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, Polletta, Riley, Rochelle, Wood

SENATOR LESSER (9TH): Senator Hwang, are you good to go?

SENATOR HWANG (28TH): So Mr. Chairman, we're good to go. Thank you very much.

SENATOR LESSER (9TH): I think Representative Pavalock-D'Amato may be having technical difficulties? Representative, are you on?

Well, in deference to the distinguished Minority Leader of the Senate, I will hold back the public hearing of the Insurance and Real Estate Committee to order at this time, and [inaudible]. Senator, good to see you.

SENATOR KELLY (21ST): Likewise Mr. Chairman, thank you very much. It's a pleasure to be back in the old neighborhood so to speak, albeit on this side of the dais instead of that. It's something different for me because I did enjoy my years serving with you and our colleagues on the Insurance and Real Estate Committee. But I thank you and Chairwoman Wood for the opportunity to come before the Committee as well as Ranking Members, Senator Hwang and Representative Pavalock-D'Amato as well as all the Members of the Insurance and Real Estate Committee. I did enjoy quite frankly my service on this Committee, and it's always fun to come back.

For middle class Connecticut families, health insurance is anything but affordable. Cost growth is out of control, and premiums are often the size of a monthly mortgage payment. These lofty bills weigh down family budgets eat into savings, leaving Connecticut's middle class struggling to make ends meet.

The Connecticut Senate Republican affordable health care proposal as outlined in Senate Bill 1006, seeks to ease burdens on middle class families. And we are offering thoughtful, comprehensive solutions to this unaffordability problem. While a public option would disrupt the current health care system and replace it with a government run system, our plan works to fix the current system so you can keep your insurance, keep your doctor and still get savings. Our plan would reduce health premiums by up to 30% by implementing a state based reinsurance program to defray high costs claims, leveraging federal dollars to bring down the cost of health insurance premiums for all individuals.

We set up a process to reduce all healthcare costs through better management of the growing cost of healthcare. Much the same way Massachusetts does, saving the people in the face state billions of dollars. We would also reduce prescription drug costs to establish a framework to import drugs from Canada and watch an investigation of disparities in the healthcare system so we can deliver on health equity for all people, no matter race, gender, background or sexual orientation.

We would require audits of the Cadillac Health Plans offered by the state, which are backstopped by the Connecticut taxpayer to ensure transparency and accountability. Connecticut Senate Republicans accomplished this without attacks on middle class families, and our ideas will not threaten the tens of thousands of quality private sector insurance jobs in our state.

I would like to provide further detail on the various components of the plan. First, reinsurance. Access Health CT's 2020 Wakely Report and reinsurance analysis as estimated that a state based reinsurance program as we are proposing would reduce health insurance premium costs from 6% to almost 30% depending on the level of state investments. The program would be further funded through existing resources within these state budgets, not a new tax or assessment on insurance premiums. Any new tax on premiums or insurers only gets passed on to consumers and increases the cost of insurance instead of reducing it.

The weight we report confirms that a reinsurance plan does not rely on any assessment of premium yield, and yield the greatest premium reduction. The report shows that an $80 million state investments with no assessment on premium will garner the greatest percentage of federal funds, up to almost 65% and lead to about a 30% reduction in premiums for all plans.

The Wakely Report also shows that assessments placed on insurance premiums yield the lower percentage of federal funding and do not reduce premiums as much as when no assessment was levy. This means proposals to pay for a reinsurance program with a tax on insurance will not yield the greatest savings for Connecticut residents. Considering Connecticut's average insurance premium is $21,000 a year, this plan has the potential to yield an average savings of $6,302 a year or $525 a month.

Number 2, benchmarking. The core goal of benchmarking is to gather the information needed so the state can work collaboratively with stakeholders and providers to take action and reduce better, and produce better health care at a lower cost for all people. Our plan will implement healthcare cost growth benchmarking, similar to the program that has

successfully kept healthcare expenses from going out of control in Massachusetts.

Under Republican Governor Charlie Baker's cost containment policies, spending on private health insurance in Massachusetts has been consistently lowered than the national rate. Benchmarking in Massachusetts save consumers over $5 billion between 2013 and 2016. Connecticut would implement cost benchmarking by setting a target for controlling the growth of total healthcare expenditures across the state by collaborating with stakeholders. I am familiar with the concerns that have been raised about the state's progress so far in benchmarking. I want to assure this Committee that under our revisions, the makeup of this program will be sensitive to and protect people who are marginalized so that complex care patients will not get lost in the process. This must be a patient centered approach, not a, not a, and must be a patient centered and patient focus.

Once the benchmark is established, the state would collect data to measure cost growth against the benchmark. Published publicly reports to identify cost drivers and utilize governmental tools to, to boost transparency and contain spending. If the target is not met, the state can require healthcare entities to implement improvement plans and be subject to further monitoring by the state. Benchmarking will also increase transparency by requiring healthcare entities to report cost information to the state.

If a certain healthcare provider is struggling to meet a benchmark, state officials could work with the provider to consider and evaluate other strategies to help them contain cost. Savings achieved through benchmarking will be invested back into the healthcare by funding the reinsurance program into the future. This ensures that the stability of our entire plan over the long term.

Massachusetts has been able to reduce healthcare costs growth by approximately 2% annually. This would yield a significant savings not only for consumers, but also for the state which spends a significant portion of our state budget on health care costs.

In fiscal year 2020, Connecticut spent $733 million on the state employee health costs, $743 million on retiree health costs, and $2.6 billion on the state share for Medicaid.

Number 3, prescription drug importation. The Connecticut Senate Republican Plan would establish a prescription drug importation program in Connecticut, administered by the Department of Consumer Protection, which will allow for the importation of safe and lower cost prescription drugs from Canada, pending federal approval. Under one pathway defined by federal guidance, states wholesalers and pharmacists could submit plans for demonstration projects for HHS to review outlining how they would import Health, Canada approved drugs that are in compliance with Section 505 of the Federal Drug and Cosmetic Act. This Bill establishes how this would work on the state level here in Connecticut.

Under our plan, DCP would be authorized to submit a plan to HHS for approval. If approved, the legislature would need to vote on the plan prior to the program beginning. While many of the technical datas of the plan would be left to DCP initiated, the legislation lays out parameters. To ensure its public safety, the proposed legislation would require laboratory testing of a statistically valid sample size for each batch of the each drug imported by wholesalers. Wholesalers will also need to provide specific information to do DCP.

I want to address some of the concerns I've heard regarding this portion of our plan. First is the

question of federal support. President Biden campaigned in support of continuing to advance this path, to reduce prescription drug costs for Americans across the country. Therefore, I have no reason to question the federal government's commitment to advancing policies that will allow us to move forward with our plans. Other states also pursue, pursued similar plans including Florida, Colorado, and Vermont.

Number 4, health equity. Our plan will investigate disparities in the health system so we can deliver on health equity for all people, no matter gender, race, background or social or sexual orientation. While we have accomplished many bipartisan achievements to increase access to care, health equity remains a serious problem throughout the country, including right here in Connecticut. The pandemic has shown an even brighter light on the disparities within the health care system that must be better understood so that equity can be achieved for all. It is unacceptable that two people can have the same insurance, the same health provider, the same coverage and still experience different health outcomes.

It is unacceptable that black and Latino residents are more likely than white residents to be uninsured to die before reaching adulthood and to report being in poor health. It is unacceptable that babies born to black mothers are more than four times likely to die before their first birthday as babies born to white mothers in Connecticut. It is unacceptable that black Connecticut residents are more than twice as likely to die from diabetes, and that black men are nearly twice as likely to die from prostate cancer as white men.

In order to develop the most effective solutions, we need to better understand the issue, including where and why problems exist. Our plan initiates more research into health equity in Connecticut,

specifically to improve health outcomes for all people. A task force will be able to move closely to study if and how better data collection and reporting can lead to more informed policy decisions and what those policy concepts might include. As we move forward with policies that seek to reduce healthcare costs and increase access for all people, we also need to ensure healthcare equity is part of that discussion.

Five, transparency. Our plan will require audit of the connectivity Cadillac health plan offered by the state, which are backstopped by the Connecticut taxpayer. Our goal is to protect middle class families and increase government transparency and accountability.

Lastly, job. Our focused on a core issue in our state, the affordability and accessibility of quality health care. However at the same time, we understand how it is, how important our insurance industry is to our Connecticut economy. After all, we are known as the insurance capital of the world and we want Connecticut to stay that way. By contrast, the public option is a national partisan concept, which fails to reduce health care costs while putting the state of Connecticut in direct competition with one of our main job sources, the insurance industry. The insurance industry in Connecticut employs 48,000 people and contributes 15 billion in direct and indirect economic activity. We cannot put jobs in jeopardy at a time when our state is already dead last in the nation on jobs and income growth. And when Connecticut private sector employment fell by one thousand jobs in December and is lowered by 84,000 from a year earlier, we must seek ways to reverse this troubling trend, not make it worse.

Our solution will make Connecticut more affordable for middle class families and increase access to quality health care while supporting good paying

jobs. It's a common sense, pro family, pro job and pro middle class path. I hope you agree. Thank you.

SENATOR LESSER (9TH): Thank you Senator and I was told by staff that you went slightly over the three minutes, but pretty good.

SENATOR KELLY (21ST): Thank you, Mr. Chairman.

SENATOR LESSER (9TH): Thank, thank you. I, I actually do have a few questions for you, I, hopefully your schedule permits. So you know, the issues that you're talking about that are in your Bill are all issues that we have talked about before on this Committee when you were the Ranking Member, we talked about them, they were certainly, many of them were bipartisan. But to my mind, they are issues, there are, many of them are solutions to problems of the past, because the situation has changed significantly in the last year, the last two years.

Specifically, I want to talk about the insurance, the goal insurance proposal because I heard you throw out the number of $80 million, which is a lot more money than we're talking about in terms of our support for the [inaudible]. So it's a big number. How do you propose to pay?

SENATOR KELLY (21ST): Interesting. You know, this is, this is an issue that keeps coming back and, and keeps, quite frankly, being pushed to us. And, and part of this is that budgets are about priorities, okay. And I know that the Affordable Care Act came out and there were promises that were made, the health care in Connecticut was going to be affordable, it was going to be accessible, and we were going to improve quality. However, those promises that were made were never delivered. And even here, you know, this is a plan that we can deliver on.

Now last week, there were Bills that proposed a tax, for instance, a tax credit for individuals earning over $433,000 on average, and that was a $300 million tax credit, that could have gone towards this. The partnership plan according to Brown & Brown, next year, is looking at a $97 million loss that is going to be backstopped by the taxpayers, and that will only be, be paying for health care for those individuals that actually help or part of the partnership plan as opposed to this, which would be available for everyone.

So we, we have this issue and there is, there is a $22 billion budget that we're looking at less than 1% of funding for. If this is really a priority, then I think it needs to be addressed, it should be the first issue. I mean, I do it every day when I go dock and door to door and during campaigns or I'm walking around in my community that the residents that I, I represent are coming to me saying I can't afford another increase in my health insurance premium. And to me that resonates. And if I were in the majority and I had a majority, we would be looking at solving this within the current budget because according to the Wakely Report, that is the best way, the most effective way to leverage federal dollars to help Connecticut residents get the most premium reduction.

SENATOR LESSER (9TH): So I would correct you there. The Wakely Report said that was the best way, but that has changed, and I'll, I'll get to that in a second. But I, I just want to emphasize, you don't have a dedicated funding stream for the $80 million new expense that you're proposing, which is a problem as those of us who have to budget it together, a responsible budget. Your party holds itself out as a party of fiscal responsibility.

But if we want to come up with a plan that lowers healthcare costs by 30%, I agree with you on that.

I, I think that is admirable. We got to figure out a way to do it, and we've had ups and downs, market goes up, we get more revenue when market goes down, we get less revenue, we get federal assistance, and that's great. But you know, as well as I do that Connecticut's fiscal situation has been a pendulum, and it is difficult for me to say that an $80 million new expenditure without a sustainable funding stream is [inaudible].

But back to the Wakely Report, and I think that is important. The Wakely Report came out a couple years ago. And at the time, reinsurance was something that states around the country were embracing as a good way of solving one particular problem with the Affordable Care Act, which are folks above the 400% class, people were not eligible for subsidies on the exchange because it brings down their premiums, and those still very effective and I supported it and yes we've made changes two days ago. Congress just voted to pass the American Rescue, which eliminates the foreign percent clip. And so as a result, that benefit, there is a problem that reinsurance was designed to solve gone away.

So Senator, looking at this Bill, it looks like you are two days late and $80 million short on how we're going to solve the problem in healthcare costs, because that problem is solved with the passage of American Rescue Plan. We had new problems, we've got sky high deductibles, we've got premiums that are unaffordable for people on the exchange; we've got a whole small business affordability issue that your time doesn't seem to touch, what am I missing?

SENATOR KELLY (21ST): Well, first and foremost, last week, you had no problem voting for a pilot program. That was nothing more than a policy and $120 million price tag. And this is something that's been done in the decade that I've been in the General Assembly, it never stopped the majority from passing policies without funding. I find it

surprising that when it comes to, I'm going to say one of the most important issues of the day, this is where Democrats will, will draw the line. It's like all, no, when it comes to people's health care, we're not going to try and find that money. And quite frankly, if, if you want us to lead on this issue, I'm more than happy to have in the Republican Party in the State of Connecticut lead on healthcare.

Now, as the same, we're two days late. I, I think the issue here, quite frankly, in the way reinsurance works is that when the Affordable Care Act was passed, back I think in 2012-2013, there was a federal reinsurance program because part of the plan was to impose legislative mandates. And those legislative mandates made insurance more expensive for Connecticut's families. And initially, Congress funded that promise for about three years until 2016. And once 2016 came, people's insurance policies started to precipitously skyrocket. And that's why we're at the point now where we have a $2,000 a year, a $21,000 a year average premium payment, and that's what's breaking middle class families backs. I don't think two days ago, Congress took that $2,000 a month problem off of Connecticut's kitchen table economics, I think they're still facing that. And that's the issue that we're fighting for, that's the issue that we're looking to solve; is to bring that cost down and meet the promise that was originally made in the Affordable Care Act with a state based reinsurance program that's going to cover those high cost mandates that have been placed on people's policies, so that when they do participate in our reinsurance, it's going to have all the promises of the Affordable Care Act. And it's going to make the, the people who purchase the insurance, they're going to get the protections that they so rightfully want and deserve.

So, whatever happened in Washington two days ago, it hasn't brought family relief here in Connecticut. And what I would say is that pass this and we will start the process to bring the relief that's necessary on a state based level.

SENATOR LESSER (9TH): I appreciate that and I think one reason it has a broad relief that is because President Biden is scheduled to sign it on tomorrow. So we got to wait until that happens before we start getting relief. But this specific problem that reinsurance was designed to solve, which is the unsubsidized portion of individuals buying health insurance on their exchange and believe that problem is, you know, can be corrected by any Member of this Committee or by any other person, that's why I believe that is going to solve the issue in the next two years. And that's why we got other problems, and you're absolutely right. There are lots of other healthcare affordability issues, but reinsurance to me doesn't seem to solve that.

I have a question about the Canadian drugs. Obviously, I support bringing in cheaper drugs. I, I believe I wrote the Canadian drug proposal two years ago working with you, and we had a bipartisan consensus. But again, this is an issue that to me, made a lot of it, two years ago. But things have changed, and the thing that changed is that last summer, Canada passed a law that outlaws the re-exploitation of drugs in the United States. And so all of the things that you mentioned, not one of them has been successful in re-importing Canadian drugs. Am I mistaken on any?

SENATOR KELLY (21ST): It wasn't across the board band, it was only on prescription drugs where Canada is experiencing a shortage. So it doesn't, it is not an absolute prohibition. I think what we have to do is look at options that will allow us to get our arms around the No.1 cost driver, which is prescription drugs. This is a, a one option that we

can utilize to do that. As you mentioned, we've worked on this in the past. Another item I worked with then Mr. Chairman, when I was Chairman in the Senate, both Senator Larson and Scanlon with regards to drug transparency when we passed in 2018. That Bill is to look at getting the pricing and the information from all stakeholders and look at the, the complex nature of, of prescription drug pricing, and to make sure that that information starts to take root, and we need to look at this issue because it's a cost driver. We not only have to get our arms around the premium side of this, but we have to get our arms around the cost drivers. And so this is one tool that we can utilize to do that, but certainly not the only tool.

