOR LESSER (9TH): Well, thank you, Dr. Mahaney, I appreciate it, your testimony and discussion and I appreciated the conversation that had a number of votes over BI report, thank you Madam.

PAIGE MAHANEY: Thank you very much.

REP. COMEY (102ND): Thank you, Senator, Representative Dathan and thank you for your patience.

REP. DATHAN (142ND): Of course, thank you nice to see there Vice Chair -- acting Chair. I just wanted to follow up I unfortunately didn't get a chance to listen to Pfizer's presentation, because I was on another Committee meeting, but so I'm going to go back to that.

But thank you for coming, Dr. Mahaney, and I'm just wondering, has your organization done studies across different jurisdictions around the world, where they can prove that, you know, restricting drugs is hurting patient outcomes?

I mean, do you have any, I guess one of my concerns is, you know, I've been CFO of pharmaceutical, very small pharmaceutical, early stage R&D companies, and I understand how much we put into companies to find first molecules that work and then take it to the next stage.

And it seems to me, what I've learned, in my time of living in in the US is that the US has funding, you know, the global R&D for all drugs.

And, you know, what I'm hearing from you is that, while other jurisdictions are, limit, what drugs that patients can have, because of their setup, in terms of how their insurance is set up in terms of either single payer public option or private insurance.

And so I'm wondering is there any sort of studies that show that patient's outcomes are not at the optimum, because of this, and have you been able to do any studies as a pharmaceutical company?

PAIGE MAHANEY: So thank you for your question. I'm not aware of those studies, and many of my comments are more anecdotal. So please take them that way. You know, I, but coming back to the right therapy for the right patient, I think it's very, very important to go down that path.

You know, I've heard of anecdotal stories about, you know, oncology drugs not being approved, because they only gave five months, six months more survival.

If you are cancer patient, and you could benefit from that patient and get six months more progression free for survival, for example, I think that's a benefit to you.

But in some jurisdictions, they don't have access to those types of life saving, even if it's only for a few months or a year, lifesaving therapy. So again, I just I want to come back to the individual patient, and the choices that they have to make.

REP. DATHAN (142ND): So in kind of going down that road, do you think that the pharmaceutical company should have global price structure for maybe sort of standard drugs, that is equivalent, no matter which jurisdiction you're in. And then premium drugs for those that can afford to pay for the better medication is that what you're suggesting?

PAIGE MAHANEY: No, I'm not suggesting any solution across countries, I'm just warning of, if we go down some paths, for example, the German system, that our selection of drugs could be severely limited, and you might not be able to get access to the drug that will benefit you or even save your life.

And so that to me, as a researcher, we focus on the value of that our drug, the benefit that it really gives to patients, and we do not want to discover drugs that only incrementally change patients' lives we're really focusing on very transformative improvements in their lives.

And in many cases, we are developing drugs where patients have no other options, where access to our drug is literally the difference between life and death. And so that's -- from a research perspective, that's what drives us to get up in the morning, every day and go into the lab, even though we face very, very high rates of attrition.

REP. DATHAN (142ND): Yeah, well, thank you for your work that you do. It is so important and you know, we've all seen when the world comes together and develops a vaccine, it can be done and I'm really hoping and optimistic that the world can come together and find a cure for cancer or something else.

Because I do think if we all work together would be great. But, you know, I still have an issue with the fact that you know, because I live in the US I have to pay more for my medication than everybody else in the world.

I've Spent a quarter my life in the UK, and I never had an issue with receiving subpar drugs, because of the NHS system, I was had better treatment in many instances that I've had here in the US.

And so that's really the issue that I have is that we have to pay so much more. And you know, salaries

aren't significantly more and, you know, our health insurance doesn't cover it. So, you know I'd like to figure out how we can get there and really make a meaningful difference to Americans and to people that live in Connecticut, to lower their drug cost, you know, it's a huge concern. So thank you for your testimony is health food for thought. So thank you for your testimony.

PAIGE MAHANEY: Thank you. Thank you.

REP. DATHAN (142ND): Thank you Madam Chair.

REP. COMEY (102ND): Excellent decision, I mean, discussion. Representative Meskers.

REP. MESKERS (150TH): Thank you very much. Thank you, Dr. Mahaney, for your testimony. Your concern in relation to drug prices, and the ability to raise prices, I assume is fundamentally focused on your ability to do your research and fund your research.

So you put us all in a horrible dilemma, basically, your reference in the insurance industry and in medication and formularies actually speak to my mind, against your position in that.

The formularies get shifted, because the price of the underlying medications goes up. Which is fundamentally, what we're arguing or you're arguing for, is to be able to use the baseline medications, raise the prices to fund the research.

I'm not making value judgments on the drugs you're researching, or the quality is what you're trying to achieve. The problem in the model is that I have people who have multiple sclerosis, who are constituents of mine, who finally found a stabilizing medication.

And whatever pharmaceutical company owned it decided they needed to raise the price to a level that the insurance companies decided they wanted to kick that

medication off the formulary so that they could control the rise in insurance costs, because of what they had to pay for that medication.

So I think we do about two fundamental issues. One is the ability of somebody like yourself, shall I say, the Mother Teresa of doing research, bringing good deeds to life and trying to save people in new and innovative ways.

And what we're trying to deal with on the other side is, how do I prevent Representative Phipps or make sure that he can afford his EpiPen, or his insulin, or his basic medical costs.

And so you're kind of in my crosshairs, not because of what you do. But if our pricing model on fine on funding research, and innovation, is either buying up or developing baseline drugs, and raising the price seven to 10 to 15% a year to fund the research, and I'm not telling you I'm looking to outlaw it, what I'm saying is, it's a fundamental problem, if I'm going to put the research funding on the back of my retail consumer, and which comes to the insurance Bill that goes up by seven to 10% a year, we end up with a structural issue that's just horrible.

That we -- that it to your mind, we're not going to solve that schizophrenic issue. And to my mind, the guy with insulin is gonna end up without with a diabetic attack.

So, and I don't think either of us has that answer. And I think your concern is maybe that I'm using a blunt tool to try to attack the issue, but we'll go back to the fundamental when I look back at it.

And I don't think it's the Governor was my clarion call. But Governor said 10% of my cost is insurance. But the coinsurance companies just pushing water around, the squeegee around the drain and 90% of the cost is the hospitals in the pharmaceuticals.

So I have to figure out how I do the pricing model. And then when I step back, again, to Representative Dathan's commentary, I've got a 40 or 50% price differential between Europe and the United States for my pharmaceuticals, and Jeanette -- and the outcomes are not materially different.

Now that doesn't say I hate the -- I won't, I won't accept a private option, I think a private option is very interesting.

The issue is when I can import my drug from, you know, London, or I can import my drugs from Canada, because they're all manufactured ultimately, in Indian and China, if I can get my prices to the same level as the rest of the free world, then I kind of feel like I'm on the competitive edge where you're getting, finding your funding and hopefully, it's you're raising your price across the globe, to get the pricing for the revenue to do your research, versus I'm telling my guy down the block, or the lady down the block with multiple sclerosis, you're going to lose your medicine, your formulary, because we've got to fund it.

You've got to fund the research out of what you're paying for the medicine, not the guy or the lady in in London, or in Geneva, and that's the structural issue.

So this may not be the ultimate solution, but that's why my dilemma is and, you know, there's nothing I want to say negatively about how you do your research, what you do, how you price, it's the way the market is set up in the United States that this is a solution to raise funds for capital research.

The problem is, it's on the back of my constituents, and the constituents, the United States, and I think it's a fundamental flaw. But, you know, I think what we can do to facilitate your concerns; I think we should have that conversation. If there's a way we

can talk about where you see the problem. Is it a blanket objection to these caps in drug prices? Or is it -- are you worried about your innovate –

PAIGE MAHANEY: Oops, I think you went on mute, Sir.

REP. MESKERS (150TH): So or is it a concern about, I'm wondering if the fundamental concern is on long term drugs, that you've already, that have been developed, that you're capped on what you can return? Or is your concern about recouping your investments on a roll out, and therefore, that you can take the price hikes as the drug reaches -- You know, because there's a question about mature drugs versus innovation, and we may need to address and, and we can look at something like that, I don't understand why I wanna pay 20% more for an aspirin, or for EpiPen, or insulin.

But if you find a schizophrenic drug, that is that we're still delving markets that share penetration, recovery of your cost. I think that's a separate dialogue to have. So I'd love to have that.

PAIGE MAHANEY: Can I can I respond, please? So I think our concerns, and this is a great dialogue. And, you know, please use us as a resource any of you, we'd love to have some of these conversations, and that we've got a great team that has more answers than I do.

But the My concern is twofold. Number one, we want solutions, we do want solutions. But we do not believe that this Bill will make a difference for patients again, because we're how we set our prices.

And don't get me wrong, we don't want to do; I think the EpiPen example is a terrible, terrible actor. And we're not asking for license to be able to do that at all. But we do want to find solutions that the patient will feel and we do not think that the pit -- this Bill, I'm sorry, will make a difference to what the patients pay at the pharmacy. That's

number one, because as a researcher, I'm absolutely focused on what benefits the patient, so that's number one.

Number two is I just want to tell you that the emerging science that's available for new drugs again, remember the horizon 15 years, but the new science that's becoming, that's emerging right now, paints a picture of just what's possible for drugs in the future regenerative medicine, for example, that could become a reality in the near future.

Meaning let's say for osteoarthritis, many of us have debilitating back pain, knee pain, instead of having to get knee replacement, you could have a regenerative approach where we inject maybe a protein into your knee and you regenerate cartilage.

That could be a cure, regenerative medicine for pancreatic cells to regenerate the beta cells in the pancreas to cure diabetes. I mean, we've talked about these things as kind of science fiction for many years.

But these -- this science is on the horizon, and we don't want to quash this innovation that could be available to patients and my researchers are working very hard to bring this innovation to patients. You know, in the next few years or next 15, 20 years, I don't want to say a few years, but you know, in the next span of a drug research and development --

REP. MESKERS (150TH): We're not disagreeing at all, I think you but you put me in the dilemma.

PAIGE MAHANEY: I know.

REP. MESKERS (150TH): Because the dilemma is what do I do about drug prices today? And, and your answer to me is how do I fund my research? Or question and I understand that.

So my point is, I have a, I have a dilemma that I'm going to fund your innovative research on the back of the guy who needs his insulin shot, or his EpiPen? You are not manufacturing --

PAIGE MAHANEY: I think its two different buckets. But I, I just think that --

REP. MESKERS (150TH): So we have to figure out how we, you there needs to be a dialogue about where we go with, if you have an issue with pharmaceutical caps and prices, I can't accept a blanket ability to raise every pharmaceutical price by seven to 10% a year to fund research, because that's telling everyone who has base needs, that there is an issue about whether or not they can afford that medicine. That – so that's the dilemma, I don't expect you to have the answer --

REP. MESKERS (150TH): Thank you. I do not. But I do say that the system is hugely complex. And I agree with my colleague from Pfizer there. And there's a lot of people in the middle that we don't see.

REP. MESKERS (150TH): Look, and again, I salute you for the research, what you bring forward the hopes you bring to us as a people to us as a Nation and to the human race for that type of research. You know, there's no way I could be critical of that.
I just have to figure out whose pocket we take it out of and how we can do it efficiently. So thank you.

REP. COMEY (102ND): Thank you, Representative maskers. Dr. Mahaney, thank you for visiting with us, and we look forward to continuing the conversation.

PAIGE MAHANEY: Wonderful. Thank you so much.
REP. COMEY (102ND): Okay, so next on our list, we have Ted Doolittle from the Office of the healthcare advocate following Mr. Doolittle, we will have Susannah Craig. And then we will be into our list of

the public names, which we are at number 13 and 44. So have a bit of a way to go. Go ahead Mr. Doolittle Thank you.

TED DOOLITTLE: Thank you, Madam Chair, and good afternoon, Senator Lesser, Representative Wood, Senator Hwang and Representative Pavalock-D'Amato and other honored Members of the Committee.

I am the head of the State Office of the healthcare advocate. And for those of you who haven't heard of it, I just want to tell you briefly what we do.

We help people like yourself, your loved ones who are having trouble with any type of health coverage, you're fighting with your health insurance, Medicare, Medicaid, Husky, got a claim denied or something of that nature, you got a Billing problem with your insurance, we can help folks in Connecticut with those problems free.

We have a staff of nurses, attorneys, paralegals and others; we're here to represent you. So if you or a loved one is struggling with any of those issues, please don't hesitate to contact us, and I know that the Members of the Committee are familiar with our services.

It's been a long here and already and you have a lot more to go. You've had a rich discussion. And now you have more, I just wanted to highlight really quickly two items that are in our submitted testimony, one with respect to Bill 6586, and the other with respect to Bill 6447.

Just real briefly on the 6447. I've made this point to some of you in person; I'll make it to you again in public today. Reinsurance is a difficult tool to use properly. If it's used alone, without in conjunction with other supports, it can result in financial harm to those who are subsidized on the exchange.

That is to say it can result in more out of pocket expenses for the folks between 250 and 400% of poverty. So please, as you're considering the insurance and not saying don't do reinsurance, we have to design it in such a way that you bring supports to the people whose out of pocket costs are going to be increased. That's my point on 6447, be careful with reinsurance, you don't want to harm or subsidize enroll leads.

The second point, again brief with respect to 6586, which deals with Prior Authorization. I want to leave the Committee here with one simple question.

What is Prior Authorization and why do we have it? And I'm asking you why in fact do we have utilization review? What I mean is why did our treating doctors get second guessed and indeed vetoed by other doctors who – you're secondary to the real mission of the medical profession. But I don't want to cast aspersions on anybody I met that just as a humorous comment.

What I'm saying is the insurance companies why if they don't trust a doctor, should they keep that doctor in the network? That's the question I want to leave you with.

Why is the insurance companies don't trust a doctor, should that doctor be a network? That is why, if you're discussing Prior Authorization and things of that nature, you need to really go deeper, and this Bill just gets into the issue a little bit scratches the surface, you need to go deeper and think, why do we need our doctors to be second guessed by other doctors?

Well, our suggestion is to move away from the modern scenario of utilization review, toward utilization review that's based at the provider level, not at the claims level, in other words, the insurance company should not deny individual claims, they should look for practice patterns that are

unacceptable, and then it can educate that doctor, that doctor changes the practice good, they can stay in network. If that doctor wants educated, that he or she is not following the best practices, then remove that person from the network.

So that's why Prior Authorization is ripe for review, I commend the Committee for taking up the Bill and thinking about it, but go deeper and think about whether you need to delve even to the next level down and determine that perhaps can I get you to start to experiment with some new types of no denial or low denial health plans, where the insurance companies go ahead and trust the doctor.

If the doctor deviates from practice, standards, then educate that doctor, and if they don't -- if that doesn't result in the result that you the insurance company want, then remove the doctor from that net network.

That takes the patient out of the equation, the patient is no longer acting as a pawn between two usually large, financially powerful organizations on one hand, a provider organization, and on the other hand, the insurance company, those are my comments that I want to leave you with.

Again, I know you got a lot of work ahead of you, but I just wanted to highlight those two thoughts, both of which are in our testimony, but I wanted to take a chance to pick them out for you. Thanks so much, Madam Chair, I'm available for any questions.

REP. COMEY (102ND): Wonderful, thank you very much for your testimony. What you're suggesting is thinking outside the box and that's what we love about the office.

Can you -- is this being done in other places? Is this something that you've seen in other marketplaces or in other states, that sort of thing?

TED DOOLITTLE: First cost and two a lot of things that you might be more familiar with standards of excellence, for instance, where the insurers are moving people to what is known as the quality institution tiering, you had a discussion about tiering.

So where again, you're trying to increase the cost or folks that go to lower value care, this is the same [inaudible] Representative called me.

It just takes it a maximum level further, and takes the patient out of the equation makes it so that the providers are getting your utilization reviewed, but not the claims.

That directly answer your question and while it's related to those other concepts, it's not being discussed. I think its incumbent on Connecticut, we claim to be the insurance capital of the world, and we should take these innovations seriously and show the world why we're called the insurance capital. So that's my answer.

REP. COMEY (102ND): Thanks very much.

TED DOOLITTLE: Thanks for all your work, you guys are doing great [inaudible] I appreciate everybody's time this afternoon.

REP. COMEY (102ND): Thank you, Senator, to stick around, Senator Hwang do you have a question?

SENATOR HWANG (28TH): I do, thank you, Madam Chair. And Ted, thank you for being here. I did have a little trouble hearing you, but I'll go begin first by offering a public service announcement touting The Office of Healthcare Advocates and what great work you and your staff do to help those in need.

You are one agency, when we talk about sometimes a bad PR relationship of insurance companies, you are the one entity that people we recommend to

addressing and redressing a concern. So thank you very much Ted can't say enough about the great work you all do.

That being said I, your point on, interesting, on the affordability issue, are those individuals whose income levels are 250 to 400%, above the federal poverty level, that that kind of make them ineligible.

Can you talk a little bit about more about that dynamic and where the real pressure points, affordability is really kind of focused on? Because sometimes we present in our, our presentations and our advocacy, a different dynamic and population, but talk about that, the population is 250% to 400%, above the federal poverty level that really is impacted by the affordability issue.

TED DOOLITTLE: Yeah, thank you for that I moved my headphones in hopes that perhaps you could hear me a little bit better.

SENATOR HWANG (28TH): Clear.

TED DOOLITTLE: So the way the ACA is set up is that Medicaid is the preexisting solution for our families with lower wealth. The Affordable Care Act expanded that it raised the income level, in other words, added people to Medicaid, and that's where the bulk of people that are covered by the ACA come in.

But then it starts to after that eligibility phases, start with income, you get into what's called the subsidized population. And that's the -- this population that is referred to the ends at 400% of poverty.

And by the way, 400% of poverty, it can be up to 104,000 for a family of four. So it's a lot of Connecticut, if not most of Connecticut, the folks in that band, Senator Hwang have to pay either co-

pays and deductibles or premium or both, and they have to pay more and more as the hit as they go up to 400.

And then at 401% of poverty. So your family of four making 105,000 instead of 104,000. You get nothing. Yeah, it goes down to goose egg, but that the point is you're asking about the law, that vulnerability, the population that is subsidized.

That's families that are probably double income working hard and they're buying insurance on the exchange. I'm on the Exchange Board, I regret to say that there's not even a low deductible plan.

I mean, all the plans are above the IRS limit for high deductibles. And that gets pretty doggone on a workable when you've got a family of four.

So that's, that's the subsidy population that winds up through the complicated math method that the ACA uses to. establish premiums. They get hurt if the overall premium goes down and I don't want to go and why.

But that's why if you're doing insurance, you have to bolster that with some new support to the families between 250 and 400% because they're going to get hurt, and in some cases seriously financially [inaudible].

SENATOR HWANG (28TH): Thank you, Ted, and you know you were getting usurped by an attractive baby in the backdrop. So thank you very much for that clarification. I will also close by thanking for your openness and your collateral collaborative and trying to find solutions where you acknowledge Senate Bill 842, as well as the Republican Bill of Senate Bill 1006, and the Governor's Bill of 6447.

None of them presents a silver bullet in your testimony. All of them have merit, and that truly

for us, all of the strategies need to be collaborated to create a better solution.

So I want to acknowledge that your open mindedness, your offer of taking bits of every good piece that not one side has all the solutions. This decision is far too important for us to be able to make a mistake on.

So I appreciate Ted all that you do, and please extend to your staff or what they do in the office of healthcare advocate. Thank you very much. Thank you, Madam Chair.

REP. COMEY (102ND): Thank you, Senator. Everyone else? no more questions. Thank you so much and we look forward to continuing to have dialogue with you throughout our public hearing. Okay, next, we have Susannah Craig.

SUSANNAH CRAIG: Hi, Susie Craig from Mental Health Connecticut here, Thanks to Senator Lesser, all Members of the Committee want to give a special shout out to Rep. Dathan for her support on H.B 6588, the provision around peer support services.

So I want to help shift the conversation a little bit. Um, but I do want to say that I appreciate the theme of today of innovation and health equity and cost savings and you know, really digging deep into ways that we can improve the quality of healthcare in Connecticut, all around.

I think no one would argue that mental health is, you know, not just a priority for those who are receiving services, but it's important for all of us across the state, especially after the year that we've all been coming off of.

So Mental Health Connecticut is a private nonprofit, we are community based. Everything we do is recovery oriented, and trauma informed and evidence based.

So we're not the only ones, many agencies and other groups across Connecticut are rooted in this approach to mental health care.

And if you don't know about peer support services, or I don't -- I know many of you do, because we've been advocating for this for quite some time, and I want to thank you for your support over the years around that.

Peer Support is, you know, an essential part of health care teams. It's one that is something that Connecticut is really behind the curve on.

So the provision in this Bill would allow for a Task Force Committee to be formed to study the reimbursement of peer support services in Connecticut, and would also obviously include people with lived experiences and people from the peer support community to make sure that we arrive at decisions that will really help expand your support and healthcare teams.

I think, you know, like I said, Connecticut is behind the curve here. Over 41 states, make peer support reimbursable, this is something that -- is work that is happening in Connecticut, but as far as ensuring that we elevate the importance of peer support as a workforce, which, you know, obviously benefits the workforce as well, as well as the people that you know, need the services.

You know, one thing that is really important to understand is that when we're talking about decreasing costs in health care, peer support services have been shown in I can share in many case studies and a lot of data that it prevents hospitalizations re-hospitalizations; it helps people in moments of crisis to find non-medical pathways to treatment.

It has been shown over and over again to reduce costs to improve health equity across the board. So

this is something that I know Senator Lesser and Rep. Dathan and many others are very much behind.

And I just want to offer up Mental Health Connecticut support and anything that we can do to help funnel resources or information or data that you need to make sure that this becomes a priority and that we finally get this passed in this session. So thank you very much.

REP. COMEY (102ND): Thank you, Susie. Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madam Chair. And thank you, Susie, for your testimony, I just lost you, there you are. Thank you very much for your testimony. It's great working with such knowledgeable folks like yourself in this. I've just started this fight in the last two years and I'm glad to be on this road with you.

Really ready to talk about some of the roles and within the initial Bill regarding the task force. And if you could maybe give a little bit of discussion around how you see those experts and why those people are so important and should be involved with a taskforce on this.

SUSANNAH CRAIG: Sure, absolutely. And I don't have the list in front of me, but I do know that, you know, it's important to understand that having folks with different lived experiences and the mix of that, from young adults, to folks from the substance use side to the quote, unquote, just mental health side, really is really important to be representative, I think that is at the root of, of the work.

The reason why peer support is important is because it is a non-medical intervention; it is someone who walks side by side with someone on the healing journey.

So have those different experiences and to help share exactly what that journey looks like, it does need to be a mix of folks who have been at this, you know, who have been trained who've been at this for a while and coming at it from those different aspects.

So I would love to work with folks, and if we want to go back and forth on the appointments and the different aspects of the community that need to be represented, we can we can do that to make sure we're we have our bases covered for sure.

REP. DATHAN (142ND): Alright. Are you aware of any organizations that do hire peer support specialists, you know, maybe hospitals or other towns that hire this? And what sort of experience and knowledge are they looking for when they --

SUSANNAH CRAIG: Sure, so Mental Health Connecticut hires peers, we hire them in our Waterbury program, the independent Center, which is our nine to five, club day program, and you know, we're always including in our hiring practice, making sure that folks know that when we hire anyone in our organization, we're looking for people with lived experience.