SENATOR LESSER (9TH): I appreciate that. And obviously, I would love nothing else, but to bring in low cost, safe, affordable Canadian prescription drugs. I've often supported the idea of organizing it when there is no pandemic going on, organizing a bus stop for folks to the Canadian border. But my understanding is that every single drug, every single drug that DCP, the Public Consumer Protection says that they would be able to import under this plan is currently banned by the Canadian government. They are all listed as shortage drugs now.

We can disagree with the Canadian government on whether or not they're shortages, but if they're saying they will imprison or arrest people who export drugs to Connecticut, I just have a hunch that's not going to work for us. And I think we got to try other things, and if you want to talk about transparency, that's great. We have, the Governor has a Bill to tax pharmaceutical price increases, we can talk about Governor's proposals. But this specific proposal doesn't look like it's gonna work for us in 2021. So that's just my take.

I had no philosophical problem with it. It just doesn't seem like it's a solution for the moment.

And then benchmarking. Benchmarking, we stood next to one another when the Governor signed an Executive Order based out of the benchmarking process. We didn't fund it in the budget. My understanding is that the benchmarking process is underway. I understand, you're seeking to codify it. Is there anything that the Governor is not doing currently that this Bill would, that your, that portion of the Bill would, would change? Do you think that you're just codifying the status quo?

SENATOR KELLY (21ST): Well, I think what we need to do is a couple of things. One is that we need to codify the Executive Order. I think that that would be important to have a solid founding foundation put in in state law so that this goes beyond the current Governor and whoever happens to succeed the Governor, would also have this opportunity to continue the benchmarking process.

My recollection also is that we need to take some legislative action in order to work the, the Executive Order and make sure that they have the proper authority from the General Assembly to get the information they need to work this process.

SENATOR LESSER (9TH): Thank you. I've taken up a lot of the Committee's time that I've poked you a bit Senator. I certainly appreciate the ability to keep working with you as we work together and we will hopefully be a bipartisan consensus on healthcare reform. I think Members of all Caucuses are hearing for the same constituents. But I just look at this Bill, and I'm like where is the beef, where are the solutions for small businesses, where are prescription drug Bills that will actually put money into peoples' arm holding out that I'm concerned might be also, I, I'm worried is, is a bit of problem? I don't want to do that. But I, I appreciate the conversation.

I know, my good friend and colleague, Senator Hwang will have a lot of questions for you as well. At this point, I'll turn it over to him.

SENATOR HWANG (28TH): Thank you Mr. Chair. But out of respect for Madam Chair, she does have her hand up, and I would gladly defer to her first. Out of respect for protocol.

SENATOR LESSER (9TH): I apologize, but really I did not see it. But yes, absolutely. Representative Wood.

REP. WOOD (29TH): Thank you Mr. Chairman. Thank you, Senator Kelly for coming. I enjoyed hearing your testimony. I was wondering, besides the, the benchmarking and you know, we've heard a lot about that in this Committee. Is there any addressing of costs in your plan, the cost of health care?

SENATOR KELLY (21ST): Well, that's, it's benchmarking, is what goes to costs because, well, we can do all we want with reinsurance and, and assisting folks in reducing premiums. The premium is a direct result of the cost of the medical services that the insurance carriers are paying for. So you have to get your arm around the cost drivers. That's where benchmarking comes in and that's where the State of Massachusetts has successfully used benchmarking in order to work collaboratively between the state and medical stakeholders to get information and to bring best practices of the delivery of medical services.

They would set a benchmark and if the rate of growth year over year exceeds that benchmark, then the state would work with that provider and bring in also other providers and decide or determine how to better bring these best management practices to the table so that they can provide better services at a lower cost. And that has helped Massachusetts to reduce their rate of growth, which was about 10 to

12% year over year, down to about 3.5% and that has saved their state billions of dollars, and we can do the same thing here.

And that was what Chairman Lesser was pointing to was that the Governor back in December of 2019, jump started that process with an Executive Order to start to create the MSA, the Committee to start getting that information and putting that, those procedures in place. We now just need to codify that and to move it forward.

REP. WOOD (29TH): Yeah, I, I know what you're saying, regarding the benchmarking. I think we're a lot of the, the plans that we're reviewing to provide lower health insurance costs, we are lacking in more incentives for lowering the costs and consumer protections. I think, looking at things like consolidations of hospital systems and certificate of needs and things like that should be part of some of these plans as we go forward.

I just was, I was wondering if you could talk about how reinsurance has reduced premiums and other states. You had said that there were a few other states that implemented this. And do you have any data points or any information that you can share with the Committee on how those premiums went down or by how much?

SENATOR KELLY (21ST): We do, actually the Wakely Report shared some of that information. I can get the actual other information I have on states that participated in a 1332 waiver. The thing that they spoke the Wakely Report in the state's experiences have been, is that when you deal with utilizing this reinsurance through a general fund appropriation, you get a, a better return on leveraging federal resources in dollars. And the reason for that is that the federal funds come because it is a pass through from the tax credits that are given.

So if we reduce premium, you get greater federal dollars because you're reducing the use of the tax credits. Now, if you put a tax or an assessment on premium, that makes it more difficult to reduce the cost because that cost gets passed on to the consumer, the price of the premium goes up before it comes down, and you don't get the same level of federal match that you would if you did a general fund appropriation. That's why we went with the general funds, was because we would rather have, you know, Connecticut residents paying less than more and garnering more federal resources back to our state.

REP. WOOD (29TH): Thank you for your answers.

SENATOR KELLY (21ST): Sure.

REP. WOOD (29TH): Senator Hwang.

SENATOR HWANG (28TH): Thank you Madam Chair. What a smooth transition there. Senator Kelly, thank you so much for joining us today, and, and I'm, I apologize for the delay and it was a, a bit of a frantic morning. And, and thank you for your leadership on the Insurance Committee. Let's get right to the cost. I, I think the bottom line in looking to address costs is an alternative solution. And let's compare it to Senate Bill 842, which we just had passed out of Committee this morning. Are you looking to collaborate more with existing structures of, of, of the insurance entities as well as you know, the, the current reinsurance products? Are you looking to collaborate rather than create something brand new of the state running health insurance?

SENATOR KELLY (21ST): Yes. What we're doing is we're operating on the current platform, okay. We're not looking the, the reinsurance program is not looking to be disruptive in the healthcare marketplace, we're not looking to go into

competition with the state's insurance industry. What we're looking to do is to operate within the current framework and to provide a state based funding source for where the federal government has stopped funding so that we can bring stability and reduction to health care insurance premiums, then we take it a step further and start looking at the benchmarking and prescription drug as, as looking at the cost drivers and start to, to pick at that issue to make sure that we can reduce the overall cost of healthcare. But under our plan, people will continue to be able to keep their insurance, keep their doctor and stay on their current healthcare platform.

SENATOR HWANG (28TH): And, and I, I was a little taken aback with the, the clip of a, a couple dollars short and two days late. I believe that reinsurance is very much a forefront of working with the existing structure of, of how our state operates, how the health insurance industry operates, and, and the goal is to redistribute and, and lower costs. And I, I know we've talked about reinsurance a lot.

But I just want to kind of be getting one on one and saying reinsurance is a reimbursement system that protects insurers from very, very high claims. It usually involves a third party paying part of an insurance claim once they pass a certain amount, right. It's used to stabilize insurance markets and make coverage more valuable. It comes down to the difference between the Governor's plan and, and your proposal is where you're going to get the money.

The Governor is looking at an assessment or a tax on insurance policies, and, and I think your proposal is to be able to use a 1332 exchange using existing federal money as well as proper, proper, proper appropriations to be able to make that commitment to, to dilute the reinsurance risk. Can you explain a little bit the contrast between the two, because

obviously, both parties, the Governor's office, and the Republicans believe in reinsurance as a part of the solution in cost containment?

SENATOR KELLY (21ST): Yes. I mean, the real differences on the Governor's plan and ours is the funding mechanism to, to boil it down to its, its basic, basic part. We're looking at a general fund, he is looking at a tax on the industry, which ultimately we'll get to premium itself. We're armed with the Wakely Report that says we'll leverage more federal dollars by doing it through a general fund, they aren't. The point here is that we're looking at reducing premium for everyone, okay, and, and what Chairman Lesser was talking about was that, that people up to 400% of the federal poverty level.

And I don't think they're the only ones that are having problems with their payment of insurance premiums. Everyone in Connecticut is experiencing that. And then what we're using Senator Hwang is the, for lack of a better term, the Affordable Care Act platform. And I didn't hear coming out of Washington that two days ago is President Biden repealed the Affordable Care Act. I think that structure is still in place, and as long as that structure is in place, then your 1332 waiver is available because it's part of the Affordable Care Act.

And what we're doing is we're fulfilling the promise that was made under the Affordable Care Act by funding it. The original Bill, the original Affordable Care Act did not have funding beyond 2016. That's why families in Connecticut premiums went through the roof, we're fixing that. And we're fixing that with the reinsurance program, albeit state base, but that's the whole purpose here.

Now, as to the 80 million, budgets are about priorities. $80 million is a big number, but in a $22 billion budget, it's about 1%. And so there is

the ability to make priorities. I think people's health care is a major priority. It would be something I would fix on the first day rather than the last day. And so the $80 million, it's there. I think we just need to make sure it's a priority.

SENATOR HWANG (28TH): I appreciate your statement as the Senate Republican leader to reiterate that we believe health care, and the priority of funding it is important in the budgetary process. I want to go back to the federal funds. You know, there is the idea of current 1332 exchanges using federal money as part of the Affordable Care Act to offset the cost of a tax on policies.

But before I get into that, but do you not think that a tax on policies will impact consumers another way? It's sort of like someone using the analogy, you're going to squeeze the balloon one way, it's going to go somewhere else. Do you think a tax is one that's going to be hurt, hurting the middle class probably the most? Welcome to the Zoom world.

SENATOR KELLY (21ST): I apologize, I think you broke up there a little bit, and I didn't get the whole question.

SENATOR HWANG (28TH): Do you believe a tax in assessment of insurance policies would hurt people and the consumer?

SENATOR KELLY (21ST): Yes, if a tax increases the cost of whatever good or service, you levy the tax on. Whether it's a direct tax on the premium or an assessment or fee on the industry, it's going to get to the consumer. And it's being done in the name of reducing the cost of the premium. So if, you know, it's going to be an effort that's going to increase the cost and make it that much less attractive to helping reduce premium for middle class families.

SENATOR HWANG (28TH): Thank you. And, and, and we talked a little bit about the 1332 exchange using the federal funds. It's, and, and I want to repeat again, it's important to note that that the Senate Republicans have made a commitment that funding priorities need to exist for health care cost containment. That being said, we're talking about the, the, the President's $1.9 trillion federal funding that's going to come to many states across the country.

And, and in fact, the Governor's proposed budget is counting on nearly a billion for of federal funding dollar into our budget process. Do you not think it would be a, a, a practical and a useful use of allocating some of that federal money to be part of that reinsurance initiative rather than taxing people? I don't know if you can hear me. Senator Kelly? You're on mute.

REP. WOOD (29TH): Senator Kelly, you're still on mute.

SENATOR KELLY (21ST): There we go. Okay, can you, am I. Can you hear me now?

SENATOR HWANG (28TH): Yep.

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

SENATOR HWANG (28TH): You need my question again?

SENATOR KELLY (21ST): No.

SENATOR HWANG (28TH): I'll repeat again that I appreciate the commitment to funding to control healthcare costs. But I also wanted to kind of share that, you know, the Governor himself proposed in his budget, counting on nearly a billion for of federal funding as a part of the, the budgetary solution on a revenue side.

Should we not look to utilize the, the, the new potential money coming from the, the, the, the COVID Relief Fund from the federal government and use that into the 1332 instead of putting a tax on policies on Connecticut consumers?

SENATOR KELLY (21ST): That's a good question. I mean, that's one, here's my reservation is that the one-time revenue stream rather than looking at the budget and saying, we're going to take this money every year and, and dedicate it to healthcare. That said, with benchmarking, what it allows us to do is if we can start reducing the rate of growth year over year and take the savings that we would normally experience and put that back into reinsurance, you would have, I believe, the ability to create a sustainable reinsurance program.

So, I mean, the money is coming in from Washington, it's a one-time revenue stream. So I prefer to see it just the general fund appropriation, but mindful that that fund, that those monies are probably going into the general fund. They might be a source of revenue for this year.

SENATOR HWANG (28TH): Thank you. You, you talked a little bit and, and, and you commended the Governor for beginning the process of benchmarking. Could you explain why the codification the legislative authority that you're seeking in this Bill is needed to further advance that program ideal?

SENATOR KELLY (21ST): Well, number one is, you know, the executive authority runs with the executives. So while this is a commitment that Governor Lamont has made, there is no reassurance that a, a future Governor would do the same thing. And by embedding it in Connecticut law, you would start to guarantee that that promise is going to continue moving forward and would only be able to be changed with consensus of the General Assembly; so that's number one.

Number two; I was under the impression and understand that the state, the General Assembly, also needs to take legislative action to continue what the Governor has started, the Governor started with creating the Committee, if you will, the, the task force to collect this data. And so we need to do some more legislative work on that.

SENATOR HWANG (28TH): Thank you. And, and my final question, Senator Kelly is there are three Bills out there, and, and as the Office of Healthcare advocate said in Tuesday's hearing is there is bits and pieces in all three of these Bills that have merit. And shouldn't we all get together and craft a, a one bill that is truly collaborative and, and meets the goals of, of containing costs that we all are agreed to?

Would you be receptive to sitting down and working with the Governor and working with the Democratic majority as well as all the affected shareholders, the prescription drug, the pharmaceutical companies, insurance companies to be able to collaborate something that doesn't reinvent the wheel that doesn't go into an untested marketplace, but to capitalize on the established reputation of, of the State of Connecticut with our insurance industries, and all the jobs that comes with it in crafting a plan where all the shareholders are in the meeting to crafting a Bill. Would you be open to that kind of a collaborative process?

SENATOR KELLY (21ST): I'm always open to that type of collaborative process. In fact, the day the Governor signed the Executive Order, I was present with the Governor in Middletown with Chairman Lesser, because that's a good idea. And I think one thing that we need to take away from this conversation is the fact that whether you've got three proposals, three, I'm going to say ideas that we're focusing on trying to bring down the cost of

health care for middle class Connecticut. I'm obviously I'm going to say I favor our plan, I think our plan is the best plan, because it not only bring down premiums, it addresses the cost driver, and most importantly leverages the most money out of Washington, and has the health care equity accounting; and last but not least, jobs, keeps Connecticut jobs at a time when we really need good paying jobs in our state. So I'm partial to our plan, but I welcome the conversation. I think it's through conversation that we actually make better policy.

SENATOR HWANG (28TH): Yeah, I greatly appreciate that, but I thought it was the last lesson. But you also raised something that's a very important contrast between the other two Bills is the requirement of the auditing process and, and a real, real process of, of transparency, not just simply saying we're going to try, but to put into statute the requirement of, of accountability in transparency. And I want to applaud Representative Kerry Wood for her focus on that area as well in being representative that we have an important responsibility to be protectors of, of people's well hard earned money, that the transparency and the spending of that needs to be shined on.

And, and we are the only one of the three Bills that, that specifically put in an audit process and a re-improved process, because the, the new plans that are proposed in the other two, do not have to go through the regulatory scrutiny and, and the requirements of approval of our Department of Insurance. We have put that provision into Senate Bill 1006. Can you talk a little bit about that? I know that was one that was keenly a source of pride for me to make sure that it is in there.

SENATOR KELLY (21ST): Exactly what you, you point to is that, particularly with regards to the public option that's backstopped by the taxpayers. So when

it runs in red, as it has for the past two years, the taxpayers are the ones who bear that cost. It's also projected to have a $97 million loss in the current year. Now, that's because it's a government run health care payment plan, where people pay a fee to participate in the program. It's not insurance as we know it. So therefore, it's not regulated by the Connecticut's Department of Insurance, which I'm going to say, the best regulators in America, if not the world, are in our Department of Insurance.

And yes, this comptroller plan, the public option will not be regulated. So you don't have the trained eye on knowing how to assess insurance risk, and to make sure that when a company offers a product, that it's capitalized, and can make payment on all its claims. Obviously, the partnership plan has operated and it hasn't operated effectively, it hasn't operated in the black, and that's a concern for taxpayers. And so we need that oversight, because the Bill doesn't have it.

Furthermore, because it's not traditional insurance, it also doesn't have all the protections of the Affordable Care Act, because that's applicable to insurance policies issued by carriers. Our plan and the Governor's plan have both of those protections, they have both the Department of Insurance oversight as well as all the protections of the Affordable Care Act. And that's a critical distinction, because I think when you talk to people throughout Connecticut, you will hear people say that they liked the protections. And we want to make sure that those protections remain.

SENATOR HWANG (28TH): And I appreciate that, and I'm eager to hear the other thoughts of, of colleagues on the Committee. And, and again, as, as people might have missed it earlier this morning, we did pass out an amendment that moved toward that direction; thanks to many of the leaders on the Committee. But again, good ideas doesn't have one

party, and I hope that we continue to work to make the one Bill that, that will move forward to reflect all the positive contributions of all Members. So thank you Madam Chair, and I'm eager to hear from the perspective of my other colleagues. Thank you Senator Kelly.

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

REP. MESKERS (150TH): So I will first apologize and, and demote Representative Hwang back to the Senate. I think I referred to him as the Representative versus Senator. And I want to thank Senator Kelly for his presentation. Couple of observations and comments. The idea of reinsurance and the idea of moving the risk pool I think has merit in leveraging the tax dollars from, from the feds or the financial aid from the feds in reinsurance. But I think that goes to the issue of cost sharing and who is paying for it. So I guess you know, it's, it's taking off the burden of Connecticut taxpayers, I appreciate that.

I think the metrics and measurements on cost effectiveness, you talked about in cost controls are where it's most important because it's the growth and the cost in the hospital system in medical care. I think the Governor's plan in relation to pharmaceuticals if that begins to put a brake on pharmaceutical prices is important. The idea of importing drugs from Canada or potentially using those benchmark prices and figuring out how we can implement our requirements on a reimbursement rate, reimbursement rate at some marginal excess over the Canadian prices are 20% premium to Canadian prices. Because what I'm finding is that the pharmaceutical companies are telling the Canadian government, we can't get our drugs out of Canada or there is a shortage, but it confuses me because the drugs are manufactured in China and India.

So they're coming into Canada, but they can't seem to come into the United States from Canada. So we have to figure out how we get a handle on pharmaceutical pricing. So I would make the observation that the public plan with the amendments is both fully insured and backstopped and audited under the, under the amendments we've, we've proposed. So I think some of the concerns during the public option are, are data on the original version, which you, which you probably saw, and I, but I appreciate that the amendments I think carry some of that risk away.

I think the question becomes, how do we control this four-headed Hydra that we talked about, which are the hospitals, the pharmaceutical companies, the policy benefit managers, and the, and the insurance industry; which I think ultimately, you know, when we talk about that, no one should, should, you know, there is a little bit of the bad news is the insurance industry. Everyday you crack up on your envelope and you get every month, your insurance bill. And what they do is the measuring and mitigating the cost is coming through the system. The system is fundamentally broken, and I don't think it's a Democratic or Republican fault line.

US medical cost system is at a 50% to 75% premium to most of the OECD countries. We have the most expensive healthcare with similar results, and it's getting to a breaking point. I think Senator Hwang admitted, you know, we spoke about it in our last session. And at some point, we either solve the problem or by the fact that we go to a public option, because when the policy costs you $45,000, there is no option, right? When it's a $45,000 a year policy with a $15,000 deductible, I'm supposed to tell people they, they should pay that out of their, you know, salary or a blue collar job.

So I care about the insurance industry, but we have to figure out the incentive structure for the

insurance industry to both save money in the process of managing those health care policies and paying pharmaceuticals and paying hospitals and paying for the you know, general healthcare, and how there is an incentive for them to, to receive a better pay on a lower premium price. Because right now, the way the system works, it seems to me is everyone's incentivized to grow the Bill?

The insurance companies have an MLR of 85%. Everyone that everyone but me benefits when there are four people with their hand in my wallet. So I'm interested in working and having a dialogue about how we can limit you know, all the, to, to give people choice, but to give people fair choice and reasonable choice, because choice when your insulin is $400 or your, your inhaler or EpiPen is $1,000, is you, you're getting choice at some point, and we're getting you that point.

So I recognize, I think there is a rational reason to have the dialogue with this. I question whether you know, personally I would love to -- do I want to run $80 million to the budget through our general fund to do the reinsurance. I would want to know that the reinsurance isn't just reducing the, the risk pool, but not dealing with the cost structure. Because I immediately reduced premium by shifting the risk pool with reinsurance, I understand that and the tax [inaudible] the government. But if I can't figure out a way to control the cost, I'm going to need bigger and bigger reinsurance dollars to pay for larger and larger risk premiums.

So yours is, what you accused many Democrats that it's the first accounting game, which is let's get the federal government to finance part of it, so I'm not criticizing that. But this is what's the next leg of that, what's the second act of that, so it's not a one trick pony ad we have to really work hard on that because I think you, you're leveraging financial reserves from the feds isn't as lot of.

And I love, you know, your observations and pushback or, or feedback on where, what I have to say would be very helpful, because I didn't get your presentation, I was in a Committee Meeting yesterday.

SENATOR KELLY (21ST): Well, thank you very much for your observation. Obviously, your diligence and looking at this issue, and looking at it objectively. You know, I think there is a recognition that there is a market failure here. And that's why families are sustaining the insurance premiums that rival that of purchasing a new car every year. And that's just, that, that's not fair at the end of the day. So, yes you're right, you know, the reinsurance looking at risk pools and that's operating on the current Affordable Care Act platform. But it's more than just about premium relief. We've got to get our arms around the cost drivers, which is what you're putting your finger on with a driver, which I agree with and why we've always had as part of our reinsurance plan was the benchmarking and, you know, prescription drugs.

Now, you're, you're taking it a step further while the prescription drug is dependent on federal approval. You're touching on the issue that the drug transparency Bill is, is working to get information, which is getting at the heart of how do we actually finance big pharma and, and who gets paid in that from, from I'm going to say, manufacturer to delivery to the patient. Where are all the cost drivers? I think we need to look at that information, because this is, that is the single biggest driver in healthcare costs. And what we need to do is take the information that we're getting from that Bill that passed in 2018 and start to look at how can we drive down on that and drill in on it in a, I'm going to say a more rational approach based on metrics and information that the state will have available to us.

In the interim now, I think the reinsurance with benchmarking that the Governor started, we need to continue that work. And I think this is really a, the way to go, it is the better approach for the State of Connecticut. And the real reason is, is that the public option, when we look at that alternative, that's disruptive to the current, I'm going to say insurance marketplace. And while it may work in other states, in Connecticut it's so dependent on insurance jobs, it might not be the best approach.

And it doesn't have that benchmarking option that would, we would be able to utilize to get our arms at the real problem here, which is the, the ever increasing high cost of health care. And as long as you have that year over year increase, it doesn't matter what we do on the premium side, it's not going to bring the relief to the people that we serve. So thank you very much for your comments Representative Meskers. I look forward to having a continued dialogue, because I think these are the kinds of discussions that are constructive to actually bringing the relief to the problem that the people experience. So thank you for your comments. I appreciate them.

REP. WOOD (29TH): Representative Nuccio.

REP. NUCCIO (53RD): Thank you Madam Chair, and good afternoon Senator Kelly, how are you?

SENATOR KELLY (21ST): I'm well, yourself?

REP. NUCCIO (53RD): Thriving. So I wanted to kind of focus in a little bit on a couple of things on this Bill, because part of this is going to -- I'm gonna vent a little of my frustration here is we have three Bills in front of us, all regarding health insurance and we've heard platitudes of, of respecting the minority and open dialogue and debate and everything. And I guess my frustration level

is, is as a legislator who truly wants to represent my people. I want to be able to look through these three Bills and I want to cherry pick. I want to take what's good in your Bill and take what's good in the other Bill and I want to take what's good in the last Bill, and I want to create a Bill that's truly going to help the people of Connecticut without worrying about who sponsored what Bill.

So I'm a little, I'm a little disturbed that we don't have that opportunity to do that, because there is one specific thing in your Bill that I think absolutely will impact the cost of healthcare and that's benchmarking. You know, benchmarking is proven and it has been shown to be working in Massachusetts, it has a, it has a demonstratable effect on the cost of healthcare. Because if you, if you look at how benchmarking works, it puts pressure on industries to keep costs at a lower amount or within a quarter of amount, right.

So in order for industry to keep that number there, they have to then work with providers, which providers are one of the biggest pieces of the cost in healthcare. And where we control the providers cost when you see conglomerations, and you know, you're talking about services and healthcare, actual hands on healthcare providers, and what's driving their costs is, you know, whether it be, there are so many factors involved in that increased usage, Medicare and Medicaid percentages, malpractice insurance, and the list it limitless, it's almost as what Representative Meskers said is, although I would challenge it's four-headed Hydra with, you know, probably about 44.

But it starts the conversations of truly looking at the cost of healthcare and holds everybody, because when you hold industry accountable to a number, they have to hold providers accountable to a number. Providers have to hold their piece of it to a number. You know, it's, it's truly a trickle down.

So benchmarking for me, I respect the fact that the Governor started with this, but I'll be honest with you, I think one of the worse ways to legislate is through Executive Order, because it changes every time you see changes and anybody who has not watched federal politics for the last three presidents, I don't understand how that can't be something that we don't have ingrained in us at this point is ruling by Executive Order is, is ruling by fear that changes with the next leader.

So for us to codify what he is doing and I would actually say codify in and firm it up some and make sure that we have good strong benchmarking in there, and a path to finding a way to reduce the cost of health care. To me, it's our job as legislators to identify something good, make it better, codify it for our constituents. So just the fact that it's there, isn't good enough for me, because it goes away whenever the next Governor comes in.

So I wanted to then focus in a little bit on the reinsurance program. It happen to be pretty knowledgeable in this session, and I do know that there are plenty of states out there that do exactly what, what you're talking about doing. When you're looking at 1332, it's funny, because we talked about things and I don't know if people always connect them. A 1332 waiver, 99.9% of the time leads to a reinsurance program. So the same things with different wordings.

So for the 1332 waiver, it's, it's a good opportunity to use federal funding, which Connecticut historically gets a ridiculously low percentage back from the federal government for what we pay in. So anytime we can tap into the money that we're already paying, I'm a fan of. So with reinsurance, the two ways that we can obviously do this is through something like your suggestion, which is the general fund usage. And then the other is through the assessment.

So those are the two ways. Obviously, I'm more of a fan of looking at the general fund perspective of this, because when an assessment takes something that can be levied against all of your tax payers, which is the general fund hit and it levies it against a narrower portion of people, depending on the parameters that are written, you're putting more cost burden on a subsection of people rather than a spread out cost against a lot more.

So I do think looking at the reinsurance portion is invalid, my pushback on that is, you know, we have already heard multiple, multiple new sources of revenue that are going to come in should things pass, legalizing cannabis, online betting, etc. All these things are out there with these glorious new revenue streams. And I would challenge all of us on this Committee and even further all of us on the floor to prioritize what's important.

You know, in the middle of the pandemic, health care is arguably the most important thing to a person. Education isn't as high if you're not healthy enough to do it, you know, unemployment. Healthcare is a key. So if we can prioritize some of the money of these revenue streams that we're assuming we're going to get into what's important to us, I would think healthcare would be one of those, will be one of those things.

So I know that was a big soliloquy there and there wasn't really any question in there. So what I would ask for the question perspective in regard to the benchmarking, because I really do think that is the absolute steak on the plate for this Bill here. Do you see a way that we can look to use what Massachusetts is doing, review where they've had shortfalls and actually firm it up so we can absolutely start to dive in and push down on the cost of health care?

SENATOR KELLY (21ST): Yes. In fact, a lot, lot of that has started with regards to the Executive Order that Governor Lamont signed back in December of 2019. You know, this would codify that and move it forward. And in our run up to this, one of the things we've been working with and, and talking to the folks in Massachusetts who have done this, and that's always one of the concerns is, now that you're armed with your experience, what did you find that worked, and worked really well?

And where were you having problems for, if you had to do this again armed with the experience that you did, what would you do differently? And I think that's part of it, and that's one of the things that I would be sensitive to is along the way is not just have as your sole yardstick just cost. Cost is important here and we need to make sure that we get our arms around the costs, but we also can't leave individuals behind, and individuals who either depend on core services of government or who are currently marginalized because of their complex or chronic care conditions by the current system.

So we want to make sure that as we move forward, we learn from that base state experience and make sure that we don't leave anyone behind. But the, the fact here is what they're doing in Massachusetts, it works, it saves money; and we need to do here in Connecticut.

REP. NUCCIO (53RD): Yeah, I don't think it's as important to be first at the table when it comes to something like this, if you can learn from what happens, you know, the stains that are on the tablecloth and I'm all about, you know, we can, we can do seconds to this, to this to really focus in on taking the good parts of it, because truly, I think the benchmarking piece of this Bill here is, is like I said it's the most important to me because it is something that will actuate savings in healthcare, which I think is what we need to start

focusing on, is how do we reduce the cost of health care, you know, the cost of insurance, the byproduct of the cost of health care.

So thank you for bringing this, this forward, and I didn't have the Wakely Report before, but I do now. So I've got reading material on top of more. Thank you very much for your time.

SENATOR KELLY (21ST): You bet. Thank you.

REP. WOOD (29TH): Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you Madam Chair. Just one question, Senator Kelly, and thank you for bringing this Bill forward and for your testimony. I had concerned about the public options, kind of competition with the exchange. And a lot of, I think the costs associated with that as far as everything from you know, that, that's, you know, I know, the exchange has struggled with or, you know, dealt with will say, and overcome, but I know it's a work in process, things like advertising, the platform of coinciding with other platforms as well. So I was wondering you know, what your take is on that end, if there any potential pitfalls in what you've put forward, some of the same problems you see or do you see it avoiding that issue and how it interacts with the exchange, if you can?

SENATOR KELLY (21ST): Well, I mean, reinsurance is, is just allowing the private marketplace to exist. It would be much the same way it was at the beginning of the Affordable Care Act where we had more participants on the exchange and I think they would participate to a greater extent with the reinsurance program than without. And I think the real difference is here is in the, the public option, is, is a different thing. You know, our plan and the Governor's plan is worth looking at reinsurance, the public option is, is its own lane.

And the public option is not traditional insurance, it's a government run health care payment program. And so you have different, these are apples and oranges. And to give you an example, it would be like if we had a car dealership, the public option would have a car dealership, selling a car across the street from a private dealership, but one is a state owned dealership, the other one is a private owned dealership. But the state owned dealership doesn't pay sales tax.

Matter of fact, you're going to get to sell the car at the same price and the, the state run dealership doesn't have to do that and as a matter of fact, may have a different arrangement with its, its employees. And then on top of that, they're going to tax the dealership across the street to subsidize the state run dealership so that the dealer can actually produce, sell the car for maybe a couple of dollars less. And that's really what the public option is, it's not a fair level playing field. And that's why it's disruptive, and that's why it's going to create a problem for an insurance market in the State of Connecticut. That's where you know, it's in its own lane and it's backstopped by the Connecticut taxpayer.

The reinsurance I think, is the best way to use the current system, the current platform. If we have a state based reinsurance program, I think more people are going to come on to the exchange and purchase their insurance through reinsurance program. And another thing too is, keep this in mind, that when we're looking at a payment plan, whenever somebody is on either a government payment program, whether it's Medicaid or Medicare that is being delivered, the care is being delivered at a discount, 65% to 80% for a dollar of care. When they have private insurance, the private insurance companies pay more for that dollar of care to offset the losses on the Medicaid Medicare payment plan.

And what happens with the public option is you're going to put more people on that or if you do a Medicaid expansion, you're going to put more people on that discounted reimbursements scale, which is up, means upward pressure on private insurance. It's a way to kind of mask the costs, the true costs when you do that, and so we want to make sure in the process here that we are putting more upward pressure, and I think the, the reinsurance offering the, the private base product is the way to achieve that. Keep the good paying jobs in Connecticut and bring with benchmarking and looking at the prescription drug cost drivers, the way to bring relief to middle class families.

REP. PAVALOCK-D'AMATO (77TH): Thank you. And I agree, and just one more point is and I still don't know if it was brought up in, in some of the other testimony. But, you know, there are in the hospitals are like you said, they take Medicare Medicaid and we're dealing with the hospitals negotiating fees. You know, they have doctors, I guess at the end of the day, I'm concerned with the level of care and you know, doctors who have already committed or working at hospitals, and now I know, in a lot of circumstances, their salaries costs reduced.