But what's really interesting about peer support is that they are throughout the system and a multitude of different ways. Right? So I know there's testimony from the Connecticut Hospital Association, they're in great support of this, you know, so peers are used in emergency rooms, peers are used, you know, with town social workers on anywhere, there is a direct care team, peers are used in place of but as a compliment to the folks on the medical team.

So it's a variety of situations, specifically to help get out of crisis, but then also, in any part of the recovery journey, right.

So it really, it helps ensure that person going through recovery, as a trusted partner, someone who has, you know, walked in their shoes, if you will, and has been there maybe not, you know, directly the same situation or the same scenario.

But they can be there to have the conversations and obviously, in a fully trained way, show up in such a way that helps that person get what they need, not what's offered to them, right, I think that's really important to understand about our very complicated healthcare system is there are a lot of services and there are a lot of things that people can have access to.

But the burden is on the person to figure that out, the burden is on the individual to find those things. And depending on what backyard they happen to be in what they have access to.

So to have someone who has walked that path who has gone through that, that who can say and almost short circuit, Hey, you know what, it sounds like you could really benefit from this, let's try this right.

And again, back to the health care costs, helping people get what they need early on in the process is extremely important to prevent heading down the wrong pathway and hospitalization to being traumatized from the system which can happen, right?

So making sure that they have access to what they need to help lower costs and get people you know, access to the again the available services that are the right fit for them not just what happens to be there and, on a website, and something that they have to you know, spend a lot of time and stress and anxiety trying to navigate on their own.

REP. DATHAN (142ND): Absolutely you hit the nail on the head because sometimes it's, having the regular support is what's key. You know, I have a

constituent who unfortunately lost their son, and they thought their son was going down the right road was, you know, involved in a peer support group service would have been really beneficial. Because what seemed like, you know, this young adult was going through, working through things seemed like everything was going right.

But someone who has that lived experience, might be able to perceive and have a little bit more knowhow, and ask the right questions and be able to intervene in a way that, you know, maybe a parent or a friend can't cannot because they haven't been through those experiences.

And unfortunately, in my constituent's case, you know, it was very sad result. And, you know, if only he would have ended up in hospital, so that would have been good.

So thank you so much, and really appreciate your advocacy here. And I look forward to taking this to the next stage.

SUSANNAH CRAIG: Thanks so much, Rep. thanks for support I appreciate it.

REP. DATHAN (142ND): Thank you Madam for your indulgence.

REP. COMEY (102ND): Oh, thank you. Thank you for your – you've been working so hard on this as well as Senator Lesser. So thank you for your advocacy on this and bring this to us. Representative Farrar.
REP. FARRAR (20TH): Thank you, Chairwoman. Hi, Susie, nice to see you.

SUSANNAH CRAIG: Good to see you.

REP. FARRAR (20TH): Yes, I'm just following up on what representative Dathan shared, you know, I certainly have heard from, you know, several

families in my district, you know, really about kind of two challenges, I think.

One, which, you know, we've talked about in this Committee a little bit prior, and shows up in a range of Committees, which is really the lack of mental health providers out there, you know, be it psychiatrists, or social workers, sometimes that folks who are in crisis feel like they can access.

And then secondly, one of the things I often hear is, once someone is, you know, in a crisis moment, you know, is, is in a situation where they might have been in residential, or hospitalized, you know, really losing structure as they leave that type of program.

So, can you kind of speak to how peer support, you know, not like, to me, I guess, when I think about it, I feel like, it could address both of these challenges that we have, you know, in our mental health care system right now, with really just the lack of folks in the market overall to serve these needs, and then what folks need as they come out of residential, or hospitalization?

SUSANNAH CRAIG: Yeah, those are, those are great questions. So I mean, if you think about it, this, this is nothing new. Right, um, you know, a peer support, you know, folks with lived experience, this has been around for a long time.

And I think what's, what's critical to this is, is a lot of really understanding that the recovery journey, which you probably hear a lot and maybe gets, you know, it kind of feels cliché as a term, it, but it's used in that way, because it is a journey, right. And any journey is a roller coaster ride, which goes up, down and up and down.

So the more stability, the more the more support, the more that someone is with you walking along that journey to help you at different points when

different things happen, you know, is critical, something that mental health Connecticut is actually research ourselves and really digging into is understanding how at scale, we're addressing the social determinants of health.

And key to the social determinants of health is this idea that there is no wrong door, right, there's no wrong door into looking at everything around the individual that needs to be addressed, ensure they get what they need to take on their long term health and wellness, right.

Which again, benefits everyone from cost savings to making sure it's the right service utilization, to making sure that someone can take on their own health and wellness, right. So having that stability, you know, and having someone with you on that journey is critical.

I think you're probably seeing other, you know, trends around community health workers, similar kind of approach, right, you know, community health workers who have lived experience and are up here at the win, win.

Those are folks, again, that are in the community that are walking side by side with someone to help navigate the system. So all of those things are trends and very progressive places where Connecticut really needs to go to get at all of these many, many, many issues in the healthcare system that that everyone's facing. I can't hear you're up.

REP. FARRAR (20TH): I just wanted to say thank you for commenting on that, because you kind of provided a bigger picture on how this model relates to what we're trying to do with community health workers, or how we're trying to look at, again, really more preventative measures that not only address costs, but have greater outcomes for the patient.

And I know similar to representative Dathan, you know, several of my constituents who have young adults who are, you know, in really a cycle that feels often unmanageable, right for them as an individual and as a family, that this type of, you know, not just having access to their current protocols for their healthcare, but really having access to this type of model could make the difference for them.

So thanks for sharing it with us. Thanks, Representative for her leadership and I look forward to learning more as we go along.

SUSANNAH CRAIG: Thanks so much, I really appreciate it. And just one more really quick thing. Some of the research we've been doing is around inequities, systemic racism, oppression, and what is at the root of all of that, and what we're finding is probably something pretty obvious and something that others I know, have done extensive research on.

And at the root of that is cultural mistrust. So I don't think it can be under you know, it can be said, and I know, it's been talked about a lot today, and then other Committees, that really any way that we can bring equity into the system. So making sure that people are paired up with folks from similar cultural backgrounds, languages, like looking at all those things, along with lived experience really has to be to be looked at as well. So I just want to make sure we get that in there as a priority to thank you so much.

REP. FARRAR (20TH): Thank you, Susie.

REP. COMEY (102ND): Thank you very much. Okay, seeing no more questions. Thank you very much. Thanks for sticking it out.

SUSANNAH CRAIG: Thanks Rep. Thank you.

REP. COMEY (102ND): Next, we have Barbara-Ann Tuzzolo.

BARBARA-ANN TUZOLLO: Good afternoon, Rep. Comey. Thank you so much for letting me be here today to speak with you all. Good afternoon, Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato and distinguished Members of the Insurance and Real Estate Committee.

Thank you for the opportunity to testify in support of House Bill 6588. In particular, section five, which would establish a task force to study mental health insurance coverage for peer support.

My name is Barbara-Ann Tuzzolo and I reside in Stamford, Connecticut. I have lived with mental health diagnoses since I was 19 years old, and have been employed in a peer support role for the last 15 years almost seven years now as a peer provider for state agency.

I began wrestling with mental health challenges in adolescence and my parents ensured I had excellent private providers who saw me through high school and most of university.

Once on my own, I fought hard to finish my degree, extricate myself from an abusive marriage and parent -- my young child. Even with wonderful clinical services, I felt as if I were alone in a dinghy paddling furiously to stay on course, in the unpredictable seas of bipolar disorder, anxiety, and rock bottom self-esteem. It was exhausting and lonely.

I was referred to a recovery and wellness program at James's Western Connecticut Mental Health Network, Torrington branch. There I met Vicki Jean and Mary Fitzpatrick, two state employees who openly shared their mental health struggles to support the individuals with whom they worked.

With their support, my mind opened to the very real possibility of mental health recovery. You see, I was a very good patient. However, none of my providers had ever suggested that I could have more or that I could be more.

From my understanding through Vicki Jean and Mary Fitzpatrick, I saw more opportunities for peer support. Even though options for a single mother in a rural area were limited. I continue to take advantage of westerns, recovery and wellness programming.

I wanted to be a part of helping others discovery recovery as well. I wanted my peers to know that life could be so much more than taking medication, making it to doctor's appointments and staying out of the hospital.

And I gratefully have been doing this work for the past 15 years. My life is full and has meaning. I am happy, and I have purpose. There are so many stories about the power of peer support and recovery. Please know that I am not an exception.

In the fiscal year 2019, my agency served almost 4000, 5000 clients and had a workforce of 359 employees. Eight of us were in the peer role.

Eight peers out of 359 employees to serve 5000 clients in southern Fairfield County. The Business Woman in Me knows that the number of peer supporters on the payroll makes sense because we don't add anything to the bottom line.

Our services no matter how hard we work, and what kind of job we do are not billable. However, I also know that peer support is evidence based, cost effective and touches places in recovery, that are difficult for clinically-minded supporters to reach.

The people of this state cannot afford for peer support to be brushed aside any longer. This

proposed task force will bring Connecticut one step closer to giving its citizens with mental health challenges, the full complement of recovery supports they deserve.

Thank you all for your kind attention. And I am, of course, open to any questions about my lived experience, or my work experience in the peer role.

REP. WOOD (29TH): Thank you so much, Barbara-Ann. And I think what struck me was really -- well, the sincerity of your story and your desire to help folks.

I just have a couple of questions. You're saying that you're -- currently it doesn't add to the bottom line, on your services.

How is that funded? Is it grant-funded or just piecemeal money added together?

BARBARA-ANN TUOZOLO: So I've worked as -- in the peer support role in three different entities. I've worked for NAMI national NAMI, Connecticut. NAMI national. and my work for them for them for three years was grant-funded through Astra Zeneca.

And then I worked as a Program Manager at a recovery and Wellness Center in Waterbury. And my work, there was, again, grant-funded, but through -- we have one grant for the state of Connecticut.

That center has since closed because it lost its funding after I had left. Currently, I work for the state, and well, you're aware how that gets funded.

REP. WOOD (29TH): Yeah, I hear that over and over is that, you know, the organization piecemealing that money together is really tough for organizations, and they would have to be really fully committed to be in a position, the physicians hopefully, going.

And I think also that, you know, a lot of times it's peer support is so important, because families, you know, experience mental health issues together, right?

BARBARA-ANN TUOZOLO: Absolutely.

REP. WOOD (29TH): So having somebody outside to be able to support the person that's struggling, or vice versa, as a family, I mean, NAMI supports family many times. But to have someone that, that someone can speak to, outside of the family, and not feel like they have to fix everything.

And that and that can be so important, I think to the healing process, and just to the healthy processing of what, what so many -- how you've lost someone. You know, how you've lost so much and that sort of thing. So, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madam Chair. And thank you, Barbara-Ann, and for your testimony. It was really heartwarming, and really means a lot to hear from folks like yourself that have been there and done it, and makes me really happy that I'm working on this Bill.

Just wanted to check in with you, if you have any -- I mean, we've talked a lot about people with lived-support, or lived-experiences, how do you think we can ensure that the industry, that peer support actually are qualified to do this? That we get the right people out there doing the job?

BARBARA-ANN TUOZOLO: That's a really great question. And I'm glad you're asking because I've been working on this now for five years.

And that is a problem here in Connecticut. And one of the greatest barriers to getting peer-support reimbursable is that we don't have a consistent product in Connecticut.

Because there are different entities that train. There's different entities that give certifications. So Medicaid or the insurer doesn't know what product, they're reimbursing for.

And that's why it's so important that we develop that this task force.

I'm definitely not asking that we just you know, blanket check the box. It's reimbursable now, because I want to know, as a consumer of peer support services, you know, what am I getting?

Not that we have to be McDonald's. I mean, a peer supporter doesn't have to look the same, because we all do very different jobs.

But the basic training and having a centralized one standard test, just like any kind of credentialing is, is super important.

And all that will come out in the investigation and the work that the task force does, if it is created, and I'm so excited for that work to come. Because as I said, I've been working on this for five years. And -- and yes, thank you.

REP. DATHAN (142ND): Yeah, I mean, absolutely. I think that's one of the things that I worry about the most, I mean, you know, when you're going to get professional help, you know, seeing a psychiatrist or psychologist, for example, you know, that they've been through certain loss training.

And really, your choice is not to verify the fact that they've had that training, it's more of a personality fit, can my family or me work with this person to help me?

And that's really what we want individuals to be able to not have to think about the sort of qualification aspect and more focus on the personality aspect of the relationship.

So thank you so much, and thank you for your discussion today.

And please feel free to reach out to me if you have any questions or I can help you with this Bill or anything like that.

Thanks. Thank you, Madam Chair.

BARBARA-ANN TUOZOLO: You're welcome.

REP. WOOD (29TH): Thank you Barbara-Ann. I don't see any more questions.

Okay, next would be Ashley starfish. Hi, Ashley, Welcome.

ASHELY STARR FRECHETTE: Hi, thank you so much.

Good afternoon, Senator Lesser, Representative Wood and Members of the Committee.

My name is Ashley Starr Frechette, and I'm the Director of Health Professional Outreach at the Connecticut Coalition Against Domestic Violence.

CCADV is the state's leading voice for victims of domestic violence and those who serve them.

We have 18-member organizations and we serve nearly 40,000 victims of domestic violence each year.

I'm here today to ask for your support of House Bill 6590.

This proposed Bill seeks to protect survivors of domestic violence from insurance discrimination by preventing insurance companies from denying or refusing coverage on the basis of abuse.

This Bill addresses a crucial barrier to accessing basic needs for victims and survivors of domestic violence.

Currently, in the state of Connecticut insurance companies can use domestic violence as an underwriting criterion for property and casualty insurance, disability and life insurance.

They're able to do this by accessing records of medical treatment for injuries and conditions resulting from current or former abuse, counseling services. applications for restraining orders, calls to police.

All of this is discrimination against victims of domestic violence.

By allowing Connecticut insurance companies to access documentation of survivors' efforts to obtain help from abuse. We are penalizing victims of domestic violence and impeding their ability to disclose and receive much needed supports.

CCADV works every day to educate medical professionals, police officers and courts across the state on how they can help support victims.

So if we end up using the same tactic against these individuals, how are they supposed to seek safety and get those supports that can help them to move on with their life and get the basic life necessities that they deserve?

Connecticut -- we strongly believe that Connecticut needs to update their policies and support victims and survivors. as a reference, the National Women's Law Center report card currently categorizes Connecticut as having weak policy. Because our state only prohibits discrimination in one form of insurance, which is health insurance.

There are only five other states in the United States with this horrible rating. 26 states have laws protecting survivors from discrimination in all four types of insurance, which is what I'm asking from you guys today.

And finally, this Bill would also add the necessary protections for the LGBTQ community.

This is something that's very important to CCADV. Being able to access all forms of insurance and IPTV services are essential gateways to safety and survival for all victims and survivors regardless of sexual orientation and or gender identity.

We strongly urge you to support survivors of domestic violence and the LGBTQ community in Connecticut, by passing House Bill 6590.

Thank you very much for your time today. And if you have any questions, please don't hesitate to reach out.

REP. WOOD (29TH): Thank you, Ashley. I have a question regarding just what you've been seeing what the field has been seen with the COVID pandemic?

ASHELY STARR FRECHETTE: Thank you for that question. In reference to this in reference to this Bill. I don't know if we have any specific situations yet where we've seen instance is where they've had discrimination regarding this.

But in general, throughout the COVID-19 pandemic, we did see quite a strong increase in the number of calls to our hotline, especially with increased concern around financial stability, housing, resources for children, et cetera.

So, kind of that increased isolation really causing not only those who are currently being abused, but those who have kind of that PTSD of that isolated

feeling that COVID has now caused, increasing as we've gone throughout this pandemic.

So yeah, unfortunately, we have seen an increase there.

REP. WOOD (29TH): Yes, thank you. And I think that sometimes too, we've not been able to move around as easily during pandemic.

And, you know, I've had constituents call me with questions from their car because, you know, they're just not quite sure what's going on in their house, and they want to have a little bit of privacy.

ASHELY STARR FRECHETTE: Yeah, that's been a really common throughout this whole thing is we get those calls with like, the one time a day when they're able to go to the store or something like that. So yeah, that inability to know who's behind that computer, that phone when you're making those calls has been pretty prominent.

REP. WOOD (29TH): Well, thank you for your work and for your advocacy on this.

Is there anyone on the Committee that has any questions?

All right, well say hi to the team. And thank you very much, and we look forward to seeing you again.

ASHELY STARR FRECHETTE: Thank you.

REP. WOOD (29TH): Thank you. Number 15. Is that next we have Paul Pescatello from the Connecticut Bioscience Growth Council. Is Mr. Pescatello here?

PAUL PESCATELLO: Yes, Hi. Hi, good afternoon.

REP. WOOD (29TH): How are you? Good to see you.

PAUL PESCATELLO: Thank you so much for having me. Again, I'm Paul Pescatello, Senior Counsel at the CBA. I'm also Executive Director of the Bioscience Growth Council.

I'm here today to speak in opposition to Section 6 through 8 of House Bill 6447.

The Bill' s drug pricing provisions are problematic on at least four fronts.

First, House Bill 6447, artificially sets prices. And unfortunately, however well-intentioned government price controls never work.

Second, the Bill undermines innovation at a time when we most need innovation.

Third, the Bill works counter to our economic development goals.

And finally, House Bill 6447 incorrectly assumes that drug prices are a principal driver of healthcare inflation, when in fact they're not.

Now no one likes or happily responds to rising prices. But prices reflect the cost of inputs necessary to make a product.

If the inventor of the product in the case at hand and medicine can't recoup its costs. When it seeks to transition from a laboratory prototype to actually producing the product in quantity for patients, the inventor simply won't produce or will produce a lot less of the product.

When government sets prices whether for flour, gas apartments, or medicine, you name the good, the result is less of the good.

In countries that artificially set prices, shortages occur frequently. Fewer drugs are available and the newest medicines are slow to come on the market.

In 2018, for example, of the 270 newly approved FDA medicines, only 52% were available in Canada, only 60% of new cancer drugs were available in Canada.

6447 just regards as well, what drives biopharma innovation. Especially now as we emerge from the COVID-19 pandemic. We should validate not undermine the biopharma business model.

In the past 12 months, we witnessed how important and effective this biopharma business model is. Companies Marshal their innovation prowess, put aside other projects and focus their research and development infrastructure, and in less than one year came to deeply understand the novel Coronavirus, develop a safe and effective vaccine to prevent COVID-19 and manufacture and distribute 116 million vaccine doses in the US so far.

This performance with biopharma delivered was made possible by the industry's unique research and development investment profile.

It takes on average $2.7 Billion in 10 to 13 years to bring a new medicine from lab concept to FDA-approved drug.

Most lab concepts fail. Only one in 1000 research projects result in FDA approved drug. The cost of valuable but ultimately unsuccessful research projects is borne by the few drugs that do make it to pharmacy winning—

CLERK: Three-minute warning.

PAUL PESCATELLO: Okay. To innovate and take on risk of such magnitude companies must have confidence so they will be able to price them Products freely and in such a way that they will able to recoup their costs and profit from their investments.

Price controls will stifle authentic innovation and cause cures and treatments to be postponed or left undiscovered since companies will be limited in their ability to adjust their prices.

6447 could have the ironic effect of increasing drug prices, as well as potentially making prices in Connecticut higher than in other states, artificial limits on price increases would incentivize companies to price their medicines higher and higher in Connecticut from the start.

Finally, 6447 mischaracterizes what is driving healthcare inflation. Despite the fact that study upon study has shown that prescription drug prices as a proportion of healthcare costs have remained remarkably stable for 75 years consistently. Add about 10% of each dollar spent on healthcare, the Bill is premised on a misguided belief that drug prices are a significant driver of healthcare costs.

In fact, BioPharm innovation is the way out not the cause of the healthcare cost prices. As expensive as some great drugs appear paying for all the R&D that made them possible makes profound public health sense.

There are many examples but decide just to quickly consider stat and monoclonal antibody medications for heart disease, or hepatitis C drugs.

In each case, the innovative medications are far cheaper than the chronic hospitalizations, surgeries and disability they replace.

90% of healthcare is something other than drug. Hospitals, day surgeries, doctor's visits, pharmacy, benefit manager middlemen insurance administration.

If drug prices were fixed at their level today, the biopharma innovation engine with saw, but healthcare inflation would continue to rage on, driven by all

the other cost drivers in the healthcare -- in the healthcare equation.

I'd be happy to answer any questions you might have.

REP. WOOD (29TH): Okay, thank you Paul.

PAUL PESCATELLO: Just rushing through that.

REP. WOOD (29TH): Oh yeah, time files. Representative Meskers.

REP. MESKERS (150TH): Yeah, well, I want to thank you for your testimony today, I think we'll have fundamentally have to agree to disagree on the structure of pharmaceutical costs.

The percentage of the dollar over the last 75 years may be the same. But if you compound the absolute dollar in expenses for medical industry, you will find both the hospital industry and the pharmaceutical industry are the major beneficiaries of that growth.

Now, the innovation in the industry is extraordinary. I don't think anyone disputes that the research and the foundation and, and the cures and the lives saved and the benefits from the vaccine, et cetera are widely visible and available to all of us. So I salute the industry for that effort.

The bottom of that industry, or the base of that is been taxing the American public, or charging the American public for the research and development and the advertising costs for the pharmaceutical industry.

We spend twice, two to three and four times more for our pharmaceuticals than anywhere else in the free world.

That model is a model that provides both the revenue stream for the profitability to pharmaceutical companies and for the advertising.

All of us sit at home. And we get bombarded with advertising for a whole host of medical, based medical cures or based medical treatments.

None of that is helpful -- none of that is helpful to us as an industry. So it's important that as we go forward, that we see what we want to do in the in the business model.

I think the initiation of attacks on the increased rises in the pharmaceutical industry is very important consideration for us.

I think the question becomes who funds pharmaceutical research? And in the current model, it's American citizens and the residents of Connecticut who are funding that research and development for the benefit of the world.

I'm not suggesting that the market should be a controlled market. To the extent that a free market would give us the ability to import drugs freely from around the world.

I have to purchase my drugs at the local CVS. I can't go over to Toronto, I can’t go over to London, I can't go over to Geneva.

The prices I pay are exorbitant. The idea of capping some of that cost and seeing how we move forward on I believe it's a reasonable approach.

There's a difference in the economic model. I'm a firm capitalist but as I can buy a hammer or a wrench or a car in Brazil, Korea, or anywhere and import it freely, and I cannot that with it with a pharmaceutical that's manufactured I, essentially India or China for the most part, I can import them into the United States except through my

pharmaceutical company and pay two, three and four times what they pay in, in Canada.

So I don't want to say it’s medical rationing. I'm concerned about what you're worried about and some of the limitations.

But I frankly don't see this as an attack on the pharmaceutical industry. It's just an approach to how we begin to deal with the pricing issue in the US versus anywhere else.

I'm more than willing -- I know that was a soliloquy, so I'm more than willing to hear, you know, what your concerns are?

I mean, I think I, I approached it from an alternative view. And if you think that it's the fundamental in Florida, I'm more than willing to listen.

PAUL PESCATELLO: Well, I'll let my testimony stand, and my written testimony, it goes into a little bit more detail.

But again, I think we all benefit from that research and developments greatly. And again, that research and development, I think there's so many examples of the -- again, as expensive as some drugs may appear, they are much cheaper than the things they replace.

So if you take hepatitis C, ultimately leaving -- leading to a liver transplant of hundreds of thousands of dollars for the healthcare system, and you have a drug that for tens of thousands of dollars, is curing the disease.

REP. MESKERS (150TH): Well, thank you. I appreciate that.

REP. WOOD (29TH): Representative Nuccio.

REP. NUCCIO (53RD): Hi, there. Sorry. Five different things going on at once here.

So I was just wondering, listening to -- sorry, listening to your testimony there. Do you have an alternative for us to consider?

PAUL PESCATELLO: Well, again, I guess I'm pushing back on the on the issue that the cost of medicine is a huge driver of healthcare costs.

people are frustrated with it, with the cost of healthcare overall. And again, there's so many other drivers -- hospitals, insurance.

In some sense, medicines are the most transparent part of the healthcare equation. I mean, consumers -- in a sense that consumers see what they paid for going into the hospital first day for surgery.

It's unbelievably cloudy, exactly what you're being charged with how much it ends up costing you. Drugs, fortunately, or unfortunately, people see in the way in the insurance plans, especially with high deductible plans work.

People are feeling the costs of those drugs more severely than they have in the past. But again, I would dispute that they are a driver. And again, there actually, the research and development we benefit so much from that and we benefit from how it produces overall health care costs.

REP. NUCCIO (53RD): Thank you.

REP. WOOD (29TH): Okay. Any other questions from the Committee? If not, we will move forward. Thank you so much, Paul. It's good to see you again.

Okay. Next, we have number 16 Laura Hoch from the National Multiple Sclerosis Society.

LAURA HOCH: Thank you. Senator Comey, Representative Wood, Senator Lesser, and Members of the Committee, for allowing me to testify today.

I am here virtually as a Proponent of Senate Bill 1003. a copay accumulator program.

MS is an unpredictable and often disabling disease of the central nervous system. Symptoms vary from person to person. And they range from numbness and tingling to walk into the -- fatigue, depression, pain, blindness and paralysis.

MS is also a very expensive disease to live with and treat. disease modifying therapies or DMTs are the drugs that are used to manage an MS disease course. And they are approximately 75% of the cost of treating MS.

Earlier ongoing treatment with these DMTs is crucial in managing disease course and preventing the accumulation of disability in MS patients.

But while there are more than 20 DMTs on the market, there's only generics for one of the brand name medications. They -- none of them are interchangeable and there's no way to tell which drug is going to work best for which patient.

And as Representative Meskers mentioned earlier, which I appreciate unless medications are extremely expensive.

As of 2020 the average brand price for an MSDMT was over $91,000 and five of them are priced at over $100,000.

More -- at least 40% of people living with MS rely on some kind of copay Assistance Program. So when copay accumulator programs are put in place, preventing patients from getting this assistance applied to their deductibles, they face longer and higher out of pocket costs, often in the thousands

of dollars, not only prevents them from accessing the medications, but it can prevent them from seeking out other treatments that they would have otherwise gotten doctor visits MRIs, rehab facility access in favor of accessing the medications because they cannot pay for both.

So, national MS Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to the escalating prices.

We understand that it is an issue. But taking away this program in the meantime, taking – I'm sorry, taking away copay assistance in the meantime, and preventing it from counting towards a deductible is not the solution.

Until there's a real reform in the system. Patients are relying on copay assistance to get through their day, month year and pay down their Bills and taking it away would prevent them from accessing the care they need.

And I'm happy to answer questions or go into additional detail on that.

REP. WOOD (29TH): Thank you, Laura. Any questions from our Committee?

Laura, thanks for coming out and speaking we appreciate you sharing your story.

Next up is Kim Aroh, followed by Danielle Morgan.

KIMM AROH: Good afternoon. Hi, everyone. Thank you, Senator lesser representatives Wood, Comey, Meskers, and Members of the Insurance Committee.

I certainly want to be respectful of your time, and we'll get to our main concerns, as we've been faced with in the recent years.

My name is Kim Aroh. I'm the President at both Aetna Ambulance and Ambulance Service of Manchester. I'm also the Vice President of the Association of Connecticut Ambulance providers, also known as a ACAP.

As you all know, this has been an incredibly difficult year. Ambulance providers are certainly on the frontline around the country.

Our two companies were no different. As we transported over 7000 COVID-positive patients, many are from the most infected nursing homes in the state.

In the height of the first wave the state also asked ambulance providers for transportation assistance with Medicaid patients that were not being provided transport by other providers due to the lack of PPE.

We complied with that and continue to do so during the remaining 12 months. We also responded to the request for many hospitals to transport COVID patients home because no family members wanted to come get them early on.

I am telling you this because even though we play a huge part in the patient care, especially this past year, we have a very small voice in the healthcare continuum that are often overlooked and ignored.

I am here to ask all of you today to be our voice and our advocate for what we have faced and with some of the largest health insurance companies that we work with.

During the height of COVID we received a significant increase in denials and refusal for payment because we did not receive an authorization prior to transport.

Some of these were for emergency transports through the 911 system.

I ask you all how does this seem practical. All I can say is good luck in obtaining an authorization especially if you call 911 on the weekends or after 4 pm.

Needless to say, we responded to all those calls. And we will continue however, we are still battling today to receive reimbursement from some of those insurance carriers.

In recent years, insurance companies have become increasingly strict and during this past year in the middle of the pandemic, they became even worse one of the largest health insurance, Medicare has the strictest guidelines and policies for proving medical necessity for an ambulance transport.

Yet they do not require prior-off for any transport and in fact during the pandemic have loosened some other guidelines for this.

I have to tell you, I was terrified for our staff and in the first few weeks of the pandemic. But I became even more scared thinking in the weeks after the first couple months that we may not be able to provide a paycheck to them because some of them practical changes that insurance companies were making to deny reimbursement.

With already low and reimbursements as well as denials and refusals to pay we are also experiencing further reimbursement challenges due to the many managed care plans and the increase -- increasing volume of them. Many of them.

CLERK: Three-minute warning.

KIM AROH: Okay. Many of those patients over the age of 65 end up receiving bills for their ambulance transports.

This is very concerning to me because the volume of these have doubled in the last three years.

Our patient care reports that we support -- their crews document support medical necessity and the hospitals in the skilled nursing facilities often support medical necessity as well.

If the documentation supports that, and the work that is completed, why should we have to fight so hard to get paid?

Physicians get paid if patients do not show up for an appointment. However, we can spend two or three hours on a transport of a critical patient that is very frail and weak and may not be able to get paid for it because we didn't get the proper authorization prior to transport.

None of this makes sense.

REP. WOOD (29TH): Kim, thank you for your testimony. Just you went over the three minutes.

KIM AROH: I'm Sorry,

REP. WOOD (29TH): No, it's fine. So you are testifying in support of the prior authorization Bill?

KIM AROH: Yes, that is the Bill that we're providing our testimony but not supporting prior authorization.

REP. WOOD (29TH): Right. And, and so are you -- is your group, you know, kind of behind on collecting a lot of this this money that you thought would be coming in based on the services that you've been performing?

KIM AROH: Yes, yes. We are still battling collecting Bills back from June, July, August, like in the beginning of the pandemic, it's getting worse

in the last few years, from all providers requiring the prior authorizations?

REP. WOOD (29TH): What happens as this number grows? I mean, what does this mean for you being able to offer these services?

I mean, it's kind of scary that you're waiting to be paid from something from last summer.

KIM AROH: Exactly that that is the greatest concern. I mean, during the height of the pandemic, there were several that just turned up the dial, I guess, I'd say, in making these restrictions, even stricter.

And it wasn't appropriate, we were on the frontline, working our hardest every day, and to pull that on us during that time.

And I said Medicare loosened their controls during this time, and the others have not. It holds up the system, it requires a lot of extra paperwork on the front end.

And it doesn't always guaranteed payment, there's a couple of them that will wait two weeks before we even get the authorization.

And in some cases, we don't get it and then it's denied.

REP. WOOD (29TH): And you've already performed the service.

KIM AROH: Yes, we will not hold up transport are not going to hold up, you know transporting a patient to their appointment or discharge to a nursing home.

I mean, the throughput of these hospitals during this time is critical.

REP. WOOD (29TH): Right, so it almost feels like you're being taken advantage of in this situation?

KIM AROH: Yeah, I mean, it's frustrating. I just paid for a doctor's visit. For that I had to cancel unfortunately, two weeks ago, $50 I paid for and I was as I was writing this, I'm thinking I have to pay for that. I didn't go, that makes sense. But we will do a transport that can sometimes take two or three hours with critical patients and not get paid.

We're small, small piece. So we certainly appreciate anything you can do to be a bigger voice for us.

REP. WOOD (29TH): Okay. Thank you. Do you have any questions? Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Madam Chair. And Kim. I can speak first person about the quality, the high quality of services that you deliver. Because we have ASM in South Windsor.

KIM AROH: Thank you.

REP. DELNICKI (14TH): You guys stepped up to the plate, and provided us advanced life support services when we were only having BLS.

KIM AROH: Thank you very much for your support.

REP. DELNICKI (14TH): And I've got to tell you, I'm very concerned about that. Because at some point in time, if you aren't receiving authorization, are we going to run into a situation -- you guys would never do it, but other services that are basically not getting the authorization they should get and not getting the payment they should get.

When is that going to start endangering people's lives that need that transportation? I don't want to comment on that.

KIM AROH: No, exactly. I mean, we certainly don't want to ever have to make that decision. And I just can't stress enough.

I mean, Medicare is the most strict and they do not require this. So the fact that the insurance carriers have started this in the last few years or several years, and amping it up, and being stricter this past year in the worst year, has been the most difficult.

We are experiencing continued volume declines of about 15% right now. That's difficult, you know, to sustain and then to have this dragon payment that can be six months to a year, it's just not fair.

And I'm also I did I just want to stress to I'm very concerned about the increase in the -- it's ballooned, these managed care plans for the elderly. I think a lot of them are getting swooned into the cheaper monthly premiums.

However, if something turns for the worse in their health situation, and our services are one of them that are constantly going to the Copays. And they get shocked by it. And it's troubling.

I think a lot of them are getting swooned into these managed care plans and not knowing what they're getting into.

And it's going to be a more significant problem in the years to come. It's already doubled in the last three years.

REP. DELNICKI (14TH): Well, you're located in Manchester and I'm in South Windsor. And of course, we have Berry Patch, which seems like you folks are going there 4, 5, 6 times a day, literally, to respond to situations over there.

And anything that we can do I mean, make the suggestions that you feel are appropriate because I

sense from the good Chairs that there is a level of concern there also.

And I commend Representative Wood for her concern on the issue.

KIM AROH: Thank you it. Our testimony that we submitted was presented by Greg Allard, who is the Vice President of American Ambulance, so it's under Ambulance Association.

So if you could read the language changes that we recommended in that letter, that'd be appreciated.

REP. DELNICKI (14TH): Well, yeah, I thank you for coming forward. Kim.

KIM AROH: Thank you.

REP. DELNICKI (14TH): And I thank the Chair for an opportunity to have a dialogue here.

KIM AROH: Thank you.

REP. WOOD (29TH): Thank you. Thanks, Kim. Kim Aroh. arrow, I'm sorry, I said your last name wrong. Thank you for sharing that with us. We appreciate it.

KIM AROH: Thank you very much for your time.

REP. WOOD (29TH): Next stop is Danielle Morgan, followed by Marion Manski.

DANIELLE MORGAN: Thank you. Good afternoon, Senator Lester. Representative Wood, Senator Anwar, and Representative Comey, Honorable Members of the Committee.

Thank you so much for giving me the opportunity to provide support for Senate Bill -- excuse me, House Bill 6588.

All aspects of the Bill are completely delightful. But I'd like to call particular attention to the section that will prohibit hopefully the 90-day compulsion to prescribe psychotropic medication.

The psychiatric A parents brought this concept forward several years ago. And back in 2019. It became live in House Bill 7261. And then again in 2020. And with House Bill 5250, Representative Doucette Representative Cook and Representative Steinberg, carried this forward. Thank you so much. We've had great energy, by my Representative from Guilford, Sean Scanlon.

There's been this this horrible standard of care over the last many years by the insurance companies, the third party payer system, compelling all providers, whether you're a psychiatric nurse practitioner, like myself, or a psychiatrist or a geriatric physician's assistant.

When you write a 30-day supply for a psychotropic medication, after that 30-day fill, providers are compelled to then write a 90-day prescription.

And this is fraught with problems. As one could imagine. We like to make medical decisions based on lots of individual factors based on individual patients.

And when third party payer systems are not privy to any of those factors, it's definitely not appropriate in all situations to write a 90-day prescription.

And insurance companies are compelling us to do that, and a global perspective now.

So we'd like to have the ability to make those individual clinical decisions and when it's appropriate, certainly provide a 90-day prescription and when it's not to provide a simple 30-day fill.

So that's what we'd like in the language of this Bill. And it's absolutely perfect. I'd like to take a moment too to just absolutely laud Representative Dathan's use of peer support counselors.

I work in a methadone clinic. I'm a member of the medical staff of a methadone clinic and have worked for the last 20 years as a psychiatric addictions nurse practitioner.

And I've worked with peer support and recovery counselors in all sorts of settings across the state of Connecticut, and they are absolutely integral to our health care team.

They provide the link that I cannot provide to community-based support and recovery. They de-stigmatizes the illnesses that we work so hard to treat. They are absolutely necessary.

And in a task force set up to somehow add some rigor to how we might credential them is so fabulous. I welcome participation on that task force, or also any kind of support that I can provide for that.

I'm a member of healthcare cabinet. It was so great to see Vicki this morning and Ted, all day. It's been a great day of testimony.

So any support, I would be happy to provide and to see another shot at the psychiatric workforce task force, which I've also been welcomed to provide some support on.

I'm happy to provide some support again on that. So I think it's so necessary. There's a paucity of psychiatric providers in this state, whether they be psychiatrists or psychiatric nurse practitioners or psychiatric social workers.

And we as folks on the inside have lots of insight about why that is. And we are happy to provide that

insight to all of you folks, so you can advocate appropriately.

REP. WOOD (29TH): Danielle, thank you for your testimony. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Danielle. Previously, you mentioned the critically inappropriate psychotropic medications portions. Did you have a personal experience with that as a special expert that you want to share?

DANIELLE MORGAN: Sure, sure. I have years of experience with that. And I have years of appropriate experience with that as well. I'll touch on that really quickly.

Just before I jumped on, I have several patients today that I just refilled many 90-day prescriptions, people who are stable, and have been longtime patients of mine and who need 90-day fills to meet their insurance requirements and have nice low copays, and makes fiscal sense for everyone involved.

So we're always happy to meet those, you know, standards across the board.

But I mean, I can think of a gentleman who I saw, a young man who came out of a psychiatric hospitalization, acute suicide attempt when I saw him as in his early 20s. I'd been seeing him for many years, and was stabilized on a poly-pharmaceutical regime, which is very common, you know, many medications.

And one of those medications that he came back to me and community on is very toxic in in supplies greater than a two-week supply.

So many psychiatric medications that very well save your life and reduce your depression dramatically,

in greater supplies than seven to 14 days can actually end your life in overdose.

And when you come out of a hospitalization, you're actually at greatest risk for committing suicide. So I did not want to dispense that medication in a greater than two-weeks supply.

And he had an insurance policy here through his parents that mandated a 90-day prescription. And I fought very diligently with pharmacists support actually remember that very horrible weekend, and was not allowed to dispense that prescription in less than 90-day supply.

So his parents who were very much on my side, which is not always the case. This causes a lot of friction between providers and patients, because obviously, they do not want that cost carried over to them.

But his parents were very understanding and ultimately had to pay an exorbitant amount of money to accept those very small refills until we were ensured that his psychiatric stability was indeed Good.

REP. WOOD (29TH): Great. Well, thank you for sharing that story with us. And definitely -- you know, you brought up some great points for us to consider. So thank you.

SENATOR LESSER (9TH): Thank you, Madam Chair for jumping into the fray a year in you think I could find the mute button.

REP. WOOD (29TH): We're all learning I can see the sun is setting on all of our faces. So we're getting there.

Next up is Marian Manski, followed by Olivia Rinkes.

MARION MANSKI: Good afternoon everybody. I am Mary Manski.

Senator Lesser, Representative Woo, Senator Hwang, Representative Pavalock-D'Amato and Members of the Insurance and Real Estate Committee.

Thank you for hearing me today. I'm here today on behalf of the American Dental Hygienists Association in Connecticut.

I'm also the Associate Professor and the Director of the Dental Hygiene program at the Fones School of Dental Hygiene at University of Bridgeport.

And I'd like you to support Senate Bill 100. Oral Health, as we know, is a major contributor to overall health. A lot of people don't understand that. But if oral health is not good than our overall health is not good.

And what happens with people who are that 26, you know, that age, 20 to 26 or 18 to 26 year olds who don't have dental insurance, it ends up being kind of tragic for them, because they have this time period that they don't have any opportunity to obtain dental health. That oral health, and they end up with problems by the time they do get the insurance.

And it kind of shocked me that medical insurance was till age 26. I remember my own children we had them on our plan till age 26. But dental is not there.

And what most people don't understand is the impact of poor oral health impacts the rest of the body, and it is of concern.

So it's sad to see that these adults who typically present too late once they do obtain insurance have a lot of treatment that needs to be done and it actually exceeds lots of times what they have in their own insurance.

So they end up paying out and providing that coverage would alleviate any kinds of gaps in care and also reduce the cost of care for them.

Because if they had the maintaining of the dental care from up until age 26, when they are, you know, able to obtain their own dental insurance and be gainfully employed, then there would be no gap and there would be no real major dental concerns.

So, it is, it is amazing that the statistics that show that this age group is affected. And who would think you know, we're the cavity-free generation, aren't we?

We all grew up with fluoride in our toothpaste, and we didn't get cavities. But what's happening is, a lot of dental problems are being presented when one doesn't get regular dental care.

So a lot of times these -- teeth are in such poor repair, they have poor self-esteem. And according to the Center for Disease Control prevention, $45 million in productivity is lost in the United States every year due to untreated oral diseases.

So we're looking at this population that has a big gap moment. And we want to make sure that they are able to be on their parents' insurance, just like medical until that age of 26. If they have to, if they don't have to, they don't have to great.

But a lot of people do, and it would be quite helpful to them. And it also would reduce the cost of overall dental care.

As I said oral health is strongly correlated with total health. And without one, there isn't the other. So these unmet needs, we feel like that having this little gap time and still having them covered would reduce their risk, reduce the total costs.

And as dental hygienists' prevention is our core, that's who we are.

We want to make sure our patients are healthy. And if they're healthy, that overall dental health, their overall health is okay also.

So I urge you to extend this dental coverage on family plans to young people up to the age of 26 as needed by the individual.

And I thank you for the opportunity to provide testimony regarding this critical care issue.

Thank you for your time. I hope you support Senate

Thank you.

REP. WOOD (29TH): Thanks, Marion. Representative Comey.

REP. COMEY (102ND): Thank you. Hi, Marion. I just wanted to say hello.

MARION MANSKI: Hi Robin.

REP. COMEY (102ND): How are you? We could probably wave to each other outside our windows.

MARION MANSKI: Yes, that’s true.

REP. COMEY (102ND): Thank you so much for your work. You know, I think that we forget or we don't think about the fact that dental decay and oral dental decay is the number one preventable children's health, chronic disease that we can prevent.
So getting them in a routine early and then continuing on as they go off to start their young adult lives, I think could not be a more critical time, I think, to continue on those good habits.

And thank you for your continued efforts to enlighten us on issues in your industry in your field.

And, see you at the grocery store.

MARION MANSKI: Yes.

REP. COMEY (102ND): Thank you, Marion.

REP. WOOD (29TH): Marion, thanks for joining us today.

Next step is Olivia Rinkes, followed by Michaela Fissel.

Michaela Fissel is up next followed by Hilary Felton-Reed.

MICHAELA FISSEL: Hello, can everyone hear me okay?

REP. WOOD (29TH): Yeah, we can hear you.

MICHAELA FISSEL: Great. I've had kids on zoom all day. So sometimes my internet is a little spotty.

My name is Michaela Fissel and I'm a registered voter in Windsor, Connecticut, and I'm also the Executive Director at Advocacy Unlimited.

I also co-chair a workgroup of advocates seeking Billable peer services in Connecticut. I'm testifying today in support of section 5 of House Bill 6588.

This Section will establish a statewide task force to study insurance reimbursement for peer services.

Advocacy unlimited as a peer led nonprofit. This means that we provide education, advocacy and support using our direct lived experience navigating mental health, addiction and trauma.

We promote individual growth, human rights and systems transformation through what's called holistic peer-led recovery supports.

Since our incorporation in 1998. We have remained committed to offering the supports and we are the largest designated pure-led training organization for those seeking employment as recovery support specialists.

I just want to note today that you're taking two important steps through enacting this legislation and Task Force.

First, you are choosing to bring Connecticut to the forefront of recovery orientation by establishing a task force with equal representation of those in recovery.

This will require that you remain committed in pointing individuals who identify as having direct lived experience.

My only ask is that you add two additional seats and make one adjustment. create two distinct seats, one for Advocacy Unlimited, and one for Connecticut Community for Addiction Recovery.

AUNCAD is distinct organization that have the longest standing experience with training and education of peer specialists in the state.

By having only one seat, you're limiting the scope of expertise.

Second, create an additional seat for a person who is working in peer services as a certified peer recovery specialist, also known as a CPRS.

Which is a certification offered through the Connecticut certification board, and has the distinction best rush presentative by CPRS.

Replace the appointment of a representative of the Department of Children and Families with a representative of the Department of Mental Health and Addiction Services.

DMHAS is the current administration that is most involved in the delivery of peer services and funding of the services.

DCF, I'm not sure if maybe that was just a bit of maybe a typo there.

Since 2004. And through the leadership of past Commissioner Kirk of DMHAS, Connecticut declared our commitment to recovery orientation.

This was a critical step forward. yet. There are two components of this system of care that remain under underfunded under as second class.

CLERK: Three-minute warning.

REP. WOOD (29TH): Michaela, you could just wrap up the sentence that you're on, we'll move to questions.

MICHAELA FISSEL: Thanks so much. This legislation will prioritize each of these components of care, and will lead us forward in a much needed dialogue.

Thank you for taking the time, and I am grateful for your commitment and service to the state of Connecticut. I'm available to answer any questions and can certainly be available as you continue to work through this legislation and move the Bill ahead.

Thank you.

REP. WOOD (29TH): Thanks, Michaela. Did you submit written testimony because I didn't see it?

MICHAELA FISSEL: I did it got in a little bit late. I apologize for that.

REP. WOOD (29TH): That's fine. We'll look for that. Because you did bring up some great points that I think we need to review.

And I just don't want to have that lost. Representative Dathan.

REP. DATAHN (142ND): You asked my first question, Madam Chair. Thank you.

I just wanted to clarify within your written testimony that you've submitted, that you did highlight some of the changes that you spoke about in your testimony?

MICHAELA FISSEL: I did.

REP. DATAHN (142ND): Okay, great. But that'll be really useful.

Second question for you. In your professional experience, just wanted to talk about accessibility for peer support services.

Can you elaborate on that for me?

MICHAELA FISSEL: Yeah, there continues to be a gross inequity within the state of Connecticut and accessibility to pure services.

As a previous Medicaid recipient, I know that I have much greater access to comprehensive recovery resources that are often available in what's called the Local Mental Health Authority. And this remains the experience today.

So accessibility to peer services are not as are not available to individuals who are within a private insurance carrier.

And so it is important that we continue to investigate this inequity. Because we know that individuals themselves with access to peer services will step forward in their recovery and become contributing members of society. And the research shows that as it's an evidence based practice today.

REP. DATAHN (142ND): My little mouse is running across the screen there.