And of course, I know my generation, and although I'm sure your's too, the future generations, who have student loans and salaries can be cut, but that doesn't mean my student loans are decreased. And so now you have, you have doctors that are now going to look elsewhere and go to different states, because if their salaries keep getting cut, well, you know, it's not, it doesn't help at the end of the day when you have, as I'm sure they have at least $300,000, $400,000 worth of student loans that I know doctors come out of medical schools with, so that was just an extra point I wanted to bring up, but I thank you for your testimony today and hope to see you again soon.

SENATOR KELLY (21ST): Thank you.

REP. WOOD (29TH): Senator Kelly, thank you so much for coming and sharing your testimony and answering all of our questions.

SENATOR KELLY (21ST): Thank you very much. Appreciate it, anytime.

REP. WOOD (29TH): Take care.

SENATOR KELLY (21ST): You too.

REP. WOOD (29TH): Next up is Ted Doolittle. Ted Doolittle

TED DOOLITTLE: Good afternoon Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato, and Members of the Insurance and Real Estate Committee. I'm not Ted Doolittle, for the record, my name is Shaun King, I'm the senior staff attorney at the Office of the Healthcare Advocate. I'm here to comment on behalf of Mr. Doolittle to healthcare advocate. Unfortunately, he has another commitment this afternoon, he sends his apologies that he could not be here to address you in person.

The Office of the Healthcare Advocate as submitted written comments to this Committee regarding both of the Bills on today's agenda, and we will for the most part let those comments speak for themselves. My primary reason for addressing the Committee today is to emphasize our comments on HB 1006. And specifically the sections of the Bill that addressed the state's evolving benchmarking strategy for seeking to control surging healthcare costs.

First of all, before highlighting our concerns, I want to restate our praise for the Office of the Health of Health Strategy and its staff and all the

contributors to the initial benchmark that we just developed within the last year. It was a tremendous effort on their part to gather a wide range of input and synthesize it into an initial benchmarking strategy within the timeframe allotted by the Governor's Executive Order five.

Initial benchmark is a product of a lot of hard work by all of those involved and they should be, should be commended for their efforts. I'm here to cast some additional light on one of the Offices of the Healthcare Advocates concerns about the methodology that was adopted under the initial benchmarking strategy, specifically the cost growth benchmark methodologies reliance on heavily weighted forecast of median income. Currently, the cost growth benchmark value is determined by a weighted average of the potential growth state product and the median income of Connecticut households.

We believe that emphasis on median income is a critical shortcoming of the current benchmark, as it tends to afford more protection for the interests of the top 50% of earners in Connecticut, while failing to protect equally those of more modest means surging healthcare costs and widening income disparities. As it stands, use of median income is the most heavily weighted factor and benchmarking health care costs growth ensures that the top 50% of households will see their income keep pace with health care costs.

But as income disparities widen between this top half of household incomes and those in the lower half, particularly those in the 25th to 50th percentile, who may not be able to access Medicaid or other subsidized insurance, lower middle class working families will not receive equal benefit from a benchmark based so heavily on median income. OHA would much prefer that the methodology utilize the 25th percentile income as a factor weighing most heavily in the formulation of a benchmark.

This alternative marker of economic prosperity for families of more modest means would yield a benchmark that is more likely to ensure that health care cost growth is restrained from outpacing the incomes of all Connecticut families, not just those in the top half. Notably, this alternative metric would also align the benchmarking strategy for cost containment more closely with another goal of SB 1006, namely the achievement of health equity. Currently, SB 1006 does not prescribe a particular methodology, leaving the development of the methodology and the ultimate benchmark values to the Office of Strategy.

In order to ensure that the future enhancement of the benchmarking strategy addresses the needs of all Connecticut residents and not just those above the median income threshold, OHA would like to see this Bill revised in a way that directs OHA to adopt a methodology that is more equitable for lower and middle, middle income families including the replacement of the median income as a factor with the 25th percentile income as the appropriate measurement upon which to construct a benchmark value.

Thank you for your time today, and for your attention to these important issues affecting Connecticut consumers. If there are any questions from the Committee, I'll be happy to answer them as best I can.

REP. WOOD (29TH): Thank you very much. We have questions from Representative Nuccio.

REP. NUCCIO (53RD): Good afternoon, how are you, Mr. Ted Doolittle.

TED DOOLITTLE: Thank you Representative, I'm well.

REP. NUCCIO (53RD): I just had a quick question, I'm not sure if you can answer or not, but can you give an estimate if the benchmarking was lower to the 25th percentile, how many more people would qualify or, or what that would do to the benchmarking numbers?

TED DOOLITTLE: I'm sorry, I don't have that particular detail off the top of my head, but I'm sure in some of the research that we've gathered, I can find it and, and get that to you.

REP. NUCCIO (53RD): I would appreciate that. Thank you.

REP. WOOD (29TH): Any other questions? Great, thank you for coming.

REP. WOOD (29TH): Thank you very much.

REP. WOOD (29TH): Next up, we have Bruce Adams followed by Kim Daigle. Just to remind our speakers, we do have a three minutes speaking length and we will try to notify you when that three minutes comes up. Thank you. Bruce, you are muted, if you would just unmute and there you go.

REP. MESKERS (150TH): Madam Chair, I'm not hearing anything.

DAWN MARZIK: Bruce, can you double check if you're not still muted?

BRUCE ADAMS: Who is this, is this better?

DAWN MARZIK: That is better.

BRUCE ADAMS: I'm so sorry. Okay, I will save the formalities and save you some time because I welcomed you now twice. My name is Bruce Adams and I'm the President and CEO of the Credit Union League of Connecticut and I'm offering testimony supporting

House Bill 6585 regarding Association Health Plans. Credit Union is really are unique businesses, and the reason why they are is that they're not for profit financial cooperatives. And those cooperatives are democratically controlled by a volunteer board of directors that are elected from their membership. So to cut to the chase, we've ticked the fox out and the hens are guarding their own house.

And I think that this alleviates a number of concerns posed by the advocates in their written testimony such as whether or not a plan, if credit unions were allowed to access an AHP that that somehow that, that labor and management wouldn't be aligned and that they would design the plan in a discriminatory fashion or some other way. And those concerns simply don't exist here.

Additionally, Credit Unions in Connecticut, because they're closed financial cooperatives like a closed loop, the money that comes in to their deposits is also the money that funds the loan. So that when credit unions, if they're allowed to, can reduce these fixed costs, those go right back into, you know, the hands of their members, right back into Connecticut communities in the form of higher interest rates on, on your checking account or savings account, or lower interest rates on your car loan.

And in that way, allowing credit unions to do this would help us participate together in the economic recovery from COVID, by keeping these dollars in the hands of Connecticut residents, your constituents and allowing them to enjoy those benefits.

I have made some other points in my testimony. I would add that, we have noted the concerns of Senator Looney and, and the advocates, we look forward to working with him in his office to craft suitable language that would help alleviate various

concerns. And what we think is that if the language were changed to allow for a nonprofit self-funded AHP with certain other particular details that that would alleviate a number of the concerns expressed here in written testimony today. And with that, I'll take any of your questions.

REP. WOOD (29TH): I apologize. Representative Tom Delnicki.

REP. DELNICKI (14TH): Thank you Madam Chair. And Bruce, it's great to see you here at a different Committee, as opposed to typically banking. And for the record, I served as one of those volunteer non-paid directors for about 15 years when I was at the employed by the Metropolitan District Commission, and I can attest to the dedicated service at a bargain price that is given to the Members and shared with the Members.

A couple of questions, and I look at the Credit Union like a perpetual motion machine from the standpoint that money comes in, money grows, money goes out as loans. And credit unions are always looking for ways to provide services to the Members, because that's what it's all about, right?

BRUCE ADAMS: Right.

REP. DELNICKI (14TH): So are you talking about operating a self-insured plan and not a fully insured plan?

BRUCE ADAMS: That's right, and, and Kim Daigle who is up after me is from the insurance trust in Maine where, where they've done it for, for credit unions up there and, and has another, a number of other aspects of her, of the plan that how it works there, for instance requiring a three-year commitment to stay on the plan. So not only are you self-funding, but you're on for a number of years in order to

increase the stability, the financial stability of such a plan.

REP. DELNICKI (14TH): Let me ask a nut and bolt question, maybe I need to wait for the, the testimony from what occurred in Maine. But from your level of knowledge of that, how did the rates compare with non, non-credit union offered plans, not association plans?

BRUCE ADAMS: Sure. I mean, if you look at credit unions, and yours as a good example, the Metropolitan District Credit Union; I think has five employees. So they're not able to access the kind of large group coverage that, that they would be able to where they need to join together with the 1900 or so other credit union employees, the eligible credit union employees in Connecticut. And so in so doing of course, they would all be participating through our pre-existing trade associations to, which is governed by the CEOs themselves. And so that's, that's the way in which I was describing, we've let the hens guard their own house and kick the fox out.

REP. DELNICKI (14TH): But I, I would be remiss if I didn't make this comment. How, what is the possibility that the actual numbers of somehow could be beneficiaries of what you're able to do when it comes to a, a plan like that?

BRUCE ADAMS: You mean the members of my members?

REP. DELNICKI (14TH): Yeah.

BRUCE ADAMS: The customers of the credit union.

REP. DELNICKI (14TH): The customers, shareholders, and I prefer the term shareholders, because each depositor is a shareholder in the institution.

BRUCE ADAMS: If I can address that last point, first, I think you're spot on Representative, and, and it's in my written testimony, sort of the, the similarities between, let's say, a publicly traded company where you own a piece of the company and a credit union where you own the credit union. The difference is, you're also the customer. But with your first part, I think that may be a bridge too far, because what we need to do first and foremost is to shore up this industry and provide the benefits through the operations of the credit union itself.

I think when we start talking about going to the members of our members, some more of those concerns that have been articulated in written testimony today become a little more real. And I'm not saying it's not possible, I think it is possible, but it would require some careful study and I think some careful guardrails put into such legislation.

REP. DELNICKI (14TH): I certainly appreciate that answer. We're talking about real world savings, we're talking about the fact that the overhead costs for the credit union to serve the Members will be stabilized, considerably reduced which in and of itself, and we've been talking a lot about underserved communities, and I have to give you a shout out. You know, credit unions, by and of themselves have gone into a number of underserved areas, and their success is our success in providing those areas with the kind of banking that they need. So anything we can do to ensure their stability financially so that they can serve those folks and, and allowing you to be able to have a plan like this would go a long way in that. Do you think that's a correct statement?

BRUCE ADAMS: Well, I do. I have, some of my colleagues read me endlessly because I've referred to credit unions as financial first responders, but we rush in when everybody else is rushing out. For

instance, we're trying to find a way to address banking desert problems in, in Connecticut. And, you know, for that reason and to further elucidate on your point, when we have, sorry, there is some cross noise.

DAWN MARZIK: Yeah, I'm sorry Bruce. Will you please hold on for a second?

REP. WOOD (29TH): Dawn Marzik? Dawn Marzik, you need to mute your -- Can you mute Dawn please? Okay.

BRUCE ADAMS: So the very nature of having a cooperative business model is different and distinct from a nonprofit charity. And I think that's important when we consider this particular Bill before us, because when you take the fixed costs out or reduce it, it necessarily has to go to the customers, to the members. So we know that those dollars that's stripping out a little bit of, of the fat from this model, we just know without question that they resolve and redound to the benefit of Connecticut consumers. Like there is no diversion of it anywhere.

REP. DELNICKI (14TH): And that, that like what you would have of a profit making institution that obviously they have to take care of their, their stockholders, not shareholders.

BRUCE ADAMS: Right.

REP. DELNICKI (14TH): Well, thank you for coming forward with your testimony. I think it's a great idea, and I think it could go a long way in bolstering credit unions stability and providing a, a good way to make sure that the folks that are working in your industry are being given the best possible healthcare, and be making sure that folks are getting the best possible banking.

BRUCE ADAMS: Thank you very much.

REP. DELNICKI (14TH): That's a best of both worlds, Thank you Bruce. Thank you Madam Chair.

REP. WOOD (29TH): Thank you Bruce, thanks for coming on.

BRUCE ADAMS: My pleasure.

REP. WOOD (29TH): Next up, we have Kim Daigle, followed by Jonathan Stein. Kim, I can't hear what you're saying. No. There you go. Kim, you have a lot of background noise.

KIM DAIGLE: Let me just try something here. Are you able to hear me now?

REP. WOOD (29TH): Yeah, that works, great. Thank you. You're on.

KIM DAIGLE: Sorry for the technical difficulties. Good afternoon, I'm Kim Daigle from the Insurance Trust, and I'm President and CEO, and we are the insurance trust for the credit unions in Maine. I have been in the health insurance arena for over 20 years, and like all of you, I am very concerned with the rising cost of health care for employers and employees. For about 10 of those years, I worked in Anthem Blue Cross Blue Shield, and had the opportunity to work on different Association plans.

In April 2019, with the partnership of the Maine Credit Union League, the Insurance Trust started and Association Health Plan. We have 54 credit unions in Maine, we started with ensuring 19 of those credit unions to start off with a little over 500 employees. And to date, we are ensuring and protecting over 30 credit unions with about 775 employees.

I have read many of the testimonies and opposition's and I think the most important thing to say on this plan is these are programs are meant to help people and not harm them. So I would like to address some of those concerns that folks may have regarding maybe insolvency, the inability to pay claims and associations not complying with state or federal mandates.

So part of what we did is we made sure going into this that we created some implementations of how things were going to be set up and run. We, as Bruce mentioned, we had a three-year participation agreement to create rating stability. We worked with a, an actuary to come up with stable rating. We also to satisfy the Bureau of Insurance in Maine, we had to collect reserves ahead of time. So each credit union that joins had to give three months of premium in order to join into the new law.

Very important part of this program along with having great, you know, a good rating justification is also to have stop loss and reinsurance coverage, I've heard folks talk about that today. But basically, I think a lot of people think one or two claims can save a program like this, when you have the appropriate mechanisms in place. For our program, any claim over 225,000 we have stop loss protection to make sure that, you know, we have that protection for our group.

We also ask that every credit union that joins submit financials, so and it's reviewed by an independent accounting firm. We have a Board of Trustees made up of Credit Union folks to ensure that the administration is moving along the way it should. We're complying with state and federal mandates., and in fact, we are able to sometimes, in certain cases, perhaps in the camps, the coverage that's available for folks.

So these programs, I have seen programs like this and my experience at Anthem, that were not set up appropriately. But when you do set them up, there is a lot of stability and a lot of savings for folks. And I, I would like to go back to Bruce's comment about the money that we've been able to save our credit unions in Maine, have not only helped Credit Union employees keep more money in their paychecks, but it's also allowed credit unions to have additional monies to lend out to their members.

So this program is, is running very successfully, and we're very happy to be able to help folks with this and I'm more than happy to answer any questions that you may have today.

REP. WOOD (29TH): Thank you. We have a question from Representative Delnicki. Thank you.

REP. DELNICKI (14TH): Thank you Madam Chair, and Kim, it's great to hear you speak about this and, and to see you. Talk a little bit about actual experiences with credit unions, when it comes to both success and failure. Were there any failures?

KIM DAIGLE: In the Credit Union block within our credit union program, no, we have not seen failures because we have a very sound rating strategy and did all those things that I mentioned to make sure that we run well, just not now but in the future. I would love to give a little example of how we've been able to help a credit union. We have a Credit Union that has 64 employees, and they were getting their health insurance coverage from other carriers in the State of Maine. And like a lot of health insurance or excuse me, credit unions that have over 50 employees, they have a portion of their claims experience that determine what their renewal rates will be.

When we originally quoted them, they were paying for their plan, the full cost of the rate for an

employee was $486 a month, because they had two large claims. They ended up getting a 30% increase from their health insurance carrier, which meant that employees or the total cost was going to be $632 a month. That's substantial, and unfortunately because of their claims experience, there were no other health insurance carriers that wanted to even bid, they had declined quotes from other carriers. But because our health insurance plan was an option for them, the rate that they paid in 2021 is $339. So it was less than they were paying, they got identical mirrored coverage. It's an HSA plan and you know, that was a great savings to the credit unions and to the employees. So that was, that's a perfect example.