You've heard that and, you know, I really do worry about the referral process because I do think that you know, if we aren't addressing the accessibility, especially for Medicare, Medicaid recipients, then you know, we do have, we do run the risk.

I mean, cognizance this Committee is insurance. But I do worry about that as well. But in terms of, you know, referrals, you know, we want to make sure that people who may be even on different insurance plans will be able to use this service because this only, you know, as good as the people who are able to access it.

And that's really my concern, you know, with the whole referral process, and also just different accessibility in different parts of the state, because this isn't a Fairfield County issue or a Hartford issue, this is an issue that everybody has, and we need to make sure that no matter where you are in the state, you have the accessibility.

And no matter you know, what kind of insurance you have, you do have the access, because, you know, we've seen through their other presentations, that these sort of services actually save money.

So if you have any other comments about referrals, I'd love to hear that.

MICHAELA FISSEL: Thank you so much, you speak so well to the current state of affairs here in

Connecticut as it relates to accessibility to peer services.

And in regards to referrals. You know, we've done a great job here in Connecticut, and in some areas of the country with creating an opportunity for residents to be able to access behavioral health services directly by calling their health insurance provider through often just like a 1-800 number, or 1-888 number.

And they themselves can say, hey, I need some help. Right now I'm struggling, can you provide me with a list of providers within my area?

I would hope that self-referral is the option for accessing peer support as well., that we don't need to go through a clinical kind of diagnostic protocol in order to access that level of support. So that would be my recommendation.

REP. DATAHN (142ND): That's good. And I mean, I think you're more apt to get people using the service if you take away that barrier.

So that's a good point. Thank you so much. And I do hope that when we see your testimony, have your contact details there because I might reach out with additional questions.

Thank you for your testimony. And thank you Madam Chair.

MICHAELA FISSEL: Thank you, everyone, for hearing me today. It's nice to see you.

REP. WOOD (29TH): Thanks for coming Michaela. Next step we have Hilary Felton-Reed, followed by Stephen Schultz.

HILARY FELTON-REED: Hi, good everyone.

Senator Lesser, Representative Wood, Senator Hwang, and Representative Pavalock-D'Amato. Thank you for the opportunity to testify before you today.

My name is Hilary Felton Reid. And by way of introduction, for those of you who don't know me for my work on other issues, or those of you who don't know me, I work with Susan Halpin, whom I know many of you know very well and I'm here today to testify on behalf of the Connecticut Association of Health Plans.

I'm here to speak on House Bill 6588, AN ACT CONCERNING MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES.

Over the years the Association has worked with the state on many pieces of legislation to improve access to mental health and substance use disorder treatment, as evidenced most recently in 2019 with Public Act 19-159.

As awareness of behavioral health treatment grows nationwide, so too has a focus of health carriers on the issue as they work with providers, consumers and policymakers to balance access quality and cost.

With respect to sections one and two of the Bill, we recognize the language is more defined than previous years' versions.

Still, we cannot support the language or the requirements with further without further discussion and a better understanding of the problem at hand.

Most would agree that behavioral health treatment is not a one-size-fits-all solution.

We support efforts to minimize and prevent medication misuse and abuse. However, whether it be inpatient treatment, outpatient treatment, home based treatment, or some combination thereof, each patient responds differently.

Prescriptive treatment and coverage requirements laid out in statute impede the ability of carriers and clinicians to adapt treatment protocols in line with clinical appropriateness.

Further, drug development and research are consistently changing with new drugs coming to the market all the time. Setting specific coverage policy and statute refuses to recognize that some drugs or potentially new drugs not yet on the market, may very well be best prescribed in 90 day quantities and such policy may be better for the consumer.

Thus, we urge cash caution and adopting a one-size fits-all policy. In addition, with the cost of pharmaceuticals ever rising, it is irresponsible and not in the interest of the consumer to statutorily prohibit the ability of carriers to manage such costs.

We Strong consideration for potential unintended consequences of this legislation, and we welcome the opportunity to discuss it with you further.

And one last point, we know that the Bill also establishes two task forces, which have been spoken a lot today.

And we would appreciate to work with the Committee on both task forces. We appreciate that the peer supports recovery Task Force does have an appointment for a health insurance carrier.

And we look forward to that discussion. And we hope that there can also be one on the task force to evaluate provider networks as well should it move forward. I thank you for your time today.

REP. WOOD (29TH): Thanks, Hilary. Just so we're clear, so you are not supportive of the 90-day supply being reduced?

HILARY FELTON-REED: So we are requesting that we have some additional discussions with the Committee about the -- about this legislation. We feel that right now, it's not necessarily specific, you know, which circumstances that might be applied to and we would-- you know, there may be some circumstances where a 90-day supplies are beneficial to the consumer, it prevents the consumer from having to revisit the doctor as frequently.

And, you know, the woman, Danielle, who spoke earlier did mention that there are individuals where their illness is managed very appropriately and a 90-day supply is appropriate for them.

And there may be instances where that is not the case and we would be happy to discuss that further with the Committee. I think we are just trying to make sure that we have a better understanding of which circumstances those are and which drugs might be more dangerous than others.

You know, currently, the language applies to all psychotropic drugs, and we would just appreciate a better understanding of exactly what the situations that the Legislation seeks to address.

REP. WOOD (29TH): Okay, 'cause let's definitely have that discussion sooner rather than later, because it is a mental health, you know, Bill, and really, you know, concerning the opioid epidemic and having these psychotropic drugs in such a large supply for someone that may need only two weeks. And, you know, I think we're all working towards that effort, so would definitely like to further talk with you about that. Representative Meskers.

REP. MESKERS (150TH): Thank you, Madam Chair. I'm just, Hilary--

HILARY FELTON-REID: Hi, Representative.

REP. MESKERS (150TH): Welcome.

HILARY FELTON-REID: Thank you.

REP. MESKERS (150TH): Good to speak to you for the first time. I'm just gonna complain because my Chair has stolen my thunder. So, I definitely I'm confused as to your objection as it talks about the health care provider deciding that the outpatient-- what's clinically appropriate or inappropriate.

And I think that harks back, it's so funny that I was at the exact same point, you know, both pain medications like opioids and psychotropics, I assume, can potentially have either recreational use or can be left around for misuse.

So, you know, I think there's probably a way to work that through, but I'd love, you know-- my experience walking into a doctor's, the only place I get exactly what I need is for an antibiotic. And I run out at the exact point of my 11 pills, or five pills, or whatever. But everything else seems to come in quantity. So, I want-- I hope we can work out with you on that in getting that, you know, fine-tuned.

You also mentioned a potential problem in the first two parts of the measure.

HILARY FELTON-REID: Those Sections are the Sections that you were referring to, Representative. And if I could just respond briefly? Since the opioid epidemic was mentioned. And I will say that that is a very good example, where carriers actually have supported quantity limits for opioid pain relievers, because there was very good evidence that opioids were contributing to a very significant addiction crisis that none of us wanted to support.

So, you know, I completely agree that there are situations where it would be necessary, and as mentioned, we would like to work with you on the

Legislation. We certainly understand the concern with dangerous misuse and abuse of medications if supplied in large quantities, and we appreciate the fact that you're open to further discussion, and we're open to that as well.

REP. MESKERS (150TH): Perfect. And my concern will be-- you may or may not be able to answer that now, my concern would be that the pharmacy benefit managers, that there's an issue in terms of the payments and the rebates related to the quantity that's issued.

So I wanna make sure that there's not an incentive structure that's encouraging anybody to push out for larger quantities than are necessary. And so that's -- so it'll be a combination of figuring out where you guys sit with that and then figure out, are there opaque incentives to issue larger versus smaller sizes based on the rebates that are potentially available?

'Cause I just don't want my-- our citizens who are taking psychotropics and presumably could have issues, I don't want them to be flooded with the wrong medication. I look forward to talking you on that and, and thank you for your testimony.

HILARY FELTON-REID: Understood. Thank you.

REP. WOOD (29TH): Thank you, Hilary. Up next, we have, Steven Schultz, followed by Kelly Ryan.

STEVEN SCHULTZ: Thank you very much. Thank you, Members of the Insurance and Real Estate Committee. I, hopefully, can be pretty short. I know you guys have had a long day.

My name is Steven Schultz, Director of State Legislative Affairs for the Arthritis Foundation. I'm speaking to our support of S.B 1003, which ensures all copay count. It's the Bill that you've heard some testimony already before, and like the

maybe after round accumulator adjustment programs which don't count, third Party payments, such as copay assistance from counting towards a patient's costs or requirements, such as their deductible, or cost sharing requirements.

Just wanna focus, really, on an element of the discussion on this issue that folks around generics and point out that 99.6% of medications that receive this type of assistance, that's the subject of accumulator adjustment programs, according to a study, were brand name drugs with how to generic.

And so in addition to that, as a patient gets on a medication that has this type of assistance, they do go through things like prior authorization, step therapy, things that ensure that this is the right medication for them and that there are no lower cost alternatives that are out there.

So most of the cases where patients get on-- go through these protocols, assistance is really their only option left to stay on their crucial medication. And then, one of my last elements is that, it's important to note that there are extremely similar Bills to this that have been enacted in West Virginia, Virginia, Illinois, Georgia and Arizona. In addition, there's about 20 other states that are trying to enact something similar to Connecticut this session.

And then lastly, I'll just say, if you're looking for a Bill that's going to, by itself, fix drug prices, as you have this discussion today, S.B 1003 is not it, but it is something that can fix the problem of cost-sharing being shifted onto the patients, while a larger discussion on drug pricing is taking place.
So for that reason, I hope you continue to work and support this important effort. Thank you.

REP. WOOD (29TH): Thank you, Steven. I don't see any questions. So we will move on to, Kelly Ryan followed by, Cara Gooding.

KELLY RYAN: Thank you, Representative. Good afternoon. My name is Kelly Ryan and I'm Deputy Vice-President for state policy at PhRMA. We represent the nation's leading biopharmaceutical manufacturers, research-driven manufacturer, some of whom you've already heard from today.

I'm here to express our opposition to Governor Lamont's proposal as contained in Section 6 through 8 of House Bill 6447. As we've talked about, the proposal would establish a price control on all medicines, imposing significant penalties on sales above a statutory threshold.

I submitted more detailed written testimony and we've talked about this a lot today, so I'll just quickly raise a few points and I'm happy to take any questions. There are a number of reasons why this proposal is concerning and not the right answer.

It raises legal concerns from both a dormant commerce clause and a patent law perspective. It could stifle the kind of innovation and flexibility that is so important, not only to drug development generally, but as evidence clearly by what we have been through this past year, talked about that earlier today.

But I'd like to focus on the important point that this proposal does not address what patients pay at the pharmacy counter. This is heavily influenced by insurance plan design. The growth of net drug prices, which reflects rebates and discounts has been in line with or below inflation for the last five years, specifically brand medicine that prices increased 1.7% in 2019.

But this is not what your constituents are feeling at the pharmacy counter, instead, they're subject to

high deductibles in coinsurance which are based on the list price and not the significant rebates and discounts that are provided by manufacturers to plans and PBMs, something that's unique within the healthcare system.

These discounts totaled $175 billion in 2019. In 2012, that number was 74 billion. So just in seven years, that gap between list and net price has grown over $100 billion. Plan design continues to shift the burden to patients in the years from 2012-2017. The percentage of commercial health plans that require deductibles on prescription drugs rose from 23% to 52%. And even outside of a deductible, insurance covers a lower share of prescription drug costs and hospital costs.

On average, patients pay about 4% out of pocket in hospital costs as compared to 12% on drug costs. You've already heard today about the impact to spend in pharmaceutical spending and the complexity of supply chain. I'd like to reiterate a point raised earlier that nearly half of spending on brand drugs goes to entities in the supply chain other than the innovative manufacturers that develop the medicines.

Instead of acknowledging the reality of the supply chain and all of the factors that influence how patients access to medicines, The Governor's proposal includes a short-sighted and legally questionable price control, it sends exactly the wrong message to the innovative companies who are producing cutting edge medicine and steering us through a pandemic while it doesn't actually help patients.

So we support reforms that are in the best interest of Americans, lowering patient costs, ensuring access to medicine, protecting innovation, and we've been at the table with this Committee and others for a number of years talking about these solutions and are happy to continue to do so, but Governor

Lamont’s proposals in this Bill is just not the answer.

I'd like to thank you all for the thoughtful discussion on this issue all day, and I'm more than happy to take any questions you have.

REP. WOOD (29TH): Kelly, thank you. I mean, I think that what we have learned from today is that we have a lot of discussing to do and how to make this the best. I'll turn it over to Representative Meskers.

KELLY RYAN: Sure.

REP. MESKERS (150TH): So, Kelly, thank you very much for your testimony. So, I'll put you in an awkward spot in your testimony. In that, you're telling me I'm shooting the messenger and maybe killing the message or something-- some metaphor to that extent. So, I guess, my question is, if the pharmacies are not where I should be going for my residents’ medical costs-- for the cost of the drugs, what is my next-- What's my resolution here? Because all I knew was that as I sit here as a Representative, that we are dealing with a compounding cost on both hospitals and pharmacies that's unsustainable.

KELLY RYAN: Understood. And my response to that would be, I'm not gonna sit here and say, “Don't look at us, don't talk to us, it's not us at all.” Right? That's not what I'm saying.

REP. MESKERS (150TH): Okay.

KELLY RYAN: I wanna be clear about that. What I am saying is, just looking at list prices, like this Bill does, imposing a price control does not solve the problem that your constituents pay at the pharmacy counter, right? There is a very long chain of folks in the middle, as we've seen by this huge gap between list prices and prices.

And, you know, earlier you talked about, you know, having a constituent that had an MS drug that was taken off the formulary and made the assumption that it was because, you know, the list price went up. Well, that's not necessarily the case, it could also be because the plan is trying to drive a bigger rebate and they get a better rebate from one or the other. Basically, access formulary inclusion, all of those factors, may or may not be influenced by list prices.

And so, just focusing on that, the way this Bill does, doesn't solve your constituents' problem when they walk into the pharmacy, in their deductible and pay, you know, $10,000 for a drug when the plan is getting a 40% rebate on that, and they're paying more than their own health plan is.

REP. MESKERS (150TH): I hear you. I guess, you know, my problem as I sit here and look at drug prices that are spiraling out of control, is any of the research I've done is that when drugs are approved for consumption and for sale in the United States, the FDA approval process and the pricing encompasses expensing the cost of research and development.

So presumably, the purchase price on day one, covers research and development, and yet I've got a spiraling cost structure that is overwhelming my constituents. So, I'm not against my pharmaceutical industry making their fair share or being able to do their research, but if we start with the issue that research and development is painful within the authorization of the FDA, I'd have to question whether or not they're-- how I control the prices. Your suggestion is, I should be looking at the pharmacy benefit managers more than half the pharmaceutical companies. That's what I'm hearing.

KELLY RYAN: As part of the whole conversation, right? I'm not trying to just say, don't-- I just wanna be clear about that. Because this—

REP. MESKERS (150TH): Okay.

KELLY RYAN: They say, "Oh, you know, everybody's pointing fingers." I'm not trying to point fingers, I'm trying to say, you need to have a comprehensive conversation.

And, you know, an issue that you've raised a couple times today, I think you're spot on, right? American consumers are shouldering the burden of research and development for the rest of the world. Like that's absolutely the case, we agree with you on that. You know, my federal colleagues are more well versed than I am as a state policy nerd in that respect, but I mean--

REP. MESKERS (150TH): It's an unsustainable—thank you.

KELLY RYAN: It's unsustainable. But this Bill doesn't solve that problem, right? We need to work on some trade agreements and we need to deal with that.

REP. MESKERS (150TH): Right.

KELLY RYAN: But you're absolutely right, we're-- Americans are paying for the innovation that's benefiting the rest of the world.

REP. MESKERS (150TH): You know, and I have had this conversation with, away from the pharmaceutical companies, with the insurance companies. And the insurance companies-- and I was in banking all my life, I've worked on Wall Street, so I'm not an anti-insurance company.

I said that you're-- you know, the insurance company is stuck as the orchestra leader between the hospitals and pharmaceuticals and the client and the constituent that I have, and we're compounding at 7% a year. At some point, very shortly, you know, I

think I qualify for a 30 something dollar a year social security payment, if I get there, God willing.

My insurance cost, if I have to purchase private insurance will be-- exceed that price in the next 2-3 or 4 years. So we are getting to the point where private insurance will fail. And not that I'm advocating for a public option, because I have serious concerns, but when in the industry-- when the industrial base of the United States has to pay $45,000 a year to insure an employee, we're all gonna have a problem about where is the private sector in this equation?

And I and I honestly think that, you know-- I think you and I will disagree, or agree to disagree in the short-term, that this is the first attempt, I'm seeing, in good faith to do something with the absolute prices of, or the profitability with the-- between the pharmaceutical companies and the pharmacy benefit managers to extract an expense for the rising cost of drugs that's going to go somewhere to subsidize the AFFORDABLE CARE ACT.

So I think it drags it back into the equation, it may not be the most elegant way, but I frankly find a lot of-- you know, there's-- I can understand the rationale as much as you dispute it. But thank you for that.

KELLY RYAN: I understand. And we can agree to disagree in the short-term. But I think your sense of the bigger problem is not off base by any means.

REP. MESKERS (150TH): No. I think 3000 a month with a $10,000 annual deductible is not insurance, it's catastrophic insurance, and that's the problem.

KELLY RYAN: We would agree with that.

REP. WOOD (29TH): Great, Kelly, and thank you.

KELLY RYAN: Thank you.

REP. WOOD (29TH): Next up is, Cara Gooding, followed by Indresh Srivasta.

CARA GOODING: Hi, can everybody hear me?

REP. WOOD (29TH): We can hear you.

CARA GOODING: Good evening, Members of the Committee. My name is Cara Gooding, I'm the Director of Case Management at Bristol hospital. I'd like to thank you for the opportunity of speaking with all of you this evening in support of House Bill 6586, AN ACT CONCERNING PRIOR AUTHORIZATION AND HEALTH CARE PROVIDER CONTRACTS.

There are several clinical circumstances in which the hospital is required to obtain prior authorization, all of which can be confusing and time consuming. The two types of authorizations we deal with in case management are authorizations for inpatient hospital stays and authorizations for short-term rehab.

The authorization process for inpatient hospital stays consists of sharing clinical information with the payer in order to establish medical necessity for acute inpatient hospitalization. Each insurance company has their own process for sharing clinical information. For example, Anthem, Atnah, Cigna, and United Healthcare all require clinical information to be faxed. This requires printing the medical record and submitting the record via fax to the appropriate case manager.

The case manager reviews clinical information based on their criteria set and issues either an authorization or denial via return fax. Fax and clinical information creates delays, mostly due to fax machines being down, busy fax line, printing issues, and pages being lost as they're sent within each payer system.

There is a solution. Connecticut Medicaid has direct access to electronic medical record. Patient information is uploaded into their portal for payer review. This allows for more timely review and authorization determination. If Medicaid can do it, why can't the rest of the payers?

Authorizations for short-term rehab also known as post-acute care is where we see long and preventable delays. There have been times when we have spent hours trying to navigate the payers automated call system. To request a short-term rehab authorization, for example, with Anthem or Atnah, it requires a phone call to the precertification phone line, which in most cases is not answered and we are instructed to leave a voicemail and the payer would then have to call us back with further instruction.

Once we receive a return call, we are asked to send clinical information, again, via fax to the insurance case manager handling the authorization. Anthem does not provide weekend or holiday staff to accept and review authorization requests. However, Atnah does provide staff during weekends and holidays, but on a limited basis. Which really means, if a patient comes in Friday afternoon in most cases authorization will not be obtained until Monday or later.

Again, there's a solution. Medicare fee for service and Connecticut Medicaid do not require a prior authorization for patient to move over to short-term rehab. If clinical criteria is met, then the patient is entitled to the benefit, eliminating authorization delays.

We estimate that the prior authorization adds $154 million of cost annually to the Connecticut Health Care System. At the very least, shouldn't there be rules and focus on making sure the prior authorization process is appropriate and efficient using 2021 technology?

I don't understand how insurance companies reporting billions of dollars in profit haven't upgraded their IT infrastructure to make the prior authorization process more efficient and timely for their members. On the provider side, we are incentivized by CMS to do so 10 years ago. Now, we would be penalized, if we haven't implemented electronic medical records.

How is it possible that nobody is holding commercial insurance companies to the same standard? Thank you for your time.

REP. WOOD (29TH): Cara, thank you so much for speaking and sharing the story. I think it's really important for us to hear, you know, what you're dealing with at Bristol Hospital, in terms of how this Bill can be helpful to you. Any questions from the Committee? Cara, Thank you. Next up we have, Indresh Srivastava. And I apologize for pronouncing your name incorrectly, followed by Dr. Andrew Lim.

INDRESH SRIVASTAVA: Do not worry. So, good afternoon, the Committee. And my name Indresh Srivastava, and I'm the head of Manufacturing, Science and Technology at Protein Sciences. It's a Sanofi owned company.

My career has been dedicated to innovation and the vaccine development, proteins. And I'm here to testify to oppose the House Bill 6447, because we believe that it will stifle the innovation that will prevent the development of innovative vaccines and medicines.

There is a lot of diseases are going on. I think we are all experiencing the challenges with COVID as one example. Protein Sciences is a vaccine biopharmaceutical company which is based in Meriden, Connecticut since 1983. Since 2017, the company is owned by Sanofi.

We have a small staff, we have about 100 people. 70 people are dedicated for the scientific jobs and projects and 30 people are dedicated for the commercial vaccine production.

Our goal is-- our mission is to save lives and improve the health of the people by developing innovative vaccine. One of the innovation that came out of Protein Sciences is the development of recombinant influenza vaccine flu block that is approved by FDA since 2013. And it is available to the public.

In a recent clinical trial study, what we have shown here is that individuals who receive flu blocks, they were able to be less likely to get influenza compared to a quadrivalent vaccine that was based on the inactivated virus. It's an old technology so there is an advantage of using new and improve technology.

Also, Protein Sciences is also researching and developing important new vaccines by providing both the scientific data and breakthrough, as well as resources that are reinvested in developing the next vaccine treatment or cure.

In 2020, Sanofi invested about 6 billion in research globally. For instance, Sanofi has also entered in a partnership with GlaxoSmithKline for developing a COVID-19 vaccine as part of the operation versus speed. We all know that the vaccine for COVID-19 is really needed.

Also, the virus is mutating, it is mutating constantly. And so we need to focus on the on the technologies that we have currently and beyond the technologies that can be used for taking care of that latent virus and the vaccine. I think protein Sciences is critically suited because we are producing the vaccine for influenza virus, which mutates every year. So, this platform need to be maintained and strengthen.

So, Sanofi is also permitted to have the same concern over the rising healthcare costs with our pricing principles, first implemented in 2017. Sanofi's fourth annual pricing report is already included with my testimony, testimony to give you an idea that we are responsibly pricing medicine. Just to give you an example, in 2020

CLERK: Three minute ordering.

INDRESH SRIVASTAVA: Okay. In 2020, a process portfolio, Sanofi has an average aggregate list price increase for 0.2% and aggregate net price decrease of 7.8%. And most important part is, that the stifling the innovation will create vaccine shortage and vaccine shortage will lead to the outbreak of serious diseases. And also if the shortage continues, then it will also impact the development of the vaccine, which is critically needed for the new diseases. Just to give you an example--

REP. WOOD (29TH): Indresh, thank you. Thank you very much for your testimony. We've hit that three minute mark, we really appreciate you coming on and waiting for your turn.