And we always test the market. We're two years into this program. I have a smaller credit union that has six employees, very much like Metropolitan Water District Credit Union. And when we quoted them in the meanwhile, and then we quoted them outside of the meanwhile with a carrier, there was a 12% savings in rates just this year alone.

REP. DELNICKI (14TH): All right. I thank you for your testimony. It's, it's like one more tool in my toolbox when we started talking about how we can actually deliver health care and health insurance. So again Kim, thank you for joining us today and have a great day.

KIM DAIGLE: Thank you.

REP. DELNICKI (14TH): Thank you Madam Chair.

REP. WOOD (29TH): Great. Kim, thank you so much for coming on.

KIM DAIGLE: Thank you.

REP. WOOD (29TH): Next up, we have Jonathan Stein, followed by Derik Wrightson.

JONATHAN STEIN: Thank you Madam Chair. I appreciate the opportunity to talk in support of House Bill No.6585. My name is Jonathan Stein. I am a pediatrician in private practice in Guilford, Connecticut. And our practice is part of Community Medical Group. You know, we're a practice that's been in the same location since 1954. We are independent. We provide care for children on the shoreline from a number of towns.

And we provide the kind of care that most parents want unfettered access to us, on site after hours care, people they know well to speak with when there is an issue, no call lines. We don't share a call with other practices. No nursing call lines after hours from out of state. We tell our families to call us day or night rather than heading to urgent care centers, emergency rooms, and we even still make house calls.

And although this is a kind of work that's incredibly labor intensive, the value to our patients and our community is indisputable. We love our work. But I have to be honest, it is increasingly difficult to manage in the present business climate. Every year our overhead increases at a crazy rate while our generated revenues are fixed or falling and obviously, the pandemic had a great effect on that, but even before that there was a problem.

The most significant contributor without a doubt is the overhead requirements of providing health insurance to our employees and to ourselves. And for years, we've looked at other alternatives trying to figure out a way that there is no escaping this truth, we are stuck as a small business with high cost, low quality insurance. And moreover, these plans tend to really absorb a tremendous amount of time and administration for people like me who are in the management side of our practice.

Most or many practices I should say, that are leaving independent work are doing it for this reason alone. And every time we lose a practice, it's a domino moving us ever closer to monolithic Medicare that is really not community or patient centered. House Bill 6585 offers a window of opportunity to support practices like ours. It has some risks involved that will require some modification of legislation to make sure we are not missing important features, but it'll give a meaningful step towards minimizing our overhead, and a relationship with groups like Community Medical Group is an avenue towards that.

I urge you to support House Bill No.6585 and help small independent practices remain sustainable. And I thank you for time, your time, and I would welcome any questions.

REP. WOOD (29TH): Thank you Jonathan. How many employees do you have?

JONATHAN STEIN: We are nine.

REP. WOOD (29TH): Nine. Yeah, so, you know, this is, this is a challenge right now in the State of Connecticut. It is a small group, plan, it's a small group that has insurance but are having to go to higher and higher deductible plans. And a lot of the proposals that are coming out of the Insurance Committee this year are geared towards providing additional products, additional solutions, additional options for this small group.

So I definitely wanted to hear about association plans. I, I wanted to give it the avenue for us to have that, you know, debate. But we have discussed many things in the Committee that fear that I hope will provide more options for companies like yours. And I just want to say thank you and we hear you, and we're confident that we can do some good, some

good work on the Committee this year. Are there any other questions for Jonathan? Great. Jonathan, thank you for sharing your story.

JONATHAN STEIN: Thank you.

REP. WOOD (29TH): Up next, we have Derik Wrightson, followed by Alan Sheketoff.

DERIK WRIGHTSON: Alright, can you hear me?

REP. WOOD (29TH): We can hear you Derik.

DERIK WRIGHTSON: Great, thank you. And thank you for having me. I'm Derik Wrightson, I'm the health insurance broker here in Connecticut. We help individuals and businesses with managing their benefits. I was also part of the team that helped launch the Access Health Shop Exchange back in 2014. There is no doubt that health insurance has become an untenable expense for the vast majority of the residents in Connecticut. After reading through the Senate Bill 1006 briefly, generally in support of the measures that details especially those that focus on bringing down the cost of healthcare and prescriptions.

In my role, I am constantly sharing the bad news of the cost of health insurance for a Connecticut resident, family or business owner. And ultimately, the insurance is just a means of paying for their health care, and ensuring they are covered in the worst case scenarios. I feel this Bill is finally at least focused on bringing down the real problem, which is the skyrocketing cost of health care and prescriptions. It is quite crazy that an MRI at a local hospital can cost thousands of dollars more than a free standing facility or a $3,000 a month prescription can be had for nothing or a small copay, but only if you know about a manufacturer savings program.

The system is completely broken on that and the things and the data and transparency and benchmarking and all that that's referenced seems to be what the Bill is finally getting up. I initially thought this Bill could find some middle ground was the other Senate Bill 842 with the inclusion of expanded eligibility for tax credits. But it did seem that the recent federal COVID relief Bill is going to step in on that regard too, so would love to hear comments on that.

I, I would like to hear too about the relevant state bodies and what power they have in enforcing those performance improvement plans that are referenced in the Bill. I thought that was a great idea. I just didn't know exactly what kind of powers the local government would have in enforcing stuff like that.

And then I would love the idea of the Canadian import for prescriptions, I think that's phenomenal. But as was referenced in the beginning of the meeting, I just feel like I think federal permission is needed at some level, and I just love to hear more about how that would be implemented. Overall, I love that we are focused on bringing the cost of health care down in Senate Bill 1006. I would love to answer any questions, and thank you for having me.

REP. WOOD (29TH): Senator Hwang. Senator, for some reason, we can't hear you even though.

SENATOR HWANG (28TH): No, everybody has a problem with the mute button. So again, welcome Derik, thank you for joining us. Now you work in a, a benefit consulting business right, in which you interact and, and advise consumers and their purchase as well as the myriad of different programs that are available; would that be correct?

DERIK WRIGHTSON: That's correct Senator.

SENATOR HWANG (28TH): And prior to that, I, I think I remember in past testimonies or exchanges, that you actually worked in the exchange in helping out the program, so you had a firsthand experience from the, the, the goal, which is noble, but the execution and, and I think in, in your service as well, you do a lot of work with Medicare and Medicaid, Part B, Part C, Part D purchases as well; is that correct?

DERIK WRIGHTSON: That's correct, yeah.

SENATOR HWANG (28TH): So that's, that's your expertise, and so allow me to ask a question on your expertise. And you also at the same time worked with multiple carriers, insurance companies, and, and I, I think you said it in your testimony quite eloquently where you said, you know, sometimes you bring the bearer bad news in regards to the high cost. And, and sometimes I'm sure you feel phone calls about people's frustration with health insurance companies. There is certainly not a lot of people's holiday list. But that being said, I want you to contrast the level of service and the care and ultimately, the, the, the quality that is provided from a standpoint of a government run system versus a complimentary private sector that has collaboration and input from all of your experiences. Contrast the two of them, and ultimately how is the consumer, the health care receiver benefiting from each of those perspectives?

DERIK WRIGHTSON: Thank you, it was a great question, big question, I'll try my best to answer. I, I think with my experience working for the exchange and actually in other roles with local government, I think when, when you're working within a government body, there is just more, there is less ability, it's more like a 9 to 5 job, where you're at a call center and you're picking up the phone, and you're providing the expertise within the, the limitations of the job and the offerings that, you

know, at least from my experience, working with the shop that we had, you know, we could service and sell the options that we had specific to that market, but not overall the entire market.

I think on the private end of things, which is what I'm consulting on now, if you want to call it that, we just have a bigger group of options to go to, and it's not a 9 to 5. You know, there is plenty of times during open enrollment where, you know, myself and a lot of the agents here are here until midnight. And a lot of the issues that we're dealing with, to be honest, especially during open enrollment are miscommunications from, you know, the exchange and trying to manage all the information that's flowing out of there and correct that.

And, you know, I think just from the private spot that I'm in now, there is wider range of options, wider range of services and capabilities that we have. And, you know, because we're independent and we represent our clients for every carrier out there, we can really keep, you know, their interests in mind versus just working for one governmental body and only having the options available, you know, speaking to my prior, prior experience with the shop. So hopefully that kind of answer the question.

SENATOR HWANG (28TH): No, it, it was very helpful to see that contrast, right. And it's important to get your experiences on both sides. And, and obviously on the private market, there is a capitalist system where you provide a valuable service and counseling, and, and you get paid for it, no doubt. But as you said, it's not a 9 to 5 proposition, and that when people call you as a consumer, health insurance is deeply personal. It's, it's critically important.

They want to be able to afford, but also get the proper coverage. You provide that information.

There, I say from your experience in, in the government sector and if they were to run the health insurance dynamic, which exists right now in regards to the Medicare Medicaid system, do you think that they would be getting the same quality service?

I always go back to the Affordable Care Act promise that you're going to get the same doctor, the same level of service and the same kind of health care providers, which just wasn't true, and that's been one of the frustrations. What do you say to that? Can you offer that contrast, because I think it's important because as we explore different programs, we have three different proposals out there; the one that seems to be kind of gaining momentum that we actually voted on today seems to be one that says this is a state run health insurance program.

DERIK WRIGHTSON: Yeah, I mean, just from personal experience, we had a client this past week who called us that was actually referred to us by the exchange to help with finalizing a plan selection, and they were informed by the exchange that Anthem Blue Cross offers national networks on their individual plan and that's not the case. All the plans through Access Health are limited to Connecticut only with their network and only emergency coverage outside of the state.

So but, you know, the level of expertise you get just from the inherent role that we're in and only dealing with health insurance, 24x7, and being independent, and, you know, like you said, there is a capitalistic nature to it, we are making money. But, you know, just our, our level of expertise and our service, I think just goes above and beyond what just a call center can provide, which is seemingly the approach right now with the exchange. And again, I mean, we do a lot of Medicare business, and for someone to sign up for Medicare, AMD, just what they do through social security, it can take two weeks to even get a phone appointment.

I return phone calls within 24 hours, if not within a couple hours, you know, so it's, it's a different level of service, and I, I don't think myself or many other brokers like me want, you know, only, only the private market; I think there is a, like I said in my testimony, I think there is a market for the exchange and for Medicaid and Medicare and tax credits.

I just think there needs to still be, there needs to be an option, there needs to be multiple options and there needs to be experts that are willing to feel phone calls at any time of the night when someone's prescription isn't working or, you know, when they are getting an MRI, and they don't know that if you go to advanced radiology, you pay $200 bucks, you know, you go to Yale or New Haven and you pay $2000. So, you know, it's little tidbits like that, that keeps, you know, folks like myself and other private individuals valued.

SENATOR HWANG (28TH): Well, that, that is, that is great example you just cited about advanced radiology versus, you know, X, Y, and Z with benchmarking and the important role of that. Let me take it from, from you, from the person down the street. I mean, in talking to so many people, one of the great, great benefits of the Affordable Care Act has been the guarantee protection of individuals from preexisting conditions. I cannot tell you how many times I've heard or so many people that are worried about their preexisting conditions and, and in the past prohibited from being able to qualify or, or not given cover because of adverse selection, which is a real, you know, a, a, a real point of concern when you're looking at risk management. It's the reality. The Affordable Care Act and all insurance products in this country and in the State of Connecticut provides coverage for everyone, regardless of preexisting conditions. Is that correct?

DERIK WRIGHTSON: That is correct, yeah.

SENATOR HWANG (28TH): And, and how much of a peace of mind does that give to people? And it does have a bearing on some cost increases because of the, the actual real numbers. So you say that's true, but does that raise a concern for you that possibly in a plan that we might be pushing forward under the state program to manage adverse risk that people with preexisting conditions could be cherry picked out?

DERIK WRIGHTSON: Yeah, definitely. I mean, you know, we deal, like I said, with individuals from all walks of life and all types of medical conditions. Our firm has been around since 1997, so we've dealt with pre and post ACA, and we have hundreds if not thousands of clients that want the Affordable Care Act passed are finally able to get coverage that's sufficient and, and covers their needs. So for any type of plans to be able to play by a different set of rules and exclude those type of clients from getting, you know, either a cheaper or richer plan, doesn't seem fair at all and seems completely against what the Affordable Care Act was trying to accomplish. I don't, I don't think we go backwards to go forwards.

SENATOR HWANG (28TH): No, I really appreciate your insights. And it's valuable to me to, to have your experience working on the exchange and the government marketplace, which is well intentioned and I appreciate your openness and receptiveness to having a variety of different plans. But also sharing with you why the private market has a, a financial if not an incentive to provide the best quality service. Yes, you get paid. But, Derik, if you're not as good as you are, you wouldn't have people coming to your door to get that service. So I want to thank you for taking the time and experiencing the testimonial and, and public

process. It's really appreciated. Hope you have a great day, and thank you Madam Chair for the indulgence of questions.

REP. WOOD (29TH): Great. Thanks so much for coming out and sharing your testimony Derik, and answering questions.

DERIK WRIGHTSON: Thank you.

REP. WOOD (29TH): Next up, we have Alan Sheketoff, followed by Susan Halpin. Alan, are you there? Alan, can you unmute yourself? Alan is getting back up. That's all right, we'll hold until someone helps you with unmuting. Is there any way we can unmute him from our end?

LOGAN COTTER: No, I can only ask him.

REP. WOOD (29TH): Okay. Okay, so we will move on. Alan, we're going to move on to the next speaker. Oh, wait, we have someone is coming for help. All right. Alan, you're up.

ALAN SHEKETOFF: Thank you. See, what I needed was, was the one who just spoke to Derik who has far more technology skill than I do. But if you remember, I was able to visit with you three-and-a-half weeks ago at the initial public option discussion, testimony. And back then I was in, in Florida, also with technical difficulties, but at least I could see a face this time; so that's better. A lot has happened really in the last one day, let alone two days. The Bill that just passed actually yesterday, federally in the Congress and apparently was just signed into law about an hour ago by President Biden has changed what I was going to say, simply because I, I didn't want to rerun the same material I did the last time when I read the public option, the 35 or so pages.

There was a lot of information in there, but a lot of it, I thought was a little vague and didn't give me a lot of the detail and I posed some questions back then, but I have not heard all the final answers, but I was happy to hear, I guess, this morning, the Committee got together and is trying to work out what will make the most sense. I've not had a chance to read Governor Lamont's version. I did listen to Kevin Kelly's Republican version, so with the three bills there, I'm pretty familiar with Kevin's because I did see that yesterday.

And I do like the idea of benchmarking, I think that makes sense. I think the difference that I see similar to Derek who just so you know works with me here. We basically represent our clients. And I've been doing this for 31 years. I've seen many, many changes in our industry. And in fact, I've always had the pet phrase, the one common thing in our industry is change because it never stays the same, ever, from one year to the next. Possibly even from one month to the next. We are certainly in the process of major changes going on now, with the public option, being one of the choices. I had a concern that, is it an option, or is it a 'everybody goes this route'? Are there two or three different choices, or is it one plan?

My concern that -- Tony just asked to Derek which I agree with, what would happen if they cherry pick of a group of say 10 people, and two of them have major issues with health. And they're basically excluded from the plan, what do we do with them? Obviously, we could always put people in individual plans. Our firm does represent everybody for both individuals under 65, over 65 and all size groups. And the groups that are 50 and below, small group market and individual.

You know, some of the biggest problems we have in the State of Connecticut is everything is done via

age banding. So because of that the costs are staggering as you get older. But that's something --

DAWN MARZIK: You've reached your three minutes. If you could please summarize.

ALAN SHEKETOFF: My summary would be just that I'd be very interested in seeing if they could take the best points of the three different options that are being posed to everyone on your Committee. And there are, and I can't remember which Representative that mentioned, there are some really good points and all three of them. It would be nice if they could put all of them into a bill that will have several options as Derek just mentioned that gives people choice. And gives them the option to take really what might meet their needs the best of whatever is available. I'm a very big believer in having options and not shoving the round peg in a square hole simply because that's the only thing that's available.

That would be it. I mean I feel like so much has happened since yesterday at 4:35 when the Congress passed that Bill. I do feel there's a lot of things that were in that, in particular for insurance that I could discuss but no way I can do that in three minutes. I just figured I would say what I just did.

I'm open to questions if you have any.

REP. WOOD (29TH): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And Welcome, Mr. Sheketoff. More importantly, welcome to the Zoom age of technology. You seem to be having a great time with it all.

ALAN SHEKETOFF: Well, you see my face today. That's better than last time.