INDRESH SRIVASTAVA: No problem. Thank you.

REP. WOOD (29TH): So, any questions from the Committee? Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Dr.-- how do I say it? Srivastava.

INDRESH SRIVASTAVA: Say it, this is close. No problem.

SENATOR HWANG (28TH): Well, I just wanted to thank you. I know, we acknowledge Pfizer, we acknowledged, obviously, Ballringer, but it's also important to acknowledge your work. Obviously, Protein Science is

one of the largest flu vaccine providers, and it's important to note that during this pandemic, through personal hygiene and safety protocols and mask wearing, our incidences of flu are significantly lower.

But prior to that, I wanted to acknowledge that you as a Connecticut-based company, now being a part of Sandoval have always been very engaged in the protection of individuals, and through your science and help. I know in this building, in the Legislative process, we're gonna have a very lengthy debate about the merits of vaccines.

For me, I wanna be clear vaccines, I believe in vaccines, I believe in the science of it, but I also believe in individual choices. But I wanted to acknowledge and thank your organization, for your work and providing health care in the flu aspect. So, thank you, Madam Chair, but I just simply wanted to thank our bioscience, biotechnology companies. Thank you.

INDRESH SRIVASTAVA: Thank you. Thank you, Senator.

REP. WOOD (29TH): Thank you for doing that, Senator Hwang. Next up we have Dr. Andrew Lim, followed by Dr. Dennis Ferguson.

DR. ANDREW LIM: Well, good afternoon. Can you guys hear me okay?

REP. WOOD (29TH): Yes, we can.

DR. LIM: All right, sounds good. Thanks for having me, thanks for allowing me some time tonight. My name is Dr. Andrew Lim, I am the Medical Director of Emergency Medicine at Bristol hospital. But more importantly, I'm a frontline ER physician in the Bristol Community. Thank you for the opportunity to address H.B 6586, AN ACT CONCERNING PRIOR AUTHORIZATION AND HEALTH CARE PROVIDER CONTARCTS.

Bristol Hospital supports H.B 6586, which provides a vitally needed solution to the pervasive abuse by health plans of the prior authorization process. In my role leading the Emergency Room here at Bristol Hospital, the prior authorization process has a major effect on patients awaiting transfer to a short-term rehab facility.

For the patient's safety, it's often best not to discharge them directly to home, especially if they're living alone or don't have family to provide assistance. Challenges with prior authorizations often occur on a Friday night or the weekends when appropriate staff from the insurance company are unavailable to approve transfer into short-term rehab. This results in the patient having to stay overnight, or even over the weekend, in the emergency room until the insurance company approves the physician's recommendations.

There is also an overlooked downstream effect that occurs in all hospital emergency departments as a result of this pending approval process. Many patients awaiting prior authorization for short-term rehab, are at the highest risk for complications from COVID-19. They will spend days either in a private room or a hallway in the emergency room. This puts other patients also at risk due to room unavailability and crowded waiting rooms.

In addition, this puts healthcare workers at increased risk, during a time when staffing shortages were already the norm due to COVID-19 illness. As a result of COVID-19, the entire healthcare system has been stretched to the limit. Doctors, nurses and hospital staff have really stepped up during this extraordinary time to care for our community.

During the same time, the insurance companies need to step up and support us who are working tirelessly, while at the same time endangering ourselves in the mission for caring for others. The

American College of Emergency Physicians or ASAP, affirms the principle that, patients should receive prompt emergency care regardless of payment source or ability to pay.

ASAP asserts that prior authorization rules instituted by third party payers must not pose a barrier to patients seeking access to timely emergency care. ASAP further asserts that insurance companies have obligation to pay for unnecessary evaluation, stabilization, and or transfer that an insured patient should be granted the expectation of coverage when seeking emergency care.

H.B 6586 provides a needed solution to the abuse by health plans of the prior authorization process. There is value to prior authorization, but we're funny that many health plans are using it routinely for procedures with established standards where there's no history of questionable use.

Connecticut's insurance laws do not protect patients and providers from prior authorization abuses. H.B 6586 sets a path to-- but pathway to by revising current statutes and implementing new provisions to create standards, transparency, and accountability in the prior authorization process.

Please approve this Bill so Connecticut hospitals can continue to provide safe, high quality and affordable health care to the patients and their families. Thank you for allowing me to speak today.

REP. WOOD (29TH): Dr. Lim, really glad that you're here and thank you for doing what you do. It looks like you are still in the office, so we appreciate.

I'm just a little concerned with the process for prior authorizations when patients need to be moved to a facility, like using fax machines, and if it's off hours, I just feel like-- is that really, you know, the case in 2021?

DR. LIM: Yeah, correct, that's definitely-- You know, a lot of the challenges is technology and, you know, not having staff on the other end to kind of confirm the authorization.

So, you know, the ER tends to be a safety net and, you know, clinically, I always try to do the right thing, and our team always does the right thing. And if a patient needs to go to a nursing home, rather than discharge them or have them wait in the waiting room, we keep them where we can continue to care for them until we have that, kind of, final destination set.

And unfortunately, in some cases, it can be, depending on the day, if it's a Friday, that can be a Saturday, going into a Sunday, which takes up a needed space or a needed private room for someone who may be critically ill coming in. So that's definitely one of the challenges that we've had to contend with.

REP. WOOD (29TH): And why is this still an issue in this day and age? I mean, I'm sure you have complained about it and asked for this to be improved. Why are we still using fax machines and, you know, we have Apps and all kinds of technology now to streamline this? Is there pushback from the insurers? I mean, I'm assuming that's what it is.

I don't know if you even know that, because you're dealing on the front lines, and not really dealing behind the scenes.

DR. LIM: It's a really good question. You know, Cara Gooding, who spoke before me, could probably speak of, you know, more about the finer details. I know that that's something she's been pushing for, in terms of a more streamlined process for communication.

You know, from my standpoint, oftentimes, I rely heavily on our great Case managers to kind of work

the ins and outs and know the system, but oftentimes, what they do have to come-- they come back to me with the, you know, the kind of the bad news that, you know, "Hey, we're gonna have to, you know, watch this patient overnight, they're not going to go anywhere, you know, at least until the morning, and maybe not even the next day, because, you know, this poor communication infrastructure that we're given."

REP. WOOD (29TH): Right. Thank you. Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you, Madam Chair. And thank you, Dr. Lim, for your testimony, I appreciate you taking the time out of your busy schedule.

I know Section 3 of the Bill discusses prior authorization, or I think. Well, it says, "Delineates circumstances where prior authorization is not permissible, such as when a treatment or procedure is performed in the middle of surgery or procedure, that the health plan is already authorized." How does it work now, if you're in surgery and you have to do something that wasn't necessarily pre-authorized, and it-- you know, doesn't it fall under an emergency situation that is going to be-- doesn't need prior auth? How does that work?

DR. LIM: You know, to be honest, I'm not-- I don't know. My specialty is emergency medicine, so that's a-- it's a situation I haven't come across.

REP. PAVALOCK-D'AMATO (77TH): Okay. Yeah, and I should have asked Cara that question. I probably have a couple others for her as well.

DR. LIM: I think Cara might still be on the call, I don't know, if there's a way to kind of let her back in, she might be able to--

REP. PAVALOCK-D'AMATO (77TH): I can contact her. I'll send her an email.

DR. LIM: Yeah.

REP. PAVALOCK-D'AMATO (77TH): But are there any other situations that you can think of that-- You know, we wanna make sure that this is thorough.

DR. LIM: Sure.

REP. PAVALOCK-D'AMATO (77TH): So are there any other ones that maybe aren't covered, or that are especially important to you in the Bill that you wanna make sure goes through when it comes to the topic of prior authorization?

DR. LIM: Yeah, I mean, that's really, you know, that's really the biggest part that kind of hits home for us, is, you know, during COVID, so, I mean, I speak in the past tense, but obviously, we're, you know, hopefully on our way out of it, but obviously, we're still in the middle of a pandemic, and one of our biggest goals was to make sure that we could take care of patients safely, and that involves social distancing.

So, you know, it became-- it was unacceptable in my book to keep people in the waiting room, and so we really had to shift our focus on throughput, and making sure that we could see people in a safe environment, but also making sure that our patients feel comfortable seeking health care. We know that one of the big issues was people were delaying care or not coming to the ER because they're scared to contract COVID.

So to be able to do so, you know, we have to really make sure that we're being efficient and that we have processes in place to make sure that we were cleaning rooms thoroughly, that we're able to get people in the rooms quickly.

And really one of the biggest challenges that we had a lot of difficulty overcoming was, what do we do with the population of patients who we were holding in the ED, you know, for many hours, and in some cases, multiple nights, kind of a waiting placement, when we all knew that-- we knew where the patient needed to go. We just couldn't get them there.

So I think this will be a good big part in helping to remove that barrier to care.

REP. PAVALOCK-D'AMATO (77TH): All right, thank you very much. And, yeah, I appreciate your testimony.

DR. LIM: All right. Thank you.

REP. WOOD (29TH): Thank you for joining us. Dr. Lim. Next up is Dr. Dennis Ferguson, followed by Wyatt Bosworth. Dr. Ferguson, are you are you on?

REP. WOOD (29TH): Okay. Is Wyatt Bosworth on? Yes, I can see Wyatt.

CLERK: Madam Chair, number 28 is on, I just don't know if they—

REP. WOOD (29TH): Okay, let's hold on and see if Dr. Ferguson can unmute and join. We'll give him a few seconds.

DR. FERGUSON: Okay, unmute.

CLERK: There you go.

REP. WOOD (29TH): Oh, all right. Thank you.

DR. FERGUSON: Am I unmuted?

REP. WOOD (29TH): Yes, you are.

DR. FERGUSON: Am I unmuted or can you hear me?

REP. WOOD (29TH): We can hear you.

DR. FERGUSON: Okay, you can't see me, I guess. I don't see my picture. Okay, I think I'm changed my-- instead of reading what I was going to present, I could probably answer some of the questions that were of concern.

I wanna thank everybody on the Committee for allowing me to talk. I've been a physician at Bristol Hospital since July 1977, and for the last seven years have been the physician advisor in the case management area, which was a job that didn't even exist two decades ago.

It now comes in necessity, because of the way insurance companies have changed things. Oh, I think I'm connected. Can you still hear me?

REP. WOOD (29TH): Yeah, we can hear you.

DR. FERGUSON: I'm sorry. Some of the questions that were asked to Dr. Lim, I could probably answer. But the bottom line is, over these seven years as a physician advisor, I've seen dramatic changes, things are happening that insurance companies are changing policies, they're almost practicing medicine without a license.

And we-- in order to take care of patients, we need the collaboration of government, hospitals, insurance companies, and community services in order to really treat them.

So, just a quick statement, instead of going through all the problems, the solutions are, what I think we have to do is, we need to have a standardized effective process to obtain authorizations. It is true, we're still on fax machines, excuse me, and, and various different requirements for different insurance companies.

We need the insurance companies to be able to access our electronic medical record, because many times

when we get denials for coverage or not getting our pre certs on time, they're saying they don't have the clinical information. But it got lost or the fax machine was broken, etcetera, etcetera. We've been trying to do this for two years now to get everything electronically sent to them, but there's been resistance.

When we ask for a pre-auth, we need to get a response within four hours, actually, Medicare rules state that it should be one hour, and then they're responsible for this, especially the Medicare plans. Unfortunately, the insurance companies don't follow these rules, and these rules are not enforced, and sometimes insurance companies will take days to respond.

We need insurance companies to provide seven days a week coverage. People really get sick on Fridays and weekends, and you can't get a pre authorization on a weekend. When we don't get a timely response, as you heard from Dr. Lim, the patient remains in our emergency department or in our hospital inappropriately. We call those, avoidable days.

So the patient stays in our hospital even though the physicians feel that the patient should be transferred out for, say, short-term rehabilitation, and they're not getting the proper care, in the right place, at the right time.

I'm gonna stop there because everything has been said already, so I don't really want to continue that. But just like the ambulance service, unfortunately, we haven't gotten paid for people we took care of two years ago. So, we have lots of problems with this system and we're very much in favor of changing it with this policy.

DR. FERGUSON: Thank you, Dr. Ferguson. We have a question from, Representative Pavalock-D'Amato.

DR. FERGUSON: Okay.

REP. PAVALOCK-D'AMATO (77TH): Hi, doctor. Thank you for your testimony. How many-- what do you think the percentage of cases are or claims are that get rejected initially overall?

DR. FERGUSON: Oh, I would say, well, it varies by the type of insurance you have. Our biggest offender or our biggest denier would be managed Medicare plans. And I would say that we see, oh, I would say 10 a week, all totaled, something like that. I don't know what percentage that would be.

REP. PAVALOCK-D'AMATO (77TH): Well, I was gonna say that how many, though, if you get 10 rejections, how many you're putting in? Do you have any idea of a number? A hundred? A thousand?

DR. FERGUSON: How many patients we have?

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

DR. FERGUSON: I don't have that. I know Cara will have that information.

REP. PAVALOCK-D'AMATO (77TH): Well, then it may-- I was gonna ask Cara, but maybe you know, from the ones that were rejected then, I'm wondering if there's resubmission then, what the percentage of acceptance or payout is on the ones-- the second time around?

DR. FERGUSON: We go through this every case, and we have the ability to overturn, I would think, half. But unfortunately, there are some that are so obvious. What happens is they actually-- the insurance companies now use a third party Cotiviti, or Optum, and after they've already been certified and approved, Cotivity will come in and say, "No, we're gonna take the money back."

And when we talk to the physicians at these companies, they're unrelenting. Even though we have

all the proof and we've actually given it to other people, and we can prove that the patient had what we said, they still resist and we still haven't gotten paid. And there's-- it's a very, very frustrating system.

REP. PAVALOCK-D'AMATO (77TH): Yeah, I'm sure especially for the patient too. I mean, they're in the real position, a vulnerable position and, you know, expecting it to be covered, and then saddled with a bill, I'm sure is-- I know—

DR. FERGUSON: Well, they won't get a bill, they won't get a bill from the hospital for this.

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

DR. FERGUSON: They do get a notice of non-coverage, but they won't get a bill from us for that. That's just not fair. It's not fair that the hospital doesn't pay for-- when they don't get to send them to the SNF, the Skill Nursing Facility for short-term rehab.

What will happen is they'll stay in our hospital for three days, four days, and then the insurance company won't pay the hospital, because they say, "Well, it's not medically necessary." Well, it's not medically necessary, yes, but we can't ship them out because they can't go home, it's unsafe and yet, you're not giving us the authorization to let them go.

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

DR. FERGUSON: It's even worse when they have Medicare managed plans and Medicaid. Medicaid will automatically send them there, but we need the denial first from the insurance company in order to have Medicaid pay for their nursing home.

REP. PAVALOCK-D'AMATO (77TH): Right, yeah. I was just thinking about that, that it's just a shifting

of, you know, ultimately, who pays. So, I can see how, though, under our state laws, I believe not being able to discharge somebody or having to discharge somebody from a-- to go to a nursing home, but them not wanting to take them, now I can see where the issue lies. So, I think that's something, hopefully, that we can discuss and work on. But, yeah, I'll definitely--

DR. FERGUSON: That's right.

REP. PAVALOCK-D'AMATO (77TH): Yeah, I'll definitely reach out to Cara, I have a couple more questions, but I think she might have the numbers that I'm looking for. So, thank you for your testimony.

DR. FERGUSON: She did have all the numbers. We broke it up into threes. But it's limited to be able to do that in three minutes.

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

DR. FERGUSON: You're welcome. Thank you.

REP. WOOD (29TH): Thank you so much for joining us. Next up is Wyatt Bosworth, followed by Mark Schaefer.

WYATT BOSWORTH: Hello, can you hear me?

REP. WOOD (29TH): Yes, we can.

WYATT BOSWORTH: Great. Well, good evening, Chairs Wood, Lesser, Ranking Member Hwang and Pavalock-D'Amato. My name is Wyatt Bosworth, I'm an Assistant Counsel with CBIA.

CBIA is Connecticut's largest business organization with thousands of member companies representing a diverse range of industries, 95% of our member companies or small businesses with less than 100 employees.

I'm here today to voice CBIA's opposition to the Governor's Bill, House Bill 6447. While we certainly appreciate the Governor's desire to stabilize the individual marketplace and expand coverage to those who currently don't qualify for adequate EPTC assistance from the federal government, we are concerned about the additional financial burdens such assessments will cause for the individual and large group markets.

Additionally, the recent developments in Congress with the AMERICAN RECOVERY ACT precludes the need for Connecticut to fix this problem by itself. Just note that I'll just be speaking on the assessment portion of the Bill, I would refer you to my colleague, Paul Pescatello's testimony on the drug pricing and CBAS position.

So, assessments and taxes continue to be a major driver and overall insurance costs for individuals and small businesses. Recent data I acquired from the health carrier shows that fully insured plans incur close to $360 million annually in assessments taxes and fees. Self-insured plans incur around $74 million annually. And this results in per member annual cost in the fully insured market of 591 annually and 54 annually for the self-insured market.

We do appreciate the language on lines 139-143 that essentially exempts fully insured small group plans from the assessment, but we still oppose the Bill due to the financial burden that would be disproportionately levied on the large group and individual markets by this assessment.

The assessment also serves a duplicative purpose. Due to the pending COVID stimulus Bill before Congress, The AMERICAN RECOVERY ACT recently passed the US senate and is before the House for a vote either tonight or tomorrow.

This package includes some of the biggest, most monumental reforms to American health insurance since the passage of the AFFORDABLE CARE ACT in 2010. And if signed into law by the President, the ACT will achieve the same objective as the Governor's Bill, similar to SBA 42, but without inflicting an additional financial burden on health insurance carriers and consumers in the state.

So current law limits eligibility for tax credit assistance to households whose income is from 100-400% of the federal poverty level. The Stimulus Bill would remove this Cap and would also limit the amount anyone pays in premiums to eight and a half percent, which is currently 10%.

The Congressional Budget Office reports that expanded eligibility will resolve--

CLERK: Three minute and running.

WYATT BOSWORTH: --in 7 million more people obtaining health insurance in the marketplace with over 40% of them individuals who are currently ineligible for any tax credit assistance under current law.

And if you look at my testimony, I attached the CBO report that I think may be of use to all of you on this Committee. So I'll just close by saying that we urge the Committee to reject this Bill, because federal dollars are imminent to fix this subsidy Cliff on the exchange, which we fully appreciate and understand is a major, major problem. But we also urge this Committee to pass other measures, like a reinsurance program that relies on state funds in lieu of new assessments so we can begin to stabilize the individual small group markets.

REP. WOOD (29TH): Thank you, Wyatt. Thank you for your testimony. I will turn it over to questions. Representative Meskers.

REP. MESKERS (150TH): Thank you, Wyatt. You know, I'm appreciative of the commentary and your concern about assessments in cross ships, but as an observation, I'll repeat what I said prior, which you're representing the entire business community, a majority of them are consumers of health care and health care costs, and I think the issue going forward is going to be one of containment of health care costs, because it's overwhelming your industry as well as my constituents.

And if a policy is costing 25-35,000 dollars a year per employee, we're gonna have issues going forward, it's like grows at 7% a year. So I appreciate your concern for assessments, I know that the government is coming forward with some plans, which will alleviate some of that, but without directly dealing with hospital costs and pharmaceutical costs, I think we're all on a path that's inevitably gonna create a problem for us.

So, I understand the concerns, I would just respond by telling you that, I'm looking for someone to address those issues and that falls to the Legislature to an extent, and whether that's the state or national Legislature, that we have to do something with the cost containment, and that's not happening. So, I thank you for your testimony, I appreciate your concerns.

WYATT BOSWORTH: Thank you.

REP. WOOD (29TH): Representative Nuccio.

REP. NUCCIO (53RD): Sorry, I couldn't find my mute button there. Thank you, Madam Chair. Good evening, Wyatt. How are you?

WYATT BOSWORTH: I'm just dandy. And how are you Representative?

REP. NUCCIO (53RD): I’m just dandy, also. Thank you for your testimony. So, I had a couple of questions

I was hoping maybe you could kind of help me parse through. So, CBIA, you guys have been pretty vocal about the plans that are before us.

So currently, we have this plan, which I think does take a step in a direction to try to start dealing with healthcare costs, but also has the punitive tax and premium pieces of it, then we have the public option piece, and then you have-- which I agree with you, I believe a lot of the pieces of that are being directly impacted by what the private industry is doing, and also this federal package is gonna be very significant in the change for that. And then we have S.B 1006.

And I was wondering if CBIA has any-- where are you guys headed for a combination, or, you know, a compare and contrast of these Bills, and which ones you think would be best for your members in the industry?

WYATT BOSWORTH: Yeah, I mean—

REP. NUCCIO (53RD): Oh, and I'm sorry, I don't mean the insurance industry, I mean, your business members.

WYATT BOSWORTH: Yeah, absolutely. And while the insurance industry are members of CBIA, we are, you know, by and large, we represent small businesses in the state that buy health insurance from those companies. So I'm here on behalf of them.

And, you know our position on public option, I'm sure, but, you know, with assessments, you know, we just have businesses who just don't wanna see the cost of their premium go up anymore. And, you know, if assessments were to go forward, I think we certainly appreciate exempting the fully insured small group market, right? Because that's the market that really feels the pain every year when it comes to premium increases.

But I think as Representative Meskers said, we really have to understand the problem with the cost of health care and why it's rising so much. I think CBIA, we appreciate the benchmarking plan put out in 1006, you know, building on the progress of the Office of Health strategy, codifying that Executive Order into law, so that program is here to stay, and really beginning to identify the major cost drivers, including primary care, which, you know, the Bill sets at a 10% Cap, which I think is integral to, you know, getting a rein on health care costs and keeping people more involved in primary care services.

And, you know, reinsurance, that's something that has bipartisan support this year, the Governor signaled his support for it, the House Speaker did, I know, some of you on this Committee have, and that's another important part of the Bill as well. But I think the place where we become cautious is where we start to rob Peter to pay Paul, where we, you know, a set-- we're essentially picking winners and losers by, you know, picking out who to levy this assessment on and who will benefit from the assessment and, you know, that not only hurts the people whose plans are subject to the assessment, but it also hurts the carriers that will be taxed in a retaliatory way if they ever want to expand their business out of the state of Connecticut, and ultimately lower the incentive for them to remain domiciled here.

And there's thousands of jobs supported by the industry in and around Hartford, that I think we need to do everything we can to make sure they stay around. So, I don't know if that answered your question. But, you know, we want to expose costs through benchmarking, we want to make that information available to the public, we want to hold the insurers and the hospitals and the payers accountable.

And then, you know, we also wanna take advantage of all of the federal dollars coming in. You know, there's massive, massive expansions to the ACA hidden in this COVID Bill, Medicaid incentives to expand in states that have been expanded, you know, extending and expanding COBRA, you know, extending free health insurance on the exchange to those who've, you know, received unemployment compensation this year.

The Federal Bill does a lot and it really removes the need, I think, for Connecticut to inflict any more harm. Because it's going to achieve the same purpose in a much less fashion.

REP. NUCCIO (53RD): I agree. I do think there's a lot of incentive in this Federal Bill that is gonna change the landscape, at least, for the immediate couple of years, so, I think we agree on that.

And I'm gonna be honest with you, I know it's painful and it's ugly, but I love the idea, I love the thought that people are starting to recognize what Legislation means to their insurance premiums. It's kind of what I do, where I work my real job and, you know, my other job. So, for me, that was always a driver for me.

When you look at all the Legislation states passed in state assessment and you start to add them up, it's significant, it is very significant. And Connecticut is obviously one of the 50+ states that do it. So, the fact that people are being educated enough to understand the driver, part of the driver of their insurance costs are these assessments and taxes, that's reassuring to me, 'cause that just means that I'm doing my job well, on the other 9-5.

But along those lines, I read the article that CBIA put out with the public option, I just was wondering if you've heard back yet from your FOIA request for the state plan?

WYATT BOSWORTH: Yeah. So we didn't ask for a FOIA request. The Health Insurance Brokerage Firm, Brown and Brown, which has a number of clients in the partnership plan and is-- really makes its money from, you know, selling coverage on the partnership plan, we rely on them to grab the FOIA data from the partnership plan every year. They send the request to the Comptroller's office, the comptroller sends the plans finances back to Brown and Brown, and then they report that financial picture to their clients who've obtained coverage through the partnership plan.

I think from CBIA's perspective, and, you know, this kind of came after the Comptroller sent a letter addressed to me after I essentially attached the report to some testimony I submitted to the Appropriations Committee. You know, he doesn't feel like the Brown and Brown data paints the full picture, but the thing is, it's his data. It's his data.

And if he doesn't agree with his own data, I think from CBIA's perspective, you know, we think if public option is going to be the vehicle this year, and we wanna add people to that plan, we should understand fully the financial outlook of the partnership plan before, you know, we expose the taxpayers of Connecticut and the small businesses and nonprofits of Connecticut to any financial liability moving forward.

REP. NUCCIO (53RD): I agree. And I think I it's important to note that industry has stepped up in regard to this. We've now seen both Anthem and Cigna come out to offer new, fully insured plans to the small business market, which I think have more transparency. But that's a whole other conversation.

So, thank you very much for your time. And at some point, I would really like to sit down and talk to you guys a little bit more about your vision on how

benchmarking can help, so we could try to incorporate that somewhere.

WYATT BOSWORTH: Yeah. And then I'll be at the hearing on Thursday as well. So I'd be happy to exchange with you guys as well.

REP. NUCCIO (53RD): Perfect. Thank you. Have a good night.

WYATT BOSWORTH: You too.

REP. WOOD (29TH): Thank you. Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. Good to see you, Mr. Bosworth, and thank you for your past testimony. And it's important for people to know that CBIA represents not only-- you represent thousands of small, mid-size, and large businesses, and hundreds of thousands of employees, and you are a consumer of health insurance products. So, this very important for your clients.

That being said, elaborate a little bit more. I mean, the tax or assessment in the Governor's Bill is a solution of getting revenue to, kinda, fulfill the components of the reinsurance program. You articulate in your testimony that the $1.9 trillion package that is about to be signed, hopefully, by President Biden will allocate significant and unforeseen federal dollars for healthcare.

Explain to people how that could work, instead of assessing or taxing insurance products, which will end up in somebody else's pocket or costing somebody else's money. Talk about how you envision using federal money, taxpayers throughout Connecticut that pay into the Federal Fund and get very little back, how could we maximize that? How does that work? If you could.

WYATT BOSWORTH: Yeah. So, let me just say, again, it's really, really hard to overstate how big this

health care package is for this country and specifically for Connecticut. So I'll just tell you what the individual market subsidy portions in the AMERICAN RECOVERY ACT do.

So, first, it fully subsidized the second lowest cost silver plan for consumers with incomes up to 150% of the federal poverty level. And second, it enhances the tax credit sliding scale for those above 150% of the federal poverty level, and eliminates the 400% federal poverty level ceiling.

So for example, I think someone making more than $55,000 a year, they fall off a thing that's called the subsidy cliff, right? These middle-class hard working jobs, there's a harsh cut-off at around $55,000. This Bill removes that, okay? And instead Caps premium contributions to 8.5% of income instead of the 10% ceiling that was currently under law.

It also greatly expands subsidies to those under 400% of the poverty level as well. And so, I think, essentially, it's doing close to the same thing that this Bill aims to do, right? It's expanding coverage on the ACA, it's expanding subsidies. It's boosting up both the bottom and high end of the federal poverty level threshold. And it's doing so without imposing a penalty on large group and individual plans.

Okay, so I just think -- I just think it's good public policy and our members think it's good public policy to just sit back on this one and let the federal government in this $1.9 trillion package, lower the cost of health care by itself.

Now, obviously, this Bill is going to expire in 2022. Right, so this is not a permanent fix. This is going to be a constant political question moving into the midterms in 2022.

I'm sure it'll be a central part of all of your races in 2022, about what we do with health care.

But for the next two years, the Bill does exactly what 842 does. It does exactly what The Governor's Bill does, but without the penalties.

SENATOR HWANG (28TH): You're talking about Senate Bill 1006?

WYATT BOSWORTH: Correct.

SENATOR HWANG (28TH): Thank you. Talk to me a little bit about -- I mean, reinsurance is a product that that obviously The Governor has put into his proposal. But also there's validation of it right. From the standpoint, we've heard references to the Wakely report.

And why before you answer, I just wanna have kudos. The Celebrity of the day, Senator Lester in the baby, there you go. Sorry, Wyatt for interrupting you. But that being said, you can explain a little bit, I understand the why the Wakely report was actually a report requested by the legislature or state government. Right? It was objective and as an agency. Can you elaborate a little bit on that?

WYATT BOSWORTH: Yeah, it's a credible report. And I think your caucuses Bill lent, great credence to the report by, you know, using the $20.2 million allocation. That's the number that the Wakely Report signified as, you know, the ceiling for getting a 5% reduction in in marketplace premiums.

And it also the Wakely Report shows and The Governor's Policy Director, Mr. Dach said today. Essentially, the federal government through pass through funding will match state funds on a one to one basis. It is one of the best ways to really capture federal pass through funding and take advantage of the funding scheme under the ACA.

So yeah, I mean -- I mean, the Wakely Report is something CBIA has reported on. It's something many

of you have reported on, and I think it carries great credibility in this discussion.

SENATOR HWANG (28TH): Yeah. And I appreciate explaining that, because I wanted to acknowledge, represent Meskers. I've been listening to him today. He's asked some very insightful questions. And I agree with him. Let's get to where we can contain the cost.

And I think one of the challenges we have read that Representative Meskers said, who's going to pay for it? Right? And I think what we're looking at is not simply a state-run health plan, but solutions to minimize cost.

And reinsurance is one. But talk to me about a second component, which is benchmarking. The Governor again, has kind of reiterated that by first having it be part of his Executive Order in initiating and having the Office of healthcare strategy begin the benchmarking process.

Could you elaborate a little bit in regards to your role as counsel but also an educator, an exchange with all of your members? What does benchmarking mean, and how does it really save money? And why did The Governor propose it in his Executive Order, but also consider it now in his proposal?

WYATT BOSWORTH: Yeah, I think one of -- one of the flaws with the Bills that have been proposed to date dealing with health care reform is we really – we’re essentially shifting money around, right. We're trying to, you know, tax one entity to lower the cost for the other entity.

But all of these reforms, eventually costs are going to catch up to them, right? It's going to be $50 million this year in pharmaceutical pricing and, and hospital spending, and specialty drugs and special -- specialist spending keeps skyrocketing as they do.

It doesn't matter how many times you come back and pass a new assessment; you're still not fixing the underlying problem. And I think that's what Representative Meskers was getting at. And benchmarking really is, is a useful tool for states to identify what are the cost drivers in healthcare? Whether it be pharmaceutical spending, hospital spending, specialty spending, primary care spending.

And it allows the state to kind of set a benchmark Right, let's say free percent, cost cannot increase by 3%. In the upcoming year, insurers and payers will be held accountable for public hearings and reports they have to give to the state, basically saying if they've complied with the cost growth benchmark, this is done in Massachusetts.

And if they don't comply, they're going to be under intense public pressure. To get their stuff together, they're going to have to submit to performance improvement plans, you know, be in constant contact with OHS and truly work towards reining in spending.

And I think what's amazing in Massachusetts is, you know, Governor Baker claims $5 Billion that's been saved by reining in the growth of health care costs in the state. And they've done that without ever utilizing a performance improvement plan. Meaning they never actually had to penalize an insurer or a payer to play by the rules.

And I think that's really fascinating. Because the public pressure was enough to make the insurance companies comply. And I think codifying The Governor's Executive Order and working with Oh, HS to really develop a robust program. So we can begin to expose the true drivers in healthcare. I think that's a necessity for trying to fix any of these problems. We have to understand the problem before we can fix the problem.

SENATOR HWANG (28TH): Thank you, Mr. Bosworth. And I want to extend the last time we had the exchange. Your president Chris DiPentima, and maybe I could just close with a comment that I saw online that Mr. DiPentima's comment was "We're not philosophically opposed to market competition, as controller Limbo says that we are opposed to putting taxpayers and small businesses at risk with a new state run healthcare plan model on one with major unresolved question about its financial health."

I think we're unified in that question that ultimately, with the possible proposal, it is the taxpayers of Connecticut that is on the hook and liability and that is one that we have to tread very carefully on. So Mr. Bosworth thank you very much for your work and, and extend my best to your membership that represent businesses in the state of Connecticut.

Thank you. Thank you, Madam Chair.

REP. WOOD (141ST): Thank you Wyatt, and your testimony was very informative. Your written testimony is also very informative. So thank you for submitting that. I hope the Committee members take time to read it.

Next up is Mark Schaefer, followed by Tom Swan. Is Mark Schaefer on? Dan, is he not coming on? Okay, is Tom Swan on? Okay, Mark Zatyrka. You are up followed by Sharon Hanford.

MARK ZATYRKA: All right. Hi, how are you? Thank you for having me here today. I'm testifying in favor of Senate Bill 1003. I'm here today as a Representative of the nonprofit patient organization, the New England hemophilia Association as well as myself, a patient living with a high-cost chronic life-threatening disorder.

My name is Mark Zatyrka, and I live in West Suffield, Connecticut. I was born with severe

Hemophilia A, which affects all parts of my life. Due to the internal bleeding that I've had throughout my life, my body is severely damaged and I'm left with severe chronic pain.

I've also come close to bleeding out on a few occasions. I have to give myself an infusion into my veins every other day at the cost of about $3,000 per infusion. I wish my medicine wasn't so expensive, but unfortunately, I have no other options.

While our medication is expensive, it's important to note that we do not have any generic options available to us. Hemophilia is an inherited rare genetic condition that affects an estimated 500 people in Connecticut.

And due to the exponential increase in deductible costs and out of pocket maximums, many of us in the bleeding disorders community rely on patient copay assistance programs. We rely on these programs like our lives depend on them.

These accumulator programs for subscribers to pay their entire out of pocket maximum early in the calendar year with one of their first prescription fills because our medication is so expensive. Very few individuals can pay the 8000 upfront costs or 17,000 for families in order to receive their monthly shipment of medication.

The argument that accumulators are needed to prevent patients from purchasing costly or brand name products makes no sense for those with hemophilia and many other conditions where no generic alternative is available. I can't tell you how grateful I am to have had access to copay assistance from the company that makes my medication.

Many families living with chronic illnesses barely get by living paycheck to paycheck and requiring them to come up with even 3000 or $1,000 immediately

if they want their child's medication is not only not fair, but it's not feasible and it's not humane.

Recent research in two of the states that have already acted to restrict copay accumulators found there was no noticeable increase in premiums. Families living with chronic illnesses like hemophilia, are not choosing their medication based on copay cards. We don't have generic medications to choose from.

All pharma companies offer almost identical benefits and benefits that are allowing families to afford their life saving medications, benefits that allow families to remain compliant on the therapies that were prescribed by their doctors and benefits that keep adults and children's out of bankruptcy and benefits that keep adults and children alive.

So on behalf of my family, and all Connecticut residents living with a bleeding disorder and other chronic illnesses, we urge you to support the passage of Senate Bill 1003. So that patients are able to fully access the cost sharing assistance available to them. Thank you.

REP. WOOD (141ST): Thanks, Mark, my question to you is, do you need to meet a deductible at the beginning of every year in order to afford your medication.

MARK ZATYRKA: Right. And so with lower cost prescriptions, that deductible and out of pocket expenses and as radical as it is for folks with more expensive drugs. So depending on the plan, that that one ship monthly shipments can be more than what your entire deductible is. And so some families have to come up with that price in order to get their first fill the year.

REP. WOOD (141ST): Okay, I'm sorry to hear that. And thank you for sharing your story. Representative Meskers.

REP. MESKERS (150TH): I want to thank you for your testimony. You gave it in a very flat calm, and clinical voice. And yet, when you listen to the details, and the ordeal you're through, you know, you should know that we're all cognizant of that.

And this is part of the face of -- of what we're trying to resolve both from the orphaned diseases or those that are rare diseases, with copays with mechanics of this with the lack of transparency with either cost-ships or copay-ships.

And, it's making a system that is picking both winners and losers. And ultimately, we're all losing from it. So, you know, know that -- you know, I think this proposal --I have to read through it. I'm not as familiar with all the details, but know that I'm inclined and favorably disposed from the testimony I've heard today.

And it's part of that bigger picture. It is that we're -- we need to acknowledge the fact that health care is becoming unaffordable, you're just the spearhead of the horrible issue that people are facing. And so I think all of us, including Senator Hwang, who and I will not necessarily agree on all, where we get to where we wanna get to.

We both have to sleep at night with our -- with our children, with our children's issues with our medicines. And we have to think about people like yourselves, and our ability to make sure that you have fair and accessible access to what you need to survive. So don't think that your testimony fell on deaf ears, and thank you very much.

REP. WOOD (141ST): I appreciate that. And yeah, I agree. I you know, our health care system has some issues and definitely needs work and things needs to be fixed. But to do that, on the backs of those of us living with chronic illnesses, I don't think is the right place to start.

REP. WOOD (141ST): Senator Hwang.

SENATOR HWANG (28TH): Thank you and I want to echo Representative Meskers' thoughts. Your testimony was incredibly thoughtful. But it also reflects an individual who's lived with that illness your whole life. And there's a -- here's a there's a patience in you that you sense and I want to echo Representative Meskers' acknowledgement of that.

And you're right, I said it earlier on this discussion, as we'll talk about it. I do believe health insurance and health care is a human right. And we need to find a solution to resolve it. We need to be able to provide care for every individual that that that wants it and needs it.

So the way is how do we find that solution? That's the he crux of the problem. But your testimony and your insight and your courage and being able to spend the time to share your story is an important role, and a talking point for many people that you represent.

So I want to thank you for being here with us tonight, and sticking it through all day. So thank you. Thank you for your powerful testimony.

MARK ZATYRKA: Thank you, Senator.

REP. WOOD (141ST): Next up we have Sharon Hanford followed by Sam Hallemeier.

SHARON HANFORD: Good evening, Representative wood, Senator Lesser, Senator Anwar, Representative Comey, Ranking Members Hwang and Pavalock-D'Amato; and Distinguished Members of the Insurance and Real Estate Committee.

I'm little nervous, but thank you for allowing me the privilege to be here. This is my first testimony. My name is Sharon Hanford, and I am a

woman in long term recovery. And I am also a certified peer recovery specialist. I'm here to represent myself and advocate with my peers for support of this Section 5 of House Bill 6588.

Peer Support Services are an essential role in health care, to support the recovery process. And the peer mentor is something that can't be duplicated unless you've been in that position. In Connecticut, if we are to increase the pathways to peer workforce, and improve upon recovery outcomes, we must make certified peer recovery specialists reimbursed of all.

In my personal experience and enroll as a CPRS to shorten the time working with mental health and substance misuse clients, I have an ethical standard by which I practice and my peer support and coaching. I've gained respect for my colleagues and I continue to be accountable and continue with continuing education credits.

With House Bill 6588, we can prevent further corruption of the peer support role and clearly define -- we have the flexibility of a broad job to define the flexibility of a broader job description. We recognize that we are professionals and we've earned our credentials.

We can have a fair and living wage. And peer support offers opportunity to recreate a life with joy and purpose as I have lived and I can identify with the peers that I work with. Please support House Bill 6588 and help Connecticut take crucial steps towards improving our system of care through a central peer support services. Respectfully and thank you for your time today. Sharon Hanford.

REP. WOOD (141ST): And, thanks so much for your testimony. Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madam Chair. And thank you, Sharon, for your testimony, it

was very heartwarming and very brave of for you didn't look like a rookie. So appreciate you coming in into you look like an old Pro.

And so I just wanted to kind of ask, you know, in your experience, why do you think we should do a task force whilst we're looking at this? And what do you envision that this will, will learn?

SHARON HANFORD: So what I what I'm hoping that will come out of it is that we will be recognized as professionals and that will become Billable for the people that we are working for as well as the quality of life for my life, as well as my peers. So, I think that it's important that it when we look at the Bill as a whole, that we're looking at the people who are serving the community and, and the people and to unify it.

I just think that it's important that we have a standard that we have recognition that we are uniformed, and that we bond together, because we are professionals.

And I've gone through -- and I've been on this all day, I listened to the woman from Advocacy Unlimited Michaela and she talked about, you know, the CCAR part and she talked about the Advocacy Unlimited part. And, you know, I went through CCAR, and I received my CPA, Recovery Coach Professional. And I went through Advocacy Unlimited, and received my Recovery Support Specialist.

And then I went further with all the accreditations and the time and the hours that I put in, and I received my CPRS from the State Certification Board. So for me, it just -- I've done the homework I've done the hours I've done the work, and I do I provide that service and the professionalism and the ethics to my client. Not saying that nobody else does, it just really makes it full circle as a career.

So with my lived life experience, and going into this as a career, it just kind of bonds it all together.

REP. DATHAN (142ND): That's basically what was gonna be my next question. It sounds like you've made a career out of this. And you know, you've been through a difficult experience in your life.

And it's probably very satisfying to know that you are able to build your life up based on your experience and be successful and help other people, it must feel very rewarding. So just wanted to thank you for your work on that because it does mean a lot to the people of Connecticut and I'm sure your clients are extremely grateful.

So thank you for your testimony. And thank you Madam Chair for letting me speak.

SHARON HANFORD: Thank you.

REP. WOOD (141ST): Thanks, Sharon. Next up we have Sam Hallemeier followed by Frank Musante.

SAM HALLEMEIER: Right. Good evening, everyone. Thank you, Madam Chair, Members of the Committee. My name is Sam Hallemeier. I'm Director of State Affairs here on behalf of the Pharmaceutical Care Management Association, otherwise known as PCMA.

And I'm here to oppose Senate Bill 1003. PCMA is the National trade association representing America's pharmacy benefit managers, otherwise known as PBMs. These PBMs administer the prescription drug plans and operate mail order at specialty pharmacies for more than 266 million Americans.

So PCMA, again opposes Senate Bill 1003, which would require health insurers to count all payments made by patients or third party towards an enrollee’s cost share. These drug manufacturers encourage patients to somewhat disregard formularies and lower

cost alternatives by offering these coupons to help the patient cover that higher cost.

Ultimately, this steers patients away from cheaper alternatives and towards these more expensive brand drugs. The State of Connecticut, as I've heard you mention throughout this hearing tonight is looking at you know cost of care drivers. And these coupons at the end of the day raise the cost of care. And here are some figures along those lines.

The prices, the prices for drugs with manufacturer of coupons increase faster 12 to 13% a year compared to non-coupon drugs, which we see at 78% per year. Medicare's has a ban on coupons at the federal level, which is considered an anti-kickback statute. And if it were not enforced, the cost of the program would increase 48 Billion over the next 10 years.

Coupons are responsible for $32 Billion increase in spending on prescription drugs for commercial plans. And then one more stat I have for you. For every $1 million of manufacture coupons for brand drugs that they offer to patients, these same manufacturers reap more than $20 million in profits. So that's a 20 to one return.

I do empathize with those that have spoken before me when they are go to the pharmacy counter and they get their medication and they're hit with the sticker shock at the beginning of their plan such as January, you know when they have these $1,000 copays.

Supporters of these coupons say that they decrease costs for patients. And while this may be true, at the pharmacy counter, they do not reduce the actual cost overall. Additionally, coupons are temporary, the individual patient likely pays more when the coupon goes away, and they are kept. Instead of being started on the formulary job from the start. It is the manufacturer who benefits by steering that

patient towards a more expensive drug. And they end up paying for that more expensive drugs.

If the drug companies were concerned about patients accessing medications, they should simply just lower their prices. But drug makers have determined that it's more profitable to increase copay systems rather than just making the medications more affordable.

Again, the simplest most effective way to reduce patient costs on these drugs is for manufacturers to drop the price of the drug. I'm happy to work with members of the Committee and other stakeholders on this Bill. But it's for these reasons and costs that we respectfully oppose Senate Bill 1003.

I'm happy to take any questions from the Committee members at this time.

REP. WOOD (141ST): Do we have any questions? Sam, thanks for coming on. We appreciate your waiting.

SAM HALLEMEIER: Sure. Thank you, folks.

REP. WOOD (141ST): Next up is Frank Musante. Is Frank on. I don't see to Frank. Next up is Ellen Andrews, followed by Teresa Sprague.

ELLEN ANDREWS: Hey, here I am. Hi. I'm Ellen Andrews from the Connecticut Health Policy Project. I'm here to actually -- again, I’m here to say that we support on 6447. But in fact, we strongly support the tax on drugs. But we have grave concerns about the covered Connecticut kid. The second half of the Bill.

The drug costs are growing faster in Connecticut than any other healthcare sector. In 2018. Connecticut residents spent more on drugs per person than all other states except New York, we spent 21.6% more than the US average on prescriptions, and it was prices.

And it's not that we're utilizing too much. We're just the prices are out of control, and we can't afford it anymore. The higher spending is driven by skyrocketing drug prices. The Institute for clinical and Economic Review found that in 2019, price increases for just seven drugs cost the US health system $1.2 Billion dollars extra with no improvement in value.

The Governor's tax on excessive drug price increases and 6447 is one of the best options to make health care affordable in Connecticut. And health care drugs are one of the main drivers of increasing premiums which I know this Committee has spent a lot of time thinking about how to address.

As for the second part, we have serious concerns about the proposed covered Connecticut plan. And federal resources are coming as you heard from Wyatt from CBIA to increase access health subsidies making the risks unnecessary.

The plan to spend 50 million in taxpayer dollars to reduce Connecticut's uninsured. Well, I guess not all text data dollars. But uninsured would be developed by only four officials appointed leaders of state entities not accountable to the public.

Their scope and developing the plan is extremely broad. And there are possibilities outlined in the Bill. There's no limits in the Bill. And the provisions for public input or feedback aren't there to ensure that the proposal won't fail and won't do more harm than good.

The Bills overly broad unchecked authority invites unintended consequences this happened in the State Innovation Model as SIM model also run by Oh HS because of conflicts of interest were a serious issue. And basically didn't work anymore. It didn't work. We spent $45 million in four years on Sim, and it ended up going nowhere.

And I would hate for that to happen again. In this one, though, that was $45 million in federal money, which is one thing. But wasting money if you get it from increasing premiums and making it more expensive, is a bigger problem. It's the current federal COVID relief Bill that's close to passage includes significant changes to improve the affordability of coverage, including increased exchange subsidies, and removing the income cliff that excludes a growing number of uninsured, Connecticut residents.

And federal policymakers have signaled that they [Mic off]

CLERK: Ms. Andrews, you've reached three-minute mark, if you could just summarize please?

ELLEN ANDREWS: All right, we just want to see Connecticut wait. To see the impact of the Federal changes before implementing a large tax on premiums to create an open ended on accountable plan that could do more harm than good.

REP. WOOD (141ST): You're on I wanted to just ask the question on the unintended consequences piece of the same plan. Can you explain a little bit about that? I'm not aware of that.