SENATOR HWANG (28TH): Now, I appreciate your time and your testimony and I think you've shared with me that this process is so confusing and so frustrating. You waited literally six hours the last time you testified. Sorry to make you wait. And you're right. We should take the best of all the points to present a package but unfortunately, we didn't do that. We rushed some things through this morning that I'm still very much smarting from.

But I want to put it -- to talk about the dramatic change in the marketplace that the president just signed the $1.9 trillion-dollar *American Recovery Act*. What does that mean from the standpoint -- because our goal as a Committee, and as a legislative body, is to look to contain cost. And what does this Bill, in your expert opinion from a consumer marketplace basis, does in reducing cost for premiums of individuals in the marketplace?

ALAN SHEKETOFF: Well, I think it did one thing that is extremely major, that I do believe will no question help facilitate reducing premiums for many of the clients that we have.

Being in Fairfield County, a majority of the people that live here, work here or work in New York, unfortunately make more than the minimal amount that allows you to get a subsidy if you were to buy through the exchange. Whether it's about 50,000 for an individual or $103,000 for a family of four. Those numbers, unfortunately, for a lot of the people we insure, close to 3,500 individuals, make more than that. In which case, the rates, as I had said earlier, are totally based in Connecticut on how old you are. No bearing on gender, no bearing on your health, good, bad or indifferent; strictly how old. And if you get older, like before I finally got some Medicare in October, the premium I used to pay for a family was $3,370 a month for a Silver Plan, which I ran out of adjectives. It's just obnoxious how much that costs. But that's what it is.

Basically because I was 64, my wife at the time, 61, and two kids in their 20's. That's what they charge. That's the model we've been using since Obamacare started in 2014, where we would plan.

What they passed yesterday, and because there were so many parts of that Bill, and in the very first section of that -- and actually Congressman Himes was nice enough to send out a letter which basically outlined most of the things covered -- it didn't cover all of the stuff but it did cover enough that was meaningful. And under the beginning part, under Individuals, it talks about a maximum cap of eight and a half percent. That any family would have to pay based on their income.

So all of a sudden, if you take 103,000 for a family of four that would get a subsidy but anybody who made 120, 150, 200 or more, basically didn't get a dime from the Government because their premium based on their age could be. I heard the number 22,000 on average. It's probably even more than that as you get into your 50's and 60's. It starts to get upward into the 3,000 a month range.

So because of that, if you use this new formula, that was in essence now become part of law. Eight and a half percent, if it was 150,000, brings your premium from 2,000 a month, just to use that number because that's real, to about $1,100. That's a $900 savings per month for many of the clients that we have. Because they currently are in that, I'll just say, that lower-middle-upper-middle class, that they're going through getting screwed because they are not getting any help from the Government. They are paying the full rate.

So nothing changed in our market. And our plans were still the same. The costs were still prohibitively high just because of what just passed in this Bill yesterday. And it's very difficult to see if you're not looking for it. It just says eight and a half

percent maximum on a family. Well, eight and a half percent is not that much when you have income of up to even 250,000, you still would pay less than what your rate would be, assuming you're going to get some kind of a subsidy if you do, you know, enroll through Access Health.

So I do feel that that has a meaningful difference in how the marketplace is going to be in whatever ends up being passed into law here in Connecticut.

SENATOR HWANG (28TH): You raise a great point in the fact that is a concern that there's so much positive unknowns from the inflow of federal money that could help address the issue. You just pointed out one example. And it seems the rush to implement Senate Bill 842, which you have read, and the substitute language that we voted on today, didn't offer a lot of substantive change, I was told. But nevertheless, you saw that it did nothing to contain the cost of premiums from a standpoint of the marketplace or the cost of healthcare.

So this is an opportunity where you're saying the benefit of this new inflow of federal money has already demonstrated that you're reducing people's premium. And that is, for me, one of the arguments that I have proposed in utilizing and maybe increasing the innovation of re-insurance to decrease premium cost to the consumer. Because that's our goal. It's to decrease premium cost to our consumer. It's interesting. I don't know if you heard, the Office of Healthcare Advocate, Mr. Doolittle, two days ago talk about the biggest spot of need are individuals that are 250% or 400% over the poverty level. That an individual family of four that's making about 130,000, they are the people that are footing the bill.

And this is where I applaud Representative Meskers for his passionate interest in this issue. He is fighting for his advocates because that's the

middle-class in his District that are dramatically impacted by high healthcare costs. So this idea of being able to leverage the federal money that's coming -- Federal cost reductions are premium cost for you on the marketplace. That's a good thing. So why are we looking to pass a plan without fully realizing the positive effects of it? It just seems, like I said before, putting the cart before the horse just because you want to pass a concept. But the reality is important in the sense that what we pass has an impact on people's lives and businesses.

Does any of that comment kind of gel with you or resonate with you or am I off-base in that?

ALAN SHEKETOFF: No, you're fully on the button. I mean, we call ourselves the doctors of insurance. But we try and do what every client we have -- and Derik, and I'm very proud of my son, Nicholas, have both worked here with me. We will talk to people, ask them what they have, what do they and don't they like about what it is, beyond how much it cost. Because no one is happy with what they are paying.

And just ask them, What are you looking for? And then we try and take the array of products that we have at our disposal, and we try and fit what makes the most sense and to their ends. So that it would make -- it would be the best fit for anybody, the best solution so they've got what they want.

The difference is, as Derik mentioned, what we've done and what I've done for 31 years, we service people. We don’t just sell them a product and say, "Good luck." And it's not that easy even just to even enroll into the system, whether it's Access, Health or this public auction.

My biggest concerns, part of all this, is having people like us that will spend 15-20 hours a day during our busiest times of the year, making sure

that we never leave people in a situation where they can't get what they need.

I have still very much not heard an answer as to how is the State going to do that. Who are they going to call when they go to the pharmacy and they say, "Sorry, your plan was canceled? That drug's not covered."? Or I have somebody that got a letter, two days ago from -- [inaudible] a big company saying, "Sorry, you didn't pay your bill, you're lapsed." Well, she got on the phone, they just said, "Nope. Sorry, you're lapsed and you can't get reinstated." I had to call up the ladder to all the people I know there just to basically say, "Look, this person has never not paid her bill. Look at the last two and a half years. She's never missed a premium.

That's ridiculous." This is just for a part D drug card. For $28 a month, I basically talked to the head of sales and said, "Look, you really think somebody would choose not playing this versus having the coverage?" It was $3,000, different story. But this is common sense. She never got the bill. Only to then find out that they left off one digit in her address, that's why she didn't get the bill. So after two days of fighting for her, they finally reversed the call and she was in tears. I said, "Please, I hope, those are tears of happiness.", because that's what we do.

Solving problems is something I've yet to hear the State say how they're going to handle. Who's going to be there after five o'clock when the day ends? Who's going to answer everybody's problems and questions? Who's going to help them even decide what Plan makes the most sense for them, based on their needs? We go through a whole process to make sure that people have what they need and they're satisfied when they have it. But we also are realists and tell them, nobody is perfect. Every carrier we use, it doesn't make any difference and God knows, especially for the State. There's no way

at any point, something's not going to go wrong. That happens a lot. But the key part is who's going to fix it? And that's where a good broker will do whatever he has to do.

I have one weakness, according my wife, I care more about my clients than my own family. And I do love my family a lot.

SENATOR HWANG (28TH): Well, don't get in trouble for that, Mr. Sheketoff. I thank you for your time and I guess the summation I could offer in listening to you is, in nearly 30 years of experience dealing and servicing customers on health insurance, change is ever-present. But there is a significant difference in your experience with a government-run entity versus the consumer marketplace.

So I want to thank you for your time. And thank you, Madam Chair, for allowing me to ask these questions. Thank you, ma'am.

ALAN SHEKETOFF: Thank you.

REP. WOOD (29TH): Thank you very much, Alan. Any other questions from the Committee? Great. Next up is Sue Halpin. Followed by Olivia Rinkes.

SUE HALPIN: Good afternoon, everyone. Can you hear me?

REP. WOOD (29TH): Yes.

SUSAN HALPIN: Good. Good. Thank you. Good afternoon. My name is Susan Halpin, for the record. And I'm here today on behalf the Connecticut Association of Health Plans. I'm here to support Senate Bill 1006, AN ACT CONCERNING HEALTHCARE COSTS AND THE CONNECTICUT HEALTH INSURANCE EXCHANGE AND HEALTH EQUITY.

It was a pleasure to see our former Senate Ranking Member of the Committee come before you today. He is ever-articulate on these issues and I congratulate him on his ascension to Senate Republican Leader.

I wanted to -- there's been a lot of things talked about today. And I guess, one of the things I'm really heartened by in this conversation, and some of the others that we've participated in recently, is the fact that the focus is really changing from the cost of health insurance to the cost of healthcare. And we have long maintained that it's that unit cost of care that is driving premiums. And the part that we find all frustrated -- so frustrating in paying those premiums.

The Bill before you, I think, as has been mentioned, contains a lot of bipartisan pieces. They're pieces that we've worked on through different bills throughout the years. And they build on, as was mentioned the Executive Order that the Governor has already issued and is already underway. And which the carriers are already participating in a number of forums in that regard.

Benchmarking will bring a level of accountability that is needed to the system. If you don't know what's broke, you can't fix it. And I think that's really what the focus is on benchmarking. You know, I come before you repeatedly to talk about pharmaceutical costs and hospital costs and other system costs that drive the healthcare premium.

One of the things we don't talk a lot about and that we probably should be talking about more, is the fact that Medicaid and Medicare both pay substantially lower rates than what commercial carriers pay. And in our world, we call that the cost shift, right. And we know from our contracting experience, our direct contracting experience, that there is a very direct correlation between the lower reimbursement rates that are paid to providers

through those two government programs and the need to charge commercial carriers more because of that. And when you look at the benchmarking data, they're collecting all that different data, going forward.

And you know we talked about that and there's disputes over whether that's accurate or not accurate. Or whether it's 20%, 25% or 10%, or what have you. But the fact of the matter is the benchmarking process will begin to allow us to take a very serious look at that and whether it exists.

We also want to -- Is that my bell already? I'm going to do --

DAWN MARZIK: I'm sorry, please wrap up.

SUSAN HALPIN: Dwan We commend the Committee for taking a look at the independent biennial audit of the State Comptrollers Plan. There's just too many questions that have gone unanswered and it's time for an independent review. We welcome the prospect of a State reinsurance plan.

And one other thing. I don't know how much it's been discussed here today, but we really, really welcome the Public Hearing and approval process before any new assessments are issued or changed or modified. So with that I will wrap up. Thank you very much.

REP. WOOD (29TH): Thanks, Sue. Any questions from the Committee? Senator Hwang.

SENATOR HWANG (28TH): I hope not to wear out my welcome. Thank you, Madam Chair, but I appreciate your time, Susan. Now, it's interesting that we are refocusing on addressing the cost of health insurance and the cost of healthcare versus just strictly focusing on insurance.

Two quick questions. One: One of the big differentials you talk about, reimbursement with

Medicare -- Medicare and Aid. Is one of the challenges where I have a lot of physicians and I have a lot of hospitals that look to support the public option idea. And the rationale they have is, you know, this is a small step forward. That, you know, we're going to still be able to get our reimbursements and all that. What do you that from a real market force? From a standpoint that, to those individuals and providers and our healthcare facilities, that look, the model and the idea is not to maintain the current market. It is to cut your margins. Which I applaud but it's important for those providers that are looking to support the public option idea, that they understand, they could be very much next to cutbacks and cost containment that they have reluctantly advocated for. What do you say to that?

SUSAN HALPIN: I think you're absolutely correct. And it's one of the frustrations that we have. This Bill is -- or the Bill's -- not this Bill, sorry. That Bill is very, very complex.

SENATOR HWANG (28TH): It's confusing, I understand that. There's a lot of bills out there.

SUSAN HALPIN: Yes, yes and you're exactly right. I mean we know that the product that's out there and is operating today under the partnership plan is unsustainable. We've seen the year-over-year deficits. If we expand that program to add additional populations, that is going to just be exacerbated. One of a couple different things is going to happen. One, they're either going to have to raise the premiums to the people that are in that market. You're going to have to raise taxes to subsidize that market. You're gonna have to raise or cover it via a deficit. Or you're going to have to go to the healthcare costs and you're going to slash provider rates.

And frankly, that's probably, you know, a very close area where that's going to happen. And that is one of our biggest concerns, frankly, in the private market is now, instead of two fee schedules that are paying the prices for big government programs, now we're going to have yet a third. And the result of that it is an additional cost shift on those that remain in the private market to pick up the shortfall. And that is one of the things we find most objectionable about those pieces of legislation. And I believe providers, if they have a chance to really, really dig down on this stuff, they will see that as well.

SENATOR HWANG (28TH): Yeah, and I appreciate that. And look, I've shared this with you in exchange that, you know, our insurance companies are our big job contributor and a big business in our State. But they're certainly not very high on popularity. Because sometimes you a lot of times you may have to say No. And the challenge of really negotiating and providing services. Look, you're in a very hard position. I understand and respect that. But let's talk focus on the two that are our doctors and healthcare providers and healthcare facilities. Here's the reality. One, our doctors struggle already with being able to get higher reimbursements and shrinking federal reimbursements. And we're losing doctors in the State of Connecticut.

Number two our hospitals have done a great job during this COVID environment, but they themselves -- - How many people forgotten nearly three years ago, when there was the hospital tax that was imposed on them. And do they not think that the possibility is the margins are going to be squeezed on them? If they hated dealing with insurance companies, they're probably going to hate even more dealing with the Government.

So that being said, I think it's important that we not discuss that from a standpoint of where is the

quality of the care that we take so much pride in? Where are the resources and the same doctors and the same healthcare that your promised under the *Affordable Care Act* that did not realize? That's my biggest concern about this premise is, we're moving away and trying something significantly new for the idea of a noble goal. But the fact is, we are literally disregarding a long-standing, established and built-in track record. However, it may be needed to be improved, an existing structure of business and maintaining that quality, it was so proud of in the State of Connecticut. This possibility could up-end that to no end with very, very unintended foreseen consequences that may take us so many years to recover, if recover at all.

SUSAN HALPIN: Yes. And we would agree. And, you know, the last thing you want is to look around for an alternative and there isn't one there. And that's what I think the result of the public option will be. There won't be choice left in the marketplace. And I think that's really an important consideration as to go forward.

I did have a second thought, but I think I lost it so --

SENATOR HWANG (28TH): So I'm so sorry but if this plan goes through, do you believe it would create a an unfair competitive marketplace, where it will dramatically impact your organization's ability to stay in business or do business in the State of Connecticut? And have employees impacted in the State of Connecticut, as you look at other venues and marketplaces? Is it very real? I'm not talking about it as a quote 'threat', but it is a very real economic rationale for your business decisions. Would that be correct?

SUSAN HALPIN: Absolutely. I don't think you would see us, you know, raising such an issue if it weren't that, right. You know, we've worked

collaboratively over the years on lots of issues, and you, actually pride ourselves on being first in the nation on a lot of big health insurance reform issues. This is something that isn't a reform issue. This puts us out of business, if you take it down to its full conclusion.

And I did remember my other point, was really simply to say all of the things you were talking about, about the providers are really important. And that's why we believe in the benchmarking parts under your Bill, because it provides the structure and the framework for those conversations. Listen my carriers don't like everything that happens at OHS. I know the hospitals don't like everything that's happening there, nor do the pharmaceutical companies or anybody else. But it is where the hard conversations are happening. And the right people are around the table. Perhaps that table could be expanded some. I know there's others that would like to be at that table, and those are worthwhile conversations to have.

But that said, you know, we've been down the rate regulation road before, it doesn't work. You know, we're in this model now. It certainly has its changes, its challenges, but we need to move forward, I think, together, and in a holistic way that looks at the system at large and makes decisions that are not just, you know, for today or tomorrow, but are, for two, four, six, eight years down the way.

SENATOR HWANG (28TH): Thank you. And I want to applaud the Committee and its Members of this Committee in our trying to make bills better, as we move the process along. That is one of the things that I've always learned from our private sector business partners, is the fact that transparency, accountability, your audit process and reporting to regulatory agencies, it is your daily and expected operational *modus operandi*. It is important for

building the confidence and creating a sustainable financial, as well as service provider system. How do you feel about that? I mean obviously, it's something that you and your Members have to comply with every single day.