ELLEN ANDREWS: Yeah, there's -- this happens -- this actually happens a lot. It happens in the public option that's happened in many places.

You could end up with poor planning, for instance, implementing a program that, you know, in improved in some places and made it worse than others. I'm sorry, but I've had a long day, and I'm sure you've had a long day. But there are unintended consequences lots of the times when you make changes to things in ways that were -- especially if you're not monitoring for what those might be. And there, there's no evidence that they're going to be looking

at how this could change access to care and especially in underserved communities.

REP. WOOD (141ST): Yeah, I kind of felt, reading through, there was a little bit of vagueness in there. So perhaps we could work together on that. But how would you structure something like this with more oversight? Is it having a Board? Is it having, you know, more requirements for the legislature in terms of benchmarks and things like that?

I just -- I was just wondering how best to structure something so that that is something that I've heard and read in a lot of the testimony. So I just was kind of brainstorming, you know, how that would work better than how it is now.

ELLEN ANDREWS: I would argue strongly against a Board there. There are a lot of Boards for a lot of these things. SIMM had a Board, an outstanding Advisory Committee that was chosen by OHS not in the usual way, you know, by the different legislators, you know, from both sides and different agencies, it was all chosen by OHS to support -- you know, a specific outcome.

And so I would not suggest that you have a Board and hear what people have to say. And I think there needs to be monitoring, and then public -- lots of public transparency about what those things have happened.

I think the Bill needs to be a lot more explicit about what the money can be spent on. I mean, I heard earlier, like -- what was it seven hours ago now that they were talking about out of pocket costs, because that that might be a gap that might be not filled by the federal money.

But we wanna make sure -- out of pocket costs are a double edged sword, you want to make it possible. Obviously, you don't want anything like what's happening with Hemophilia patients. But there are

out of pocket costs that can help, you know, get people to think about medications, and it does keep people from filling everything.

They start to ask more questions of their doctor. Well, why do I have to have this? How much is it going to cost? That's not a bad thing. And there's also a dignity that we've had that in Medicaid sometimes when people have testified, you know, I'd be willing to pay, you know, a few dollars for something. There's a dignity to it.

So I think there's – that we really need to monitor for how what we might think is going to do a good thing doesn't really. And also, sometimes things are put in place and they're so expensive to administer that the juice just isn't worth the squeeze.

REP. WOOD (141ST): Thank you, Alan. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And thank you, Ellen, for your testimony. Good to see you. I want to just go back to Representative Wood's question about your concerns about the subsidy language in this Bill, Recovery Connecticut program.

First is, I'm recalling back a few weeks ago to your testimony on Senate Bill 842, when I believe you testified in support of the language in that. They're both about the same amount, about $50 million.

That Bill has much more prescriptive authority about what the money should be used for, and also about legislative oversight. Am I to understand from your testimony that something more along the lines of the program in that Bill would be a better way to go about solving presumably the same problem?

ELLEN ANDREWS: Yes, I think more prescriptive -- more prescriptive about -- just some guardrails around what the money could be spent for. And I do

think some legislative oversight is really important and public transparency.

I am -- I mean, I'm a consumer advocate. And if you want to spend money on helping people afford insurance, I am all for that. I just think we need to be really thoughtful about how we do it. And, you know, sometimes what you think is going to work doesn't and so we really need to monitor I know I sound like a broken record, but we don't do it. We just put things in place because they sound right. And they end up not working.

SENATOR LESSER (9TH): Well, that that Bill, I think is pretty prescriptive, among other things, it directs that premiums be eliminated, or persons on the exchange with incomes of under 20 under 1% of poverty, which is something that becomes a little bit easier with the passage of the rest American Rescue Plan. But isn't fully done by that note.

So, you know, I'm hoping that we provide enough guardrails on that Bill, to really make sure that we have an appropriate level of legislative oversight, and then we would have to vote on the plan it wouldn't just be adopted?

If you have other suggestions for how we can ensure adequate stakeholder engagement and community engagement that would be -- that would be helpful for me for us to consider. If you want to send it to the Committee, I would certainly appreciate that.

ELLEN ANDREWS: That's a much longer conversation. And how do you reach out to -- that goes back to like days when I worked for the Medicaid Council, you know, how did we engage, especially communities of color and underserved populations, when, you know, we had these great ideas that we thought they were just going to solve everything for them? How do we really engage them to find out to test it first, to see if we were as smart as we thought we were? It's a longer conversation.

SENATOR LESSER (9TH): One last question. We saw some testimony in though in the last hearing about the inclusion of racial and ethnic data collection, as part of the process throughout our efforts to increase the insured rate in the state. Is that something that you think would be an important thing to do right into the law?

ELLEN ANDREWS: I think that would be great to include. On that though, I again, it's sort of like the cost cap issue. I just, you know, we couldn't we can take get data till the cows come home. But we do have some if there is a problem, we know that there are disparities, and there are tested options that are working in other places, and we could test them here. So I don't think I don't think we should wait for data. I think we should get it.

We need to we need to see whether we're doing better when those to evaluate those things. But I think we should start working on the kinds of things that can make a difference as soon as we can.

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

REP. WOOD (141ST): Representative Meskers.

REP. MESKERS (150): Thank you for your testimony. I think it's always good to bring to us the framework of the question of do no harm and do good in terms of, you know, the road to hell is paved with good intentions. So I appreciate that.

So, I noticed here that -- you know, the first commentary from on the Bill is in support of the pharmaceutical tax basically, or the assessment on drug prices. You didn't have any problem with that. Do you have any thoughts in relation to the hospital system is with a corollary like that?

ELLEN ANDREWS: Yeah, yeah. That's harder, it's a lot harder. Because it's consolidation I need to

trust and we had a great presentation from -- blanking on her name, and I probably couldn't pronounce it but from Hastings School of Law at the University of California this morning at the health care cabinet.

And they've been studying this and had a lot of ideas around, you know, tearing and steering. That that large systems can force contracts where you have to put them in the highest tier meaning the lowest copay, regardless of their prices, and regardless of their quality.

Known compact, that non-covenants that physicians sign on to, when they join things where they cannot -- non-compete, they can't leave. And when they do, or they come in with huge bonuses that are often funded by as my understanding facility fees at their same practice.

So as a patient, you're going to a doctor, and he's an independent doctor one time, and then you go back next year for your mammogram or whatever. And all of a sudden, it's $1,000. More, well, that often funds, those increased bonuses that they get for signing up. There are other things within that state contracting, or contracting, which is governed by state law.

So and I am not an attorney, I, you know, I've been dragged kicking and screaming into the loss. So I'm not I shouldn't go any further than this. But there are things within that that we could do. And I think the first thing we should do is there should be a moratorium on more CEOs and more approvals.

We have to lower the limit for which you have to get a CON to bring more doctors into a large health system right now, it's way too high. And we need to there was something else in my head, but it's gone, I'm sorry.

REP. MESKERS (150): Related to the competitive environment baseline --

T ELLEN ANDREWS: There are actually quite a few things that we could do. And she gave us more to think about this morning. So I think it needs and I'm usually not a fan of Committees. But I do think it needs a taskforce of really smart people, independent people to get together and talk about what would happen because that, you know, these could have unintended consequences as well.

REP. MESKERS (150): So if it happens to be a cheat sheet or summary of the presentation you got today, maybe through our chair, or let's use chairs? You could send it on to them. And we could have -- because we are – you know we need those --we need to finish up the ideas to do you know what we're, you know, again, no one wants to hear me go on again, it's pharmaceuticals as hospitals, insurances, at the small end of the stick. Where we're paying through the nose, and we have to figure out how we get control of this.

ELLEN ANDREWS: Yes, you're right. And I'm, I'm glad you're looking at the drivers, the consolidation and the drug costs. That's the rest of it. I agree with whoever said it is we're just shifting money around otherwise.

REP. MESKERS (150): Well, you know, and again, just not to beat a dead horse. If we doubled the price of insurance in the next seven years, which is basically pharmaceutical hospital care. And we're at 50,000 for an insurance policy, we aren't going to have a private system.

ELLEN ANDREWS: Right.

REP. MESKERS (150): So I mean, I will, you could argue in some ways that I'm in favor of a private system, it needs to survive, and it can spread a

cost that at 50,000 ahead for insurance. It's just not sustainable.

I mean, CBIA will come out and scream against the industry and against the medical industry, when all of their industrials and all the small mom and pops have to pay those kinds of premiums to give health insurance to their employees. So we really do have to do something it's important.

ELLEN ANDREWS: And consolidation has other drawbacks as well. I mean, I live in New Haven, and I used to have a choice of two hospitals. When I had my son, I had him at St. Raph's. Now you don't have that choice anymore.

So it does also reduce your levers to make decisions based on quality. And we heard this morning that consolidation, they always sell it as it's going to increase quality. It never does it in very narrow circumstances does it increase quality and there are plenty circumstances where it reduces it.

REP. MESKERS (150): Thank you very much.

REP. WOOD (141ST): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. Ellen, great to see you. Thank you very much. Now, obviously, we see the support that you have on part one of The Governor's proposal on the prescription drugs.

But what do you say to the fact that it could be a balancing point, right? Because one of the challenges we have is we have one of the best innovation and research, biotech and pharmaceutical entities in the world, as evidenced by our ability to create the COVID vaccine in less than a year, which is, to me an incredible miracle.

You have heard some feedback from the pharmaceutical companies as the fact that there's a contrast in

regards to cost containment versus innovation. We as a country, and maybe in some ways, as said earlier is we bear the burden of innovating at the expense of --benefit to the rest of the world. What do you create that balancing act? Right?

Because you've heard some testimonies today where you know, they've vividly opposed these kind of restraints and cost burdens on their ability to compete and innovate? Where's the balancing point? Any?

ELLEN ANDREWS: Actually, I think there is. There's, I think there's good news on that. And full disclosure, I am on the Board of the Institute of clinical Economic Review. It is a nonprofit, based in Boston, that with hot and cold running PhDs who look at comparative effectiveness research for drugs, and look at on launch. And then also, as they increase their prices, they've looked at that, but they also look at the launch of new drugs, what is a fair price for it? What is it worth?

Obviously, we'll pay more for something that cures cancer, then we would something that cures toe fungus. And it looks at those kinds of things.

And then actually, and now, right now, drug companies, they're a new product is coming so that they could anticipate, as they're putting them in the pipeline, and may show some promise on which I want to get back to that actually -- research and promise that.

They could look at it and see what it would turn out to be worth and whether it's worth going forward for them. And that's something that we need to look at, because we need to be using the dollars, we have very wisely. And so do that for investors. So I do think there are places where we can get to it.

I also agreed with The Governor's staff earlier today, that I think they should set their launch

price at a fair price that was that captures, you know their R&D costs, and then just increase it by you know, whatever the CIPU is. And that's fair.

And that's a fair process. It's something that, you know, as a patient, you don't want to be started on a drug, and then the next year, at a low level just to get you on, and then the next year, they go up, you know, 20%, then I'm going to get kicked off of that drug, or my premium is gonna go up, so either way, I'm in trouble.

So we need to get to a fair price. And it needs to start from the beginning. As far as research and development, we haven't heard anything about this, but I don't think that -- I used to be -- in a former life, I was a scientist, a bench researcher at Yale, and a lot of the people who went through my program, and then also postdocs that I worked with, are working in drug -- for drug companies now.

And think it's really important to understand and, and many of them, the work that was done by my colleagues at the time, my other students went off, were spun off to drug companies for because they were promising and that was wonderful.

But I don't think we recognize all of us were funded by the NIH to do the work that we did. And I don't think that contribution, taxpayers' contributions is always recognized, adequately included in the cost price. You know, the basis for prices? Because it's a huge amount, I mean, scientists and the people I graduated with who are still working in that do.

I mean, they are the scientists who -- many of them came up with the vaccines, they did a lot of the work on it, and do the things that get it to a promising place where the drug company picks it up and I think that's not captured, certainly in the prices that then we end up paying.

SENATOR HWANG (28TH): Thank you. And I'm glad I asked the question. Was there something you remember that you were gonna say, I just didn't get a moment of? I didn't interrupt that.

ELLEN ANDREWS: Talk about the research and the scientists. I'm a big fan of scientists, drug companies, maybe not so much.

SENATOR HWANG (28TH): Okay. Now, the second part of your testimony talks about your concern with the Cover Connecticut account.

And, and we had an earlier exchange with Ms. Veltri and Johnny Dach's, and I'll be honest with you, I was -- I've always been impressed and have great respect for the integrity of both individuals.

But with Ms. Veltri, my work with her in the Office of Health Care advocates. I know she's committed, and she made a commitment that she would be receptive to looking at some audit and accountability process.

And you have been involved in this advocacy circle. I have the most profound respect and objectivity that you demonstrate. Saying that. I see in your testimony that look, I believe you but you know, verify, trust, verify.

ELLEN ANDREWS: Nearly quote, Ronald Reagan, but yes, we need to trust but verify.

SENATOR HWANG (28TH): Right? I mean, I think that's the sense of it is the fact that if you're using either it be federal resources, Or assessments/taxes or premiums or even appropriated money, you're using money and there was always a concern you cite some articles in regards that, without transparency without accountability or the observation of sunlight, that things may not go as the way you should. And what you're saying in that is because

what we're looking at is pretty much a reinsurance product, et cetera.

But what does it broad and unchecked authority invites? Unintended consequences due to poor planning, conflict of interest, and serious unintended consequences, has plagued by the other previous indication of SIMS.

So I'm reading through that and sort of like déjà vu, all over again. And we have an opportunity to not engage in something and putting the cart before the horse. And, and, and hopefully we learn our lessons, you know, either to use the federal money to be able to save taxpayers or premium payers tax to be able to use a plan.

So I read your testimony. And even though it was short, and succinct, it indicates a tremendous level of objectivity and experience. And I think we all should heed some of the warnings you're giving, and not rush too quickly, into any set of policies, maybe take the best of ideas and formulate that.

So I thank you very, very much for your time and I know it’s late hours, but I wanted to compliment you for your insight and sharing the experiences that a quick rush to do what is in the best interest or maybe seem the best idea, or the over promise may come back and bite us. And you've seen that already.

So thank you very much, Madam Chair. And, again, thank you, Ellen, for your very, very good and objectives.

ELLEN ANDREWS: Thank you. Theresa Sprague is next followed by Garrett Sheehan.

THERESA SPARGUE: Good evening. Can you see me?

REP. WOOD (141ST): Yes, we can.

THERESA SPARGUE: Okay, good evening. My name is Teresa Sprague and I'm the manager of patient access at Bristol hospital. And I'd like to address House Bill 6586 AN ACT CONCERNING PRIOR AUTHORIZATIONS AND HEALTH CARE PROVIDER CONTRACTS.

I would like to thank Senator Lesser, Representative Woods, Senator Anwar, Representative Comey, Senator Hwang, and especially I'd like to thank Representative Cara Pavalock-D'Amato for her longtime support of Bristol hospital, and her continued advocacy on behalf of our patients and families.

Bristol hospital supports House Bill 6586, which provides a vitally needed solution to pervasive abuse by health plans of their prior authorization process. Prior authorization is a utilization management tool to ensure that patients receive the right care in the right place in line with their benefit plan and best practices.

While Bristol hospital recognizes the value of prior authorization, we are finding that many health plans are using it routinely for procedures established standards where there's no history of questionable use.

My team and I are on the frontlines as we communicate to our patients that their procedures are on hold until we see prior authorization from their insurance company. Stat authorizations are a particular burden as patients are at times left waiting for hours, sometimes in great pain and discomfort for an authorization that will avoid costly emergency department charges.

We recently had a patient that waited hours in our diagnostic area while the provider tried to get an authorization for that CAT scan, the patient did end up having to present through the emergency room rather than wait any longer for their authorization.

Bristol Hospital registration team is extremely diligent, working weeks in advance to ensure that authorizations are updated and corrected. But there are instances when a patient has had to fast for hours, sometimes days or even two days ahead of time, only to have that procedure cancelled because their prior authorization has not yet been approved.

This happens for our patients that come in for our testing and our Connecticut gastroenterology Institute. We've also had patients present for their MRIs, echocardiogram stressed us and various other tests that we're still waiting on authorization. These patients were had had to be advised that they could not have their tests on their scheduled date because we were waiting for the insurance company to prove that authorization.

This leads to frustration and further concern on the patient's part. Many times patients have already waited days and have also taken time off from work to have their test.

There are times that it can take between seven to 10 days to receive the authorization approval. Sometimes an unexpected change can result in having to get another authorization which results in further delays for the patient.

This can occur while the patient is present and ready for the exam. If a radiologist deems that a patient scheduled for an exam that does not require contrast, for instance, needs to be changed to one that requires contrast, it would be a halt in the procedure until the authorization has been obtained and updated accordingly.

The need for a change approval adds extra stress to a patient who is already worried about their health and the diagnosis awaits them. Additionally, the system and staff at Bristol hospital has added to address the endless authorization dilemmas or adding unnecessary costs to the health system.

The authorization process reduces efficiency because the staff physicians and equipment have been reserved for their care.

CLERK: Ms. Sprague, you've reached your three minute mark, can you just summarize, please?

THERESA SPARGUE: Just that we are we please approve the house Bill of 6586 so that Connecticut hospitals can continue to provide safe, high quality and affordable healthcare to their patients and families.

REP. WOOD (141ST): Teresa, thank you for coming on and sharing your testimony. We have heard a lot about this. And I really appreciate you coming on and sharing these stories.

It is a concern and we definitely want to be helpful. Are there any questions from the Committee? Teresa, thank you.

THERESA SPARGUE: Thank you.

REP. WOOD (141ST): Next up, we have Garrett Sheehan, followed by Nicole Hampton.

GARRETT SHEEHAN: Representative Wood, Senator Lesser, Members of the Insurance and Real Estate Committee. Thank you so much for giving me the opportunity today to speak in opposition to House Bill 6447.

My name is Garrett Sheehan. I'm the President and CEO of the Greater New Haven Chamber of Commerce. It’s been very interesting listening to all of the testimony today. And I wear many hats. I too, like CBA represent many small businesses. And we are always concerned about the rising costs of healthcare and how that impacts business.

But it also wear a hat as an economic developer, and the biotech industry being a primary driver in Greater New Haven. And we've seen a lot of growth over the last decade of our biotech companies.

So my opposition is that this portion that adds the cost structure to drug prices, is something that came out just -- you know, from my perspective, at least came out of the blue and to many of our biotech companies. And it's an area that our state, The Governor included, our economic development efforts have been very focused on so I was encouraged by what I heard from Representatives from pharma, and many of the other pharmaceutical companies that they want to work with this Committee to find opportunities to lower costs and deliver that to the consumer.

My request of this Committee would be to continue to work with them. I did hear Johnnie Dach say that the Governor will be meeting with some of the CEOs. And that's by no means to say that you should just listen to what industry says but that biotech being a key economic driver that we've identified for the state, and specifically for New Haven, I hope that you give them that opportunity to be part of this process and hear them out.

So I appreciate your time this evening.

REP. WOOD (141ST): Garrett, thanks for coming on. I appreciate your testimony. Any questions from the Committee? Great. Thanks, Garrett.

Next up, we have Nicole Hampton, followed by Sue Halpin.

NICOLE HAMPTON: Good evening, Representative Wood, Senator Lessor, Senator Anwar, Representative Comey, Ranking Members Hwang and Pavalock-D'Amato, and Distinguished Members of the Insurance and Real Estate Committee, and a special shout out to Representative Dathan.

My name is Nicole Hampton, and I live in Norwalk. I'm a woman in recovery from alcohol use disorder and mental health. I work as a certified peer recovery specialist at normal hospital, and I volunteer at Connecticut Community for Addiction Recovery in Bridgeport. I also Co-Chair the Catchment Area Council Area 1, 2, 3, and 4 and Co-Chair the Billable Peer Support Group.

I want to thank you for the opportunity to let me testify on House Bill number 6588. I'm testifying in support of Section 5 of House 6588 which would establish a statewide task force to study insurance reimbursement for peer services.

Establishing the taskforce would elevate and formalize the discussion at a state level and make officially recognize recommendations ahead of the next session.

In Connecticut if we are to increase pathways to the peer workforce and improve upon recovery outcomes, we must make certified peer recovery specialists reimbursable. Peer support services are an evidence based practice and Medicaid reimbursable in over 41 states for certified peers.

The opposite of addiction is not sobriety but connection. And my first CPRS connected with me in many ways. No one else could You treated me like a human being he was empathetic, resourceful, and even my cheerleader when I was ensuring this clearly demonstrates the benefits of lived experience, he inspired me to pay it forward and I went on to get my CPR recovery coach professional designation and my CPR state certification through the Connecticut certification Board, which follows specific standards for responsibility, validity and legal defensibility to protect the population we serve.

Bottom line, peer support offers opportunity to reclaim a life of self-defined purpose. I myself

work on the community care team with greater Norwalk, I'm able to court coordinate care with numerous community and municipal providers, and help break down barriers and overcome setbacks experienced by the population I serve.

I'm humbly asking for you to please support HB six 588 and help Connecticut take critical steps towards improving our system of care are essential peer support services.

I'm open to any and all questions, and respectfully and thank you for your time today.

REP. WOOD (141ST): Thank you. Representative Dathan.

REP. DATHAN (142nd): Thank you very much, Madam Chair. And thank you, Nicole, so much for coming to speak to us this evening.

I know you've probably been waiting to speak to us all day thinking you had a number 41 thinking you might be mid-afternoon, and here we are after seven o'clock and really appreciate that.

And thank you for sharing your experiences. You know, one of my concerns about putting the Bill forward was creating a task force. And sometimes things can get lost in the legislative process and things might not happen.

Do you have any support why you think you know, a task force is the right way to go here and how we can make sure that things don't get lost in appointments and kind of the admin that we have to do here to create a task force. Do you have any input on that?

NICOLE HAMPTON: Absolutely the Billable peer support group that I coach has all the relevant stakeholders coming to the table already. And we're

more than interested in the Committee would like me to provide names I can.

REP. DATHAN (142ND): I might reach out to you. I really appreciate it. And my second question really is about accessibility. I asked this to somebody else earlier, but because you represent a different part of the state and different wanted to ask you the same question to you, based on your experience here in Norwalk or in in Bridgeport or other areas. Do you think this is something that people are going to be able to access and reach out and get in? Do you have any advice for how we can make that more accessible?

NICOLE HAMPTON: Well, I think if it becomes visible, absolutely. Because, for me working at the hospital, you can only assess my services, if you come in more than six or more times in six months, or if you're connected to a community care team provider. But if you're not on probation, or you don't live at the shelter, you know what I mean? If you're not connected with one of those providers, I will not see you. Or if you come in five times you come on my radar, but I'm not allowed to engage until the sixth time. So I think it would be an absolute, for me, it's a must. I mean, I have to you know, recovery coaches myself, along with a therapist, a sponsor, it definitely takes a village, you know, to be able to sustain long term recovery.

P. DATHAN (142ND): Absolutely, absolutely. Well, thank you so much for your testimony and, and hanging in there. And thank you Madam Chair for letting me speak.

REP. WOOD (141ST): Nicole, thanks for coming on and sharing your story. Next up, we have Susan Halpin followed by Mark Schaefer.

SUSAN HALPIN: Good evening, everyone. It's lovely to see you all. Thanks for sticking it out with all of us.

My name is Susan helping and I'm here today on behalf of the Connecticut Association of Health Plans. There's a lot of benefits to going first and there's a lot of benefits to going last. I would say that I wanna to affiliate my remarks with those of several people that came before me. I was able to do most of the testimony today, but not all of it. But I was able to catch Wyatt Bosworth testimony earlier today.