SUSAN HALPIN: Absolutely. And once a year, you know, our rates have to be filed and approved by the Department of Insurance. They have to be signed off by a licensed actuary who puts his or her signature and license on the line when they affirm that the rates are sufficient to cover the expected claims. So you know, I've said this before and I'll say it again, one of the most important things that the Department of Insurance does. They don't just make sure rates aren't too high, they make sure rates aren't too low. And you know, insurance is not an easy business. We've seen lots of different groups try to be insurers over the years and they have failed. And the other carriers, the established carriers in the market have been there through things like the Guarantee Fund, to pick up that -- you know, to pick up the costs.

And that financial monitoring that the Department does is exactly to make sure that when people seek care, it is covered, at the end of the day, by their insurer because they have the reserves necessary to cover that.

We also file more reports. I'd like to think that all of them are looked at, perhaps not all of them are. I'll give a shoutout to Ellen Andrews, because I know she looks at every report that's filed and looks at the Managed Care Report Card, that is -- comes out annually and compares us on a whole set of statistics. I think, as I've reported before, we contribute data to the All-Payer Claims Database. So you know, we are heavily regulated industry. And it's an important -- it's an important regulatory structure. And that's our question for the plans that are being offered under the Comptroller's

Office. Are they held to the same standards as our private plans are?

SENATOR HWANG (28TH): Thank you, Ms. Halpin, and then I just want to be clear, for most people -- for some people may think I'm carrying the water for the insurance industry. They need to know that I've appeared before the Department of Insurance on your rate increases. And absolutely berated your entities for the rate increases as being unsustainable, impractical and insensitive.

Let me be clear, I have come and spoken against your organization's rate increases, but as a Member of the Insurance Committee, I have learned so much more. It's not just simply health insurance costs, it is in the entire ecosystem of healthcare. So, I want people to be clear. I'm just as critical on our health insurance companies as I am to be a partner in reducing costs. So thank you, Madam Chair, for the indulgence and the time, thank you.

SUSAN HALPIN: Thank you.

REP. COMEY (102ND): Thank you very much, Senator. Representative Nuccio.

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

SUSAN HALPIN: Good afternoon.

REP. NUCCIO (53RD): Good. Okay, so you said something that I think we -- we on the Insurance Committee are incumbent to hear and to register. I wanted to talk to you a little bit more about the benchmarking aspect of this. First of all, I want to commend you said, it's the hard conversations and not everybody likes what's happening, and I want to say that they shouldn't, you know. There should not be anybody walking away with any big victory here, with the exception of the residents of the State of

Connecticut. Everybody else has to come to the table and has to have the hard conversations, whether it's industry providers. Prescriptions, across the board. These are the conversations that we are incumbent to have. So I welcome that.

And again, as Senator Hwang was saying, there is no favorite pony in this. Everybody has a role to play, be it a provider, the R&D prescription, the services that insurance provides and everything else. There's a role for everybody to play in this. But what I really wanted to kind of focus in on is as far as you're concerned from the benchmarking, everything that I've seen with it has shown that it can be very successful in actually doing what we should all be figuring out, which is reducing the cost of healthcare.

So I'm just going to ask you to kind of give me your little high level, and if you had -- If you had a crystal ball here, how could you see us implementing benchmarking? Using what we've discovered from Massachusetts, any pitfalls that they had and additional, like you said, hard conversations where everybody has to give a little. To show that benchmarking can be the first part to actually controlling the cost of healthcare without doing unnecessary damage to any of the people at the table. And most importantly, reducing the damage to our residents.

SUSAN HALPIN: Thank you for the question. And I think the good news is a lot of that's already underway. And I think there's going to be a presentation in the next week or so by the Office of Health Strategy to review for folks and kind of give everybody a status update on some of those activities that are underway. You know, they have they have focused in on a certain percentage of dollars being aimed at primary care as a target. And I think we do have to be careful because it's often referred to as a cap and it's a target. And that's

important to our industry, because I think one of the most important things is, you know, flexibility to change with the changing landscape, right. And that is why we do support the Office of Health Strategy and the framework that exists over there. Because it is a place where you can pivot with whatever is changing in the landscape. And that is what needs to be done. I mean we've had conversations today -- and it's really, quite honestly, one of the reasons why we come before you to oppose so many things. Once you get something in statute, it's very difficult to get it out.

REP. NUCCIO (53RD): Right. Or it comes in but it never goes out.

SUSAN HALPIN: You know, if you look at, you know, you'll see at the end of my testimony on 1006, is that we look forward to working with the proponents of the Bill to update certain technical aspects that have changed, right, since you know, even as earlier testimony suggested, since this afternoon, right. We have an enormous new piece of legislation coming into effect from the federal level that has significant dollars that are going to flow through the State. So my question is, you know, when we talk about all these proposals globally, is how much do we want to put into statute and are we not better off just putting together the framework to receive those dollars and to make recommendations and changes with the appropriate legislative approval, right? For all of these things.

Because every idea, whether it's reinsurance, whether it's benchmarking, whether it's the quality aspect of benchmarking, which is clearly one of the most important pieces of this, right? It's not just about cost. It's about are you getting value for your dollar? Are you rewarding a provider for seeing somebody 10 times in a week financially, when they only need to see them two times in a week. Right.

Is the costs -- are there cost outliers out there among, you know, hospitals or surgery centers or whatever, you know, whoever you want to name, that are way outside the bounds of, you know, other actors of a similar status? And then maybe there's a reason that they are, right. Maybe they have a more acute population but that's what you have to -- that's what you're looking at with a benchmark. That's what you're looking at with the quality standards. That's what you're looking at with a cost growth targets, and you know, aligning incentives and align -- you can change and look at insurance, as opposed to just narrow anecdotal scenarios.

REP. NUCCIO (53RD): So I think you mentioned a couple of good things there when you start talking about a healthy populace and a non-healthy populace and how we can kind of drive that to spread that risk over a multitude of areas. And benchmarking to me, you know, I'm a data person. I'm a numbers person. You said, having that information in front of you to be able to identify high-risk areas, high-risk populations. You know, I see industry's role in this -- and again, the conglomeration of the three Bills that we kind of have, you know, the mixing of the landscape that we have, the conversation around the small business industry has been happening pretty frequently in the last 18 months. I would say, more so in the last 18 months than it has in almost any other time period. And we've seen industry pivot and you know, we've seen new plans come out from Anthem that just started this year in '20 -- or in 2021. Or are starting in 2021.

We've seen new plans coming out in Cigna entering back into the small business market. You see industry responding and to me that's the role of industry. They're looking over our efforts at those health benefits and wellness initiatives and how to reduce the cost. So putting pressure on industry with this benchmark to me means results. Because how they how they function, it's all result-driven.

So I am interested in what OHS is going to put out there. I am interested in trying to find the piece of this Bill most definitely around the benchmarking. And looking at the good pieces from all three -- all three Bills. And then finding a way and again, this is the new Bill, maybe we don't do this kind of thing, but finding the way to actually get all of these different organizations and people at a table to craft a piece of legislation that will help control the costs of healthcare. Doing the most amount of good, hurting the least amount of people and making sure that all of the heads of the Hydra as Representative Meskers said, feel a little bit of that pain equally. Because overall that's our role. Our role is to do that.

So I appreciate your feedback on the benchmarking and I look forward to the presentation from OHS. And I look forward to actually making sure everybody that you said needs to be at that table. We hold you all accountable to come to the table. So thank you very much for your testimony.

REP. COMEY (102ND): Thank you very much, Representative Nuccio. Representative Meskers.

REP MESKERS (150TH): Susan, thank you for your testimony today.

You know, I'll repeat what I said in the past which, and you know, I've heard Senator Hwang about the insurance industry and, obviously, we're the insurance capital, and so we all celebrate the insurance industry. But your role is the guardian of the public purse at some level in the delivery service. So I'll point you to a report done by John Hopkins that came out I believe in 2003 and then was reissued in 2019. Where the US healthcare is -- It cost about 25% more than Switzerland. And on average, about 50% more and 100% more than Canada. But I think it's 50% higher than the OECD. So that's

not your fault but that's the structural issue that we have with healthcare in the United States, which is falling below our residents.

So, as we go forward on the Committee, I think the important thing is, you know the insurance industry has got, you know, it's got a goal in targeting revenue streams They also, you know, have regulatory burdens and issues, and I want to make sure that the structural incentives for the insurance industry are appropriate, so that they benefit by achieving further cost savings that we can drive down premiums and drive down the care of healthcare -- the cost of health care.

I think it's important that we look to resolve the issue that -- you know, we just had a man testify who owns an insurance company. And he sat there, and you know, Senator Hwang was applauding the free market and the quality of their service. But all of our jaws should have fallen off when he said, "If you're over 55 or 60, you can expect to spend $30,000 a year for your healthcare insurance."

So that compounds at five percent or seven percent, you're at 40 or 50,000 before you can blink. So you know, we need to work on that.

So I appreciate your concerns that we're going down a difficult path or might be going down the wrong path. I think we have to exercise a judicious approach to it. I think there are interesting proposals in front of us. And I look forward to working with the Committee on the ideas presented. You know, both the potential for reinsurance and looking at how we lay that off, the potential for further aid from the Federal Government. But I think that what's most important to me is that we reach a coherent approach to the metrics on the cost of healthcare.

We cannot have a relentless growth of five to seven percent a year in the cost of hospitalization and pharmacies. And with the deductible, and the strategy in the healthcare industry to make insurance affordable is to raise the deductible. And they did -- that raising of the deductible is only going to lead inexorably to people not getting primary care. Because when their deductible is five to $7,000, they're going to turn around and say, "Well, I can just let another. visit to the doctor go, because I can't afford to pay for the deductible." And you're going to find that healthcare and the results in hospitalizations going to go through the roof, we're gonna end up in a vicious cycle.

So I really -- you know, we need to address those issues. I think it's incumbent on all of us to address this as best as possible. And so well, I appreciate the conversation. They're going to be tough conversations going forward. I thank you for your commentary.

SUSAN HALPIN: Agreed. And if I may, I think you know, as always when we have our conversations, you hit the nail on the head and you challenge us.

You know, there is a perception out there, that more care is better care. And if the outcomes don't demonstrate that, then that's not accurate, right. And we also know there's a seesaw approach out there, so if you lower rates utilization is going to come up because you're maximizing the number of times somebody gets a certain service. Or you may be maximizing. And that's why I know we've had these conversations about value-based payment arrangements that health carriers have really led the way in in private sector markets of, you know, looking at total cost of care. And you know, assigning a kind of per Member per-month based global rates. Those kinds of budgeting techniques. And I know you've

turned that around and said, you want to put that on us as well.

So I look forward to having those conversations with you and as always, appreciate your comments.

REP MESKERS (150TH): Thank you.

REP. COMEY (102ND): Thank you very much. Thank you, Susan. Seeing no more questions, we will see you next time.

SUSAN HALPIN: Thank you very much.

REP. COMEY (102ND): Next up, we have Olivia Rinkes. Is Olivia here? I'm looking for her.

LOGAN COTTER: She's not.

REP. COMEY (102ND): Okay. I don't see her either. We will go move on to Tim Phelan from the Connecticut Retail Merchants.

TIM PHELAN: Thank you. Representative and Members of the case Senator Lesser, Senator Hwang, Representative Wood and other Members of the Insurance and Real Estate Committee, thank you for your time. For the record, I am Tim Phelan, President of the Connecticut Retail Merchants Association. CRMA is a statewide group representing some of the world's largest retailers and the State's mainstream merchants.

I'm here today to testify in support of House Bill 6585, AN AT CONCERNING ASSOCIATION HEALTHCARE PLANS. I've submitted written testimony, so I won't read that but I did want to take -- make some brief remarks and then answer any questions you may have you may have.

On behalf of the thousands of small independent retailers of our State, we appreciate you raising

this Bill. We believe association healthcare plans is a viable option for groups and businesses like ours and for our Members who want to help lower their healthcare costs. We certainly believe it's a better alternative for this Committee to consider as a public option.

The reality is that healthcare insurance is that well it's not -- It may not be a mandated coverage, like Workers Comp or other insurance, no business in Connecticut cannot offer health insurance to their employees. You have health insurance choices for Connecticut businesses, especially small retail businesses, are not all the same. Small retail businesses cannot access the same rates or premiums, so therefore, they cannot compete for employees, while larger businesses can offer more attractive health insurance packages for employees.

What is proposed in House Bill 6585 would allow organizations like CRMA to pool members together and then negotiate with carriers based on our collective size, just as big unions can and big businesses can. In our opinion, it levels the playing field for our businesses and our employees.

Now we know this Bill and its concept has drawbacks and the bill as drafted may need some work. But I want to make clear that our goal in this Bill is to not eliminate any of the mandated coverages that are currently called for in Connecticut law. Or rather, we just seek the ability to go into the market as a group, to do our best to lower rates and to provide better choices for our Members, which they then in turn, can help lower their costs and then offer to their employees.

A similar concept of AHPs, in this case called cooperatives, is allowed in other states. Specifically, in our neighbors to the north, Massachusetts. My counterpart in Massachusetts, the retail association of Mass, now has a thriving group

and they've been able to give their members retail -- small retailers real choice and where they get their health insurance and provide real savings.

We think the time is now for this Committee to give Connecticut retailers the same opportunity. Especially, given the challenges that they faced this past year and the challenges that they will continue to face as we move closer to a normal economy.

And thank you again for raising this Bill and for giving me the opportunity to testify and holding a Public Hearing on its -- in its concept and I'm happy to try to answer any questions you may have. Thank you.

REP. COMEY (102ND): Thank you very much. How many members do you have in the Connecticut Retail Merchants Association?

TIM PHELAN: We have about 1,500 members.

REP. COMEY (102ND): Okay, and the size of businesses are -- ?

TIM PHELAN: Well, yeah, they would range in size from a mom and pop operation, which typically do maybe one or two employees, three employees, to probably 40 or 50 employees.

REP. COMEY (102ND): And --

TIM PHELAN: Then we get into the, you know, the regional and national chains. That's not what this Bill is targeted for. This Bill is really targeted for the micro to mid-size retail businesses.

REP. COMEY (102ND): Okay, okay. Thank you. And Senator

SENATOR HWANG (28TH): Thank you, Madam Chair. Tim, I'll be real quick. I wanted to say hello, and and extend my appreciation for your tireless work on behalf of small businesses, mid-size businesses and even the corporate entities that do business in our state in these very difficult times. Please extend my support and appreciation for their jobs and their business in the Community.

And I look and I gotta tell you, I really appreciate, you know, having Representative Meskers in this Committee because of his backdrop. I have [inaudible] new -- is the epitome of your retail operation, so I hope that will engage him to say thank you as well. But Tim, thank you. I'm sure for all of our Committee Members, even though it's a long and tiring day, I just want to extend my thank you and appreciation for your tireless effort.

TIM PHELAN: Well, you're welcome, Senator. It's a pleasure to represent these businesses. They are the backbone of Connecticut's economy, as we all say, but thank you for those kind words.

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

REP MESKERS (150TH): And just for that, I'm not saying thank you. Maybe explicit. But I want to do -- I do want to comment on your suggestion there. I don't know that I'm -- I want to bring the concept forward because I believe it has merit, to look at the merits, to make sure that we're comfortable on the surety basis in terms of that the capitalization is sufficient so we're not laying a burden on the rest of the insurance industry, as they do in self-insurance. So I just want to make sure.

But I understand the need for that kind of consolidation for -- to help the small retailers get a reasonable price for insurance. I mean, my avenue, it's a very nice picture, that the leaves are out

and the stores are full. That's not necessarily where we stand right now across a multitude of our Districts and our towns. So the issue that we can do as we see now and we, I think, the Senator might have referred to the 1.9 trillion almost as a -- it seemed hard to say but there's good aid coming to my mind, to our retailers and I'm hoping that we can we can help you with this measure. We can reach an agreement between yourself and the insurance industry to help support what I think is the backbone of the State's economy. It's that small retailer. And so everything you do there, I really appreciate. So I guess you forced me to say, thanks, a lot for showing up.

TIM PHELAN: Well, thank you. And if I could just make one point of clarification. Our concept with the Association of Healthcare Plans may vary a little slightly from your previous speaker, who I think was describing more of a sort of a self-insured plan. My -- our concept doesn't do that. We want to work with the Connecticut insurance industry, the carriers that are located in Connecticut for a fully-insured plan regulated by the Department and overseen by the Department of Insurance, we just want to have the ability to go in and negotiate maybe discounts or some plan variations that may have some savings. So I, you know, simply put that is kind of what our goal is.

But I think what's really encouraging to me in listening to your conversation and question and answers was that this community is open and willing to work on a bunch of different ideas to help small businesses. And for that, I thank you and I hope I can participate and contribute to that conversation.

SENATOR LESSER (9TH): Thank you, Tim. And thank you for your testimony. Next up, we have Ellen Andrews, who we haven't seen in two days.

ELLEN ANDREWS: I know you miss me. Yes, I'm Ellen Andrews from the Connecticut Health Policy Project. Can you hear me?

SENATOR LESSER (9TH): We sure can.

ELLEN ANDREWS: Okay. I am here to share our concerns with SB 1006. Specifically, with the Cost Cap-Cost Growth benchmark plan. I gave you a lot of testimonials, so I won't go into -- you're going to hear from some of my colleagues who also have concerns with it, other advocates. We have problems with the Cap, although it was created, the impact of it increasing primary care, while you're doubling primary care, while you're decreasing the entire pie and unintended consequences. We have concerns with quality and the monitoring is very weak for under service, adverse selection for reductions in access to care.

And we also -- we have big problems with the enforcement mechanism, the performance improvement plans. Those are governed entirely by one agency that -- I've heard a lot of wonderful things about OHS from industry and I understand why. I don't know that you'd find as much in the consumer world. Not feeling the love there. And the concern about giving that much power to one agency is well, it's scary.

But what I'd like to spend most of my time is this idea that I've heard from many people, speakers and members, that Massachusetts's Cost Cap Plan is a massive success. And it just really isn't even by their own admission. But since the Cap was implemented, there is little difference between Connecticut and Massachusetts' growth in total premiums, employees share premiums or deductibles. In fact, administrative costs are consuming a growing share premiums in Massachusetts since -- this is all since the Cost Cap. Rising 16.9% in 2018 and a growing share of those costs are going to profit. The out-of-pocket costs are up. The

healthcare is growing under despite the eight years. Cost-sharing grew 5.6% in 2018 on top of 6.7% the year before. Those are both higher than here in Connecticut without a cost cap.

And I have a brief at the end of my testimony that I hope you'll look at it. It does have some numbers and I won't scare anybody, but it is -- really, we need to look at that. It has not made coverage affordable in Massachusetts, by their own admission. The Health Policy Commission there talks about how it has just continued to become unsustainable there.

And whenever you say that something saves money, it's always a question, and I'll go, "Compared to what?" And that's a -- so there's a lot of mischief and those kinds of numbers, but when you look at it, they started saving money. Costs started coming down in Massachusetts before the Cost Cap was implemented. And also, it's been coming down in Connecticut at an even greater rate at the same time. Between 2014 and 2018 since the implementation of Cost Cap, commercial plan spending per person has grown 23.5% in Massachusetts while Connecticut's only grew 17.5%.

So, if this is what we're, you know, chasing in terms of trying to model this, I think it's a bad model. It really isn't worth the risks. And I think I came in under three minutes this time.

SENATOR LESSER (9TH): [inaudible] three minutes. Thank you for your testimony. Representative Wood.

REP. WOOD (29TH): Thank you, Mr. Chairman. Hi, Ellen. Thanks for coming on today. I have heard you talk about ways we need to be addressing the high cost of care here in Connecticut, with the consolidations and through the Certificate of Needs. Are there states that are successfully using policy to help drive down costs? I know I've read things about Maryland. We always kind of point to

Massachusetts like they're the Golden Child, but you just have told us that it's not -- everything is not always as good as it seems. So are there other things that we can look at that our neighbors or that our colleagues are doing, you know, across state borders?

ELLEN ANDREWS: Yeah. This is something I'm still. learning about but there are states. California, for instance, has done -- there was an amazing settlement that Secretary Becerra when he was AG, brought against Sutter Health, they put -- they don't allow all-or-nothing contracting anymore. So the idea is that if a large system, for instance, has one cardiologist in -- there's only one cardiologist in a county, and so he's got to be very expensive but everybody has to have him in. That doesn't mean that every cardiologist across the entire rest of the system necessarily gets paid at that same amount. If there's a higher quality and/or better rate, you can't contract and they put these into the contracts and you don't have any choice if they're so big. You need to have a cardiologist in your system. So that's a problem. They can insist on being in the top tier, even if they haven't earned their way there, by either -- the top tier meaning consumers pay lower co-pays and lower deductibles to access that provider or provider group. But they can insist on that in their contracts, even if they're not either efficient or high quality.

There are other things that other states have passed. Some have passed some -- and Connecticut actually has one, Most Favored Nation, which would take me like an hour to explain it. I'd probably mess it up because I'm still learning. But there are things we can do. We can also fix our CON process. Out of 74 of the last decisions in the last three or four years, all but three were approved. That's, you know, that's just -- I don't understand the CON process that's really a rubber stamp, essentially. So we need to work on that.

That also happens through OHS. I think that goes back to a lot of consumers' concerns about OHS running a Cost Cap program and sitting down and negotiating how we're going to save money. When honestly, we have not seen the record at OHS of lowering costs in a responsible way or responsiveness to consumer concerns. There's no monitoring in the Bill, no meaningful monitoring, for reductions in quality or access and there's a lack of -- it's really easy to save money if you're just going to reduce quality or just, you know, reduce the number of site beds, for instance. You can save money, but you can do a lot of harm to communities in the meantime.

REP. WOOD (29TH): Thank you. Those are some really good points, and we'll probably be reaching out offline to, you know, get your opinions on some of these benchmarkings. Because I think it's on the right path but needs a lot of work. So thank you, Ellen.

SENATOR LESSER: It does. Thank you, Representative Wood.

I will remind the Members of the Committee that I know there are a lot of interest in health policy, this is an exciting and interesting topic. We are also on Speaker 11 of 23, I believe. And then we must return to our Committee Meeting, which is in recess at this point. So we will surely have other opportunities to engage if any of the speakers before us on health policy. With that, I recognize Representative Meskers. I think he had his hand up.

REP MESKERS (150TH): Thank you, Ellen. You -- Thank you, Chairman Lesser. I think the commentary is very insightful and yet altogether frightful. It concerns me that we are standing here in front of yet an issue of a metric that's lacking. Or a metric that

doesn't achieve the results which is -- I guess, what we're looking at as a metric to improve or maintain outcomes and reduce costs. And you're saying you don't see the metric there. And you're saying Massachusetts is currently failing and that metric. That's all I can come out with.

ELLEN ANDREWS: Right.

REP MESKERS (150TH): So the Massachusetts model you're telling me is flawed.

ELLEN ANDREWS: Yes, yes. It's basic.

REP MESKERS (150TH): Okay. And in California is basically the only place that this point that you feel is.

ELLEN ANDREWS: No, no. There are other states that have passed and now are looking at more competitive -- fostering competition in the marketplace. And I am going to get you -- it's not going to be a one-pager and I know you asked for that. It's not going to be, sorry. But I'm going to do my best to make it small. And I'm working with an expert that we heard from the Hastings School of Law to get that for you.

REP MESKERS (150TH): Okay and I'll try to maintain my attention past the page then. I appreciate that. I think it's imperative that we drive down and figure out the metrics and get it measured right. It is healthcare processes -- just it's horrific what our residents are facing. So I thank you for your commentary. It did ensure me. I was hoping that Senator Kelly had the magic bullet and it sounds like it, you know, we're still looking for it.

But conceptually, I think, we'll all talking now that there's a metric we need to look at. The question is what's the measurement tool, right? I mean, that's what you're telling us. So I look

forward to further conversation on that metric. Thank you.

ELLEN ANDREWS: Thank you.

SENATOR HWANG (28TH): I guess we're waiting for the Chair.

REP MESKERS (150TH): I was going to say I don't think I can pass the baton to you, so I don't know.

ELLEN ANDREWS: Well, maybe Senator, you and I can just chat.

SENATOR HWANG (28TH): I want to respect the process and respect our Chairs, Ellen, but I always enjoy chatting with you. Thank you so much for you, but I'll wait.

REP. WOOD (29TH): Hi. Is there no one running the meeting?

SENATOR HWANG (28TH): You are.

REP. WOOD (29TH): Okay. Sorry about that. I'm tackling way too much right now. Senator Hwang, did you ask your questions?

SENATOR HWANG (28TH): I have not. I wanted to respect the Chairs.

REP. WOOD (29TH): Sorry about that.

SENATOR HWANG (28TH): I want to respond. Great to talk to you and thank you for your tireless work and, you know, as much as we go back and forth in the building when we used to be in there, is the fact that, without a doubt, Ellen, you're the most objective. And your thoughts and comments are value on all sides, because you are truly a tireless advocate without any political agenda. So I always value talking to you.

Obviously, you don't like the Cap and the benchmarking aspect. And some aspects -- we've tried it and I also believe that we could learn from Massachusetts' initial foray. And learn from the challenges and the potential pitfalls of what they try to do. Would you be receptive to working on that to kind of create a better system? And, you know, avoid the challenge of being kind of quote, as Massachusetts had to bear of being first in the nation in doing something that's innovative? But all the pitfalls are to be lived with and consequences with the residents.

Would you be agreeable to that statement that perhaps we can learn a lot? I'll give you one example, the current Chief Strategic Officer for Nuvance Healthcare system, was a similar officer in that role with Baystate Medical System. And in our exchanges with them, she's had the experience in which we could learn from the Massachusetts efforts. And wouldn't that be nice for us to be able to learn from other entities that have gone through this process? And your points are very well made. Shouldn't we look at benchmarking using the best available resources? Do you believe in benchmarking as a possible cost containment if it is done properly?

ELLEN ANDREWS: Yes, I do. You should ask my colleagues that, when they come up because you may get a different answer. And people who represent, you know, only -- I represent everybody. There are people who represent just people on Medicaid. Or people who are underserved. And they have a lot more to lose, no question about it. People at the lower end.

So I understand their concern but I'm certainly open to it because I also represent middle-class families that are getting crushed by costs. And we have to do something. And so I'm open to it. I think we can

learn a lot from Massachusetts. I've learned a lot from Massachusetts. I go up there on a regular basis. I used to work with the Council of State Governments in the northeast region. And so it was one of my regular stops. And I call it a day spa for walks. It's wonderful.

The Health Policy Commission is phenomenal. I know many of the people on their Advisory Board and there you know, just it's -- it's fun to walk into a room where everybody's smarter than you are. And so I give them a lot of credit and I learned every time I go to Boston.

So I think that's true. I am -- I guess my biggest problem with it is starting from -- starting with the end in mind, was starting with an amount that it has to stay under that's based on other things in the economy, that might be related to gas taxes or gas or, you know, whether OPEC shuts down production. All of a sudden, we're supposed to stop spending money on healthcare. Things that aren't related. I think we should start from a better place. And I think we also have to be ready to be realistic about what the investments are going to be, what the timeline is. So I don't think you can start with a benchmark and move backwards and back into it. I think that's a very dangerous thing to do with healthcare.

I also have a big problem with already saying what the enforcement mechanism is going to be. It might be that we need to do some more regulation through CIB. We might need something through -- we might need something from OHS on the financial side for hospitals. But it might be the AG's Office. It might be through DPH and the licensure. It might be through working through things like how we got patient-centered medical homes in Connecticut, was a collaborative process where we just brought everybody together in a task force. And I co-chaired it. It was -- I know you had a rough morning, but it

was a rough task force to bring them all together and figure out how we're going to pay for it and how we were going to make sure that we were buying something that was valuable.

But we can do that. And it didn't involve any state agencies. DSS picked it up and started doing it and Medicaid, but so did other payers. So it's not always about Government running out and shaking a finger at people. I think setting up what we're going to do in response to what we find before we've even looked at the data, is a bad idea.

SENATOR HWANG (28TH): Yeah and I agree. It -- And you say something that's it's very poignant early on, where you said other advocates may have a different perspective, different ideas, because it may be coming down to their costs. And how their particular Part B's may be impacted by cost. And that is really the hardest thing about healthcare, isn't it? Because invariably, I hate to make you and Susan Halpin agree again, okay. But here's the point is, that it was clear. Finally, we're talking, hopefully, talking about the cost of healthcare itself. Instead of simply looking at insurance. And that's the crux of it, right, is everybody as a shareholder has a vested interest in the dollars and cents that healthcare as a multi-billion-dollar business, really has become. Everybody has a kind of adopted and articulated system to maximize their returns.

That is a system that's very hard to road. And what we're trying to do is to attack it, but we're only doing it piecemeal. So it's important that that either it's a public option, the Republican Plan or the Governor's plan, it's a piecemeal operation unless we're willing to look in a mirror and really make a comprehensive change. That may be for another day and another year.

But the second point that is not written in your testimony, because I think you focused on benchmarking, is your thoughts on prescription drugs. We had the meeting with the Governor. We saw our valued and innovative pharmaceutical companies come out and speak. That this is going to impact their ability to do business and innovate. And obviously, the Governor's proposal. I'd love to have you -- I know you have a very strong viewpoint. So I wanted to give you a chance to kind of share your thoughts on the prescription drug, which is another huge cost factor.

ELLEN ANDREWS: Right. I get that they're going to be challenged as to any of these, including importation from Canada, including attacks. And nothing you're going to do, as you pointed out, all the different silos and the different interests in healthcare, nothing's not going to come that's going to be painless to everybody. However, I think there's plenty of money in innovation. There is still -- pharmaceuticals are one of the most profitable industries. And I don't think we need to be increasing the prices on old drugs, the way we have been, like an Epipen and insulin and some of those things, to keep them afloat. I don't think that's how that works or how it should be working.

So I -- we do have to deal with it. We have to deal with it with our federal partners, and I think you know, they're interested in looking at that at the federal level. They are interested in looking at consolidation. There have been good -- interesting good sort of feelers coming from the feds. So I think the State needs to work with them, but there are things we can do, and we should -- honestly try everything.

SENATOR HWANG (28TH): Yeah. And the third component of Senate Bill 1006 and we are so glad, as a proponent of that Bill, to have your support on the reinsurance side. You didn't mention anything about

that, but I really appreciate that you looked at the utilization of potential federal funds and allocation of money to be able to minimize risk and reduce costs.

So I really wanted to publicly acknowledge and even though you didn't write in your testimony, your support of reinsurance as a cost-saving alternative.

And I think the fourth factor that that was in our Bill that you did not mention in your testimony was, the issue of audit and transparency. I think you're one of the biggest fans of the all-payer database and how valuable it is on a transparency basis. And as much as you challenge the insurance companies, and rightfully so in many cases, you also appreciate that they are subject to audit review and transparency processes. So -- with an all-payer system.

So I kind of share what you said earlier in our past meetings is, I wish our testimony had simply not simply Yes or No, but you know, Maybe. And as I said to you earlier in the day was, I will happily take three out of four of your support of reinsurance, of transparency, of prescription drugs and work on benchmarking. So in a way, I guess, I'm lauding and thanking you for your strong -- not strong but cautious and advisory support of Senate Bill 1006.

So thank you very, very much, and again, I appreciate the Committee's indulgence, and I know it's been a long day but it's important for the incredible credibility and the input that you have. And the objectivity to be able to comment on 1006. So thank you, madam, and thank you, Madam Chair.

REP. WOOD (29TH): Thank you. I don't see any further questions. David and Mario, I don't see in the room, but I see Lisa Winkler. Did I skip over anyone or is Lisa the next person? [crosstalk]

Alright, we'll go to Lisa Winkler, followed by Sheldon Toubman.

LISA WINKLER: Thanks so much. Can you guys hear me okay?

REP. WOOD (29TH): Yeah.

LISA WINKLER: Okay, perfect. Good afternoon, Representative Wood, Senator Hwang, Distinguished Members of the Insurance Committee. I am testifying today on behalf of my President, Amanda Gunthel. She actually had oral surgery today, otherwise, she would have been here in person. But I'm testifying on behalf of the Connecticut Association of Ambulatory Surgery Centers to express concern with key aspects of Senate Bill 1006.

There's no doubt that containing healthcare costs and improving access are critical and necessary goals for the State of Connecticut. The Office of Health Strategy has actually made important information available. It helps consumers make informed choices about healthcare, and we support the goal and the sharing of information.

In the context of this discussion, I think it's important to understand that ambulatory surgery centers are always a lower-cost option. Saving patients millions of dollars each year through lower co-payments and the State tens of millions