And that leads me into my testimony on House Bill 6447 which you know, has a lot of components that we support, as do you know other Bills that are before the Committee, this Session. 6447 has some of the most important work that needs to be done on health insurance reform. And, you know, it establishes a meaningful framework for some of those conversations to be done under the Office of Health strategy.

And it also begins the hard work of looking at healthcare costs, through the sections on the pharmacy and pharmaceutical pricing that could be expanded even further than it is today.

But that is, in essence, where we see the real need for conversation. Premiums, as many people have already reflected on today are really just a mirror or reflective of what the underlying cost of care is, whether that's pharmaceutical pricing, whether that's, you know, hospital care, whether that specialty services, you know, or copays, and cost sharing, and all of that kind of goes together.

And that's what Executive Order No. 5, begins to look at. And that has been a very positive Executive Order. And we have participated on behalf of the carriers gladly in a lot of those conversations and think that this legislation as does 1006, really, really complements that Executive Order. And we look forward to working with folks on those sections.

Regrettably, on this Bill, we have to oppose the $50 million assessment. For the reasons that have been stated by others very eloquently that came before me. Really, it just, you know, as I think why it said it creates a situation where we're robbing Peter to pay Paul.

And the carriers are already subject to a significant amount of taxes and assessments. I mean, if you look at the bottom of my testimony, which I'm not sure whether you've had the chance to do you know, we're already subject to a one point a 1.5% Premium Tax.

We are paying over $120 million in assessments. Today. We fund everything from the Department of Insurance to the Office of Health Strategy to the Office of Health Care Advocate. We find the positions at OPM, at DDS, at the DHMAS, at DPH.
CLERK: Ms. Halpin, you've reached your three-minute mark.

SUSAN HALPIN: Already? I thought I was just getting started. Okay. So in that instance, we've hit the breaking point in terms of assessments. And just really quickly on that issue, I think one thing I want to correct for the record, there's been a lot of talk about the HIT tax that was removed, and that this is just going in place of that.

That HIT tax was repealed at the federal level and it is out of the rates that insurers have on the market today. So if there is any new assessment passed, it will be added into the rates. So there will be a direct increase as a result. So I'll leave it with that. And with one -- if you'll, if you'll indulge me one more second. Just to talk about the Prior Authorization Bill.

When I first started in the business, one of my earliest tasks was to participate in a working group around clean claims. And there are a few people around still that remember those summer sessions

over at the Department of Insurance where we walked through various aspects of a claim form of HCA 1500 and an ICD 910, or something like that. Mark can correct me afterwards if I got the terminology wrong.

But we went through a painstaking process, it seems to me that the prior off stuff lends itself to that kind of conversation, and we would welcome the opportunity to engage in that conversation. So look forward to --

REP. WOOD (141ST): Yeah, I did want -- I was hoping you could talk more about the Prior Authorization. So just real quick, I mean, you had basically left it as in, you're willing to have that discussion, but just comment on -- we heard from a lot of people from the hospital systems, in particular Bristol hospital, I don't know if you want to share your side of it.

But we are hearing things like seven to 10 days to receive authorizations. You know, people waiting unnecessarily in the ED and taking up beds, using fax machines and things like that to communicate. I'd just like to hear your side on that.

SUSAN HALPIN: Sure. And I think it's probably -- you know, a number of factors. And I'm sure there is fault on our side as well and that's what argues, you know, for a sit down conversation.

Whenever we enter into one of these types of concerns, the first thing we always want to say is, let's sit down and look at the data and look at where the issues are, and what they are -- where they're originating from right and then tackle it from there up.

We have had some conversations with various hospitals over this time. This past year has been enormously trying for everyone. There were some

processes in place that, as in everything else, did not lend themselves to a pandemic.

The carrier's waived for a long period of time, Prior Auth. requirements around transfers to post-acute care. So that was waived, I imagine, you know, as we reach the end of this -- you know, this crisis stage, I guess, if you will, some of those are going to be eased.

But those are conversations, I think that we can have, you know, and I know Mark is going to go after me, I'm sure he's going to talk about this. But, you know, is it unique to Bristol hospital? Is there something you know, that's unique to their portfolio of patients that is driving the issue?

Those are the kinds of things that we want to look at and want to, you know, dive down on and have those conversations. Prior Auth. is an incredibly important part of the process. I did hear a statement earlier that you know, Medicaid, does it electronically.

Medicaid also pays substantially lower rates than private carriers do. And I think you have to look at the full picture, when you're looking at Prior Auth. to make sure that the appropriate level of care is being provided. I shared some statistics on my testimony about the amount of unnecessary care that is delivered in this country.

And that was -- again, not to say that we are correct 100% of the time, I am sure that we are not and I've gotten personally involved in cases where we've needed to engage. But, having said that, I think it's -- there's a lot of complex, very complicated issues contained in the Bill.
And there's a lot of very, very tight timeframes in the Bill. And I worried that there would be enormous unintended consequences around those.

There was also, just to add one more thing, you know, there are provisions around Medicare requirements that the state doesn't necessarily have authority over. So you know, that's another piece of the complexity that we'd need to work through and look at.

REP. WOOD (141ST): Alright, and my last question is, just could you respond to Ellen Andrews' testimony that said, they're waiting for reimbursements that go back, you know, June and July, like, you know, any feedback on that and why they're still not being paid for services going back that far?

SUSAN HALPIN: When I heard that testimony, I reached out to my carriers to ask the same question and if there are what we can do to facilitate that if it's accurate, and I'm awaiting that information. So I will get back to you on that.

REP. WOOD (141ST): Yeah, thank you, I thank you for reaching out, I'd love to get some feedback on that. Great, Representative Meskers.

REP. MESKERS (150TH): So first, you know, Susan, you and I don't see eye to eye, and we have different views. But I think your carrier should know, how awfully incredibly well they're represented, and what a good job you do in the process, right. And the level of information. So I guess in tonight, I will challenge you a little bit about the assessment.

Only in and on the extent, and I'm sure that Senator Hwang will catch me on this. But if we're down around 80%, on the MLR, because no one has been able to get to a hospital or claim a procedure.
Over the next year or two, even if the demand goes up. We're assuming on a smoothing basis, either, there'll be refunds to the policyholders, or potentially an assessment assessed from the state.

So it's not a free lunch. But I wouldn't suggest that our rates have to go up tomorrow, given the fact that you're probably added MLR of about 80%. Right? So I want to, all of us to understand that we're not, you know, Tony will say it's not a free lunch, and I'm taking someone's refund. But I would say that there's probably profits in the system so far.

But I want you to bring back to the carriers. One of the issues that we've, you and I have spoken about, which is that, you know, the MLR model is 15%. Means that you guys make money, if the Bill is $1, you make 15 cents, if the Bill is $1, $2, and you make 30 cents. So running more water through the hose gets you a higher payout, gross.

So we're working in a system with a disincentive for the insurance industry to save money in the allocation of our healthcare dollars, and not be able to keep a larger share. Because if my premium is $2, today, you keep 30 cents roughly, or the MLR is 30. And if my premium is $1, you get 15 cents. So there's, there's a perverse incentive not to see the Bill shrink.

So we have to think about in the event, we become more effective in managing our healthcare system, how the insurance benefit, system benefits on their premium collection for the savings they might bring from the system. Because on the other side of the equation, you know, I said it three times tonight. If we're premiums at 25,000, this year, and it's going to 50,000 in seven years.

This the CBIA is going to turn against the insurance industry, and the pharmaceutical healthcare industry. And all of us will turn against all of you, because we can't afford to spend 50,000 for health care premiums.

So we have to figure out how we work together collaboratively. Because if we go that route,

ultimately, we go into a public option, which is either good or bad. And you end up with an insurance industry that is the supplemental insurance policy that you'd get in the UK, with a national health care and supplemental policies for concierge service.

So what I want to see us work on is, how do we protect the private sector industry by getting value for dollar? And that's I think the first attack with the governance plan is on the attacks on the pharmaceuticals is beginning to look at how do we control pharmaceutical costs.

So I'm looking at that. The next place is I want to know why my nonprofit hospitals are grossing up and the practices that they're running and the treatments are going through the roof. So I -- we're going to need the insurance industry to basically pick their battles, and help us figure out what the most constructive way to run the industry, or the constructive way to administer health care to really drive down costs.

Because, you know, frankly, for going up 7% a year. If, when I was in Catholic grammar school, I get a D minus. So my insurance company is supposed to be driving down my class, they're gonna get a D minus. It's not their fault. But who has a better insight, Fox can house process the insurance industry? So I would love to work collaboratively with you guys figure out where the oversight needs to be, and where we can do this better.

So, you know, and I and I appreciate all of your feedback. It's been nothing but insightful that every time you've spoken in front of us. Thank you.

SUSAN HALPIN: And likewise, Representative Meskers, as I've appreciated the challenges that you've put before me, time, and again, you will always lead the conversation in important ways. And I appreciate the back and forth that you and I have had.

I think a couple things to respond, because I actually have thought about your question. And I'm actually bringing it back to some of our executive team. But the MLR, first of all, as it stands today, I understand your point. But we do issue those rebates today, if we're in a fully insured plan, and the MLR, you know, goes below those thresholds, the 80 and 85%.

I guess I would also add that in a fully insured competitive market that we have, that is the check and balance to some extent, to your issue that you raise about, you know, you're going to get 30% more, or whatever, 15 or 20%, more, if out of $2 than $1, right?

We hit a breaking point at some point, we're hitting that right now. I mean, that's -- we have, we're reaching the tolerance level of our consumers to pay for our product. And that is what is causing, you know, all of the consternation that is landing on your desks at the Capitol. Right?

So I think, you know, your point is, is really well taken. And I think, Representative Nuccio, you know, noted a couple of plans that have come on to the market just recently. I don't think that, you know, the carriers are sitting on their hands, I think they are putting competitive innovative products out there in the market.

I think the other piece of this that you have to consider is the self-insured side, right? In those instances, you know, you've got about 70% of the market that's self-insured today. Those bank accounts are the employers. We are the administrators in that sense. So you know, when anthem and Cigna and Aetna, et cetera, they are reaching into that bank account, to pay the claims.

So in that instance, those dollars are directly the employers' dollars, we're not taking the risk in

that. So their tolerance to, I think for you know -- they hold us to MLRs themselves, right? It's not the same MLR as what you see there, but you know, they're looking at --

REP. MESKERS (150TH): They must be reaching the same breaking point?

SUSAN HALPIN: Yes, exactly. And that's, that's why we are, you know where we are today. But you know, the other reason that those MLRs are at 80, and 85%, is because there are going to be years when we go above those, right?

We're gonna go then not, you know, when we're going to go to 90, we're going to go to 95. You know, as we start to creep up some of these going, what the heck is going on, right? We didn't price our product? Well, you know, we have our own kind of reinsurance products, you know, mechanisms out there.

But that's not a healthy plan when you get up to that level. And that's what you see in the partnership plan, because at some point your premiums are not covering your claims, and that's when you hit insolvency. So I think --

REP. MESKERS (150TH): But, but Susan, you're on the wrong road there, it's not a criticism. It's not that I have any issue with the MLR. Yet the incentive is to run more water through the process to get --

SUSAN HALPIN: I guess I would go for that one, I would go to the competitive marketplace and the tipping point that I think we're at today.

REP. MESKERS (150TH): Which is where I'd like, I would rather see your MLR get reduced to 80. When you turn around and say it's not $2 for my premium, it's $1. So that the incentive is reversed that when you can save me money, you keep a larger share of

it. So there's an incentive to drive the process. The price is down. That's --

SUSAN HALPIN: Right, understood, and we'd look forward to working with you on that kind of proposal.

REP. WOOD (141ST): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. It's actually kind of fun to follow Representative Meskers, and he actually promoted me to be a House Member. So you know, Susan, thank you for your time. So look, and I agree with, I'm tending to agree with represent Meskers a lot.

Just for the record on this, is the fact that if health insurance increases, rises to 50,000 per year, we have all failed in our job. And absolutely. And I think we're all united in trying to find solutions that contain costs, and in fact, possibly lower it.

So I don't have a copy of your testimony. I don't see it but I don't I didn't hear you mentioned the fact that, what would you through your plans and your insurers make some suggestion in regards to that prescription drug cost containment?

That is up a big part of the governor's cost consideration. And it is indeed one of the big cost explosions because of innovation or the cost of innovation, as you've heard, from our pharmaceutical and biotech companies.

What are your thoughts for your members and efforts that you've made in regards to prescription cost containment?

SUSAN HALPIN: And you're raising really important points, and I welcome the opportunity to respond to them. First, with respect to the Governor's program, it is something that, you know, we are generally

supportive of want to make sure that, you know, that there are unintended consequences in there. But, you know, absolutely, that's where, you know, the focus needs to be on those underlying health care costs.

Second, and I say this a lot. And it is not, it is not the sound bite, and it can be a painful conversations at time. But the tools that the health plans have in their toolbox need to remain. And those are things that you're hearing on the other side of the equation, which give us leverage against the pharmaceutical companies.

Which are around formularies, which is around, you know, tearing and step therapy, trying to make sure that it's the right drug at the right time at the right place, right? That the incentives are not aligned towards the highest cost drugs, but instead, the most effective or quality level drug at the less expensive levels.

Not that there shouldn't be protections in the statute for that, the appeals processes, the direct overrides that are in there, there are all kinds of consumer protections in there.

But at the end of the day, if we don't have those very important tools, to manage the costs that give us the leverage over the pharmaceutical companies in those conversations, then we will lose the battle even more.

SENATOR HWANG (28TH): Yeah, and I appreciate that. And you pose a very interesting question is the fact that the formularies and the toolboxes that you have.

I would dare say that is a big part of the reason why, quote, the bracket of health insurance companies aren't on a lot of people's holiday list. And it's very easy to not like you, because you have to say no. But I hope that you're basing it on an

actuarial analysis, based upon hundreds of 1000s of case analysis, you've got the experience rating, you know, Connecticut proudly calls itself the insurance capital world.

But it is because we have insurance companies that have a length of record, and actuarial analysis and risk management. It is why we're in a business that is able to succeed. And I think the second part of it is, you don't always articulate that from a point of this is why you say we can't do it. But you have to report all of your information and evaluations and data points, to the Department of Insurance.

You buy every contract that you have and every transaction that you undertake, you are an open book from a standpoint of transparency, auditing, and regulation. Would that be a fair statement?

SUSAN HALPIN: Yes, it is. And, and I go, you know, a couple points further. One is, and it speaks to the benchmarking and the transparency pieces that are in part of the other Bills. You know, we give data to something called the all payer claims database that Connecticut was late to an act that has now -- it's reached a maturity level that allows it to be used for public policy.

So it has all of the claims are health care claims, so you can look at and segment out on a blinded basis, you know, what are the costs in the system? What are the drivers in the system? So that is all-- that is that is that is something that is always you know, best when you're making policy decisions is let the data drive the policy, right?

The second piece to your, and I appreciate your sentiments around the actuarial analysis and our ability around those. I think what people don't often understand is that our protocols are evidence based criteria, right? We all talk about evidence based medicine being that should be the driver, you know, what care is delivered, right?

The criteria that our carriers use are developed, developed by all the professional societies. Those are the, you know, the way in which medical necessity is determined when people go for their Prior Auth. is by that criteria. So, you know, when you talk about evidence based medicine, everybody's like, yes, yes, yes, to your point.

But when you talk about it as a Prior Authorization, and questioning whether that's the right drug at this time. And I appreciate the gentleman who spoke earlier about saying, you know, there is no generic drug for what he's offering. Absolutely. And those need, those things need to be considered. But that's, but evidence based criteria is what the health plans are using when they're making these types of decisions. So thank you for the opportunity.

SENATOR HWANG (28TH): Well, absolutely. And it's kind of interesting. You know, Ellen Andrews, earlier said, you know, I don't always agree with the health plans. But I can, I can be clear on this, that you're both in agreement that you think the all payer system is one of the gems of transparency, and comparative cost analysis that we have in the state of Connecticut, that a lot of people don't know about, and I hope they're able to utilize it in their cost comparison.

So, but I appreciate your time. And I think the key is, obviously, our insurance companies have a way to go. And, and obviously, it is a sensitivity and a consumer responsiveness. But you've been in this business, and you have a track record. And you can't over promise, because you're regulated, and you have to substantiate this to the Insurance Department.

And that's important, because you're a proven entity, whether we like it or not. And I think we should collaborate and work with entities that are an integral part of a Connecticut business fabric,

to succeed and contain cost, we all have the same goals.

I think the other important point to leave on is, I'd be remiss to not acknowledge the hundreds of emails I've gotten from insurance company, employees and people that whose livelihood and connected businesses are impacted by many of the insurance businesses, because it is not an amorphous, unpleasant entity.

It is an employer that puts a lot of paychecks in people's mailboxes, and ultimately pays mortgage and support people in these very difficult times. You can't discount that, and I appreciate Lee sometimes that you present a human element in that, that sometimes the insurance companies don't do.

So I appreciate your time. And I know the hours long but thank you Madam Chair. And I appreciate your time and the work that you provide as well.

REP. WOOD (141ST): Thank you, Senator. Thanks Sue. Next, we have Mark Schaefer, followed by Pareesa Charmchi Goodwin.

MARK SCHAEFER: So Good evening, Senator lesser and Representative Wood and thank you for adding me back to the docket after I ducked out to get my first COVID shot. And I just want to give a shout out to the New Haven health department who's kind enough to loan me an exam room from which to offer this testimony.

So I'm the -- I'm here to testify as see. I'm here to, on behalf of the American Hospital Association, to testify on House Bill 6586, concerning Prior Authorizations and health care provider contracts.

CHA strongly supports this Bill. As you know, from the many folks who have testified thus far in recent years, a number of health plans and began abusing the prior authorization process. And even though we

recognize that that process was is really in place to help ensure patients receive the right care, we believe that the way this is used today often negatively impacts patient care and results in significant added cost and burden to hospitals and other health care providers throughout the state.

This isn't a new thing and Connecticut, aggressive authorization practices were common in the late 90s. Shortly after the introduction of capitated Medicaid managed care, private health insurers then when they were administering the Medicaid benefit used aggressive Prior Authorization focused on inpatient care especially, and it resulted in significant industry penalties, including loss of license.

Things did improve for a time but we're finding now that aggressive Prior Authorization is again, a very, very prominent fixture on the healthcare scene and an ever present burden that hospitals have to cope with I think part of the reason is it's not just employer sponsored coverage anymore.

Many Medicare beneficiaries are getting their Medicare benefits managed by the private health plans, which are using the same Prior Authorization, basically methods to manage the Medicare benefits in a way that CMS doesn't do for the Medicare fee for service program.

There are a variety of ways that today's Prior Authorization practices are unnecessarily burdensome and jeopardizing patient care. There's the variation across health plans with respect to authorizations submission process that creates inefficiencies that are unnecessary and costly.

Prior Authorizations applied to services where there's no evidence of inappropriate practice and care standards are well established. Health Plans typically have different requirements for the information a provider must include in a Prior Authorization request for a particular uncovered

benefit, and health plans often change these requirements unilaterally throughout a contract term.

Health Plans also delay prior authorization decisions, returning requests multiple times claiming insufficient information. Delays are most common when patients come in after hours or on weekends when most health plans, things have staff available for reviews.

REP. WOOD (141ST): If you could just summarize, please.

MARK SCHAEFER: Sure up so I think that a couple of sort of final points. One is, if this was restricted to the sort of borderline medical necessity cases that might be okay, but an OIG report found that for Medicare Advantage, 75% of the denials were overturned, which suggests that the tool is being over utilized and extended to situations that shouldn't be in question.

So it's the complexity of what exists today in the Prior Authorization world. How difficult it is to negotiate, how profoundly burdensome it is for the clinicians on the front lines for the hospitals that have to develop the staff and infrastructure to manage it.

And we believe that the Bill proposes a practical means by which a greater degree of harmonization consistency, predictability, and efficiency can be introduced to the process so that it can work the way it was intended. Thanks so much for the opportunity to testify tonight.

REP. WOOD (141ST): Mark, thank you appreciate you sticking it out in the room there for your getting your shot. So, yes, I just want to make a comment that I hear you know, your concerns. I am sure you were around when we were talking with Sue Halpin

from the Association Plans, and I think there's a lot of work to be to be done here.

So I appreciate the testimony and your work on this. Any questions from the Committee? Thank you, Mark. Next step we have Pareesa Charmchi Goodwin, followed by Gisela Pena.

PAREESA CHARMICHI GOODWIN: Thank you, Representative wood. My name is Pareesa Charmchi Goodwin, and I am the Executive Director of the Connecticut Oral Health Initiative. We are a nonprofit oral health advocacy organization that advocates for increased access to quality, affordable oral health services for all Connecticut residents.

I'm here to strongly support Senate Bill 1004, which will extend the period which a child can be on their families dental and vision coverage up to age 26, if they need the coverage, being that they don't have it through their own employer or some other way. So the idea is that it would be an option to carry it on just as you can with your health insurance, currently under Connecticut law and federal law.

And so you know, I am almost your last for the evening. And I do want to be conscious of that and your patients and your time, and not repeat what Representative Gary Turco said about how this is something that is sensible is good for Connecticut families really across the board, and make sense to align it with the law for health coverage already.

And also what Marion Manski said, she's from the Hygiene Association. And they think she really outlined how this is important for oral health and also for your overall health. There's also some great information about what it does for just chronic diseases, for lowering your risk of preeclampsia and other poor maternal health outcomes, how it lowers your risk of heart disease and how it helps manage diabetes.

So that's good for your health. And it's also actually good financially, there's going to be savings on the health side, and there's going to be savings for your own kind of out of pocket expenses, so it can prevent a lot of harm and disease and save money.

So it's all around a good sensible thing to do. And I did want to note that there's over 50 pieces of testimony and support on the CGA website right now. A lot of them are from people in their 20s, a lot of college students. I know I've spoken to some students in the past couple of weeks who've let me know that they found out that they didn't have their dental insurance anymore when they showed up at the dentist, and then some of them had a bill or had to decide if they were going to have the cleaning or not.

So it's something that is a confusing surprise, I think a lot of families to find out that the dental coverage typically is not carried over unless the employer sets that up ahead of time. So I'm happy to answer any questions, but I want to keep it short and sweet. And I do encourage you to look at some of that testimony if you haven't had a chance to already from people that have been impacted themselves.

From dentists, hygienists, a lot of dental students and dental hygiene students. So I think it's a lovely thing to support. And I'm happy to answer any questions. Thank you so much for your time.

REP. WOOD (141ST): Thank you, Pareesa. And I give you a lot of credit for staying on from [inaudible 0:30:59] and listening to all the testimony today.

PAREESA CHARMICHI GOODWIN: Oh, yeah. It was a pleasure. It was a lovely day so I was really patient.

REP. WOOD (141ST): Great, you know, discussions for all of us out there that love insurance. All right, any questions from the Committee? Great. Thank you, Pareesa.

PAREESA CHARMICHI GOODWIN: Thank you all have a good night. You're almost done.

REP. WOOD (141ST): Next up, we have Tuozzolo. Followed by Patrick Charmel.

CLERK: I don't think either of them are here.

REP. WOOD (141ST): Is there anyone else waiting to speak?

CLERK: I don't see anyone in the waiting room.

REP. WOOD (141ST): Okay, great. Well, thank you, Insurance and Real Estate Committee. Thank you, Diane, Zoe, and Logan, for getting us through this. And we'll see everyone on Thursday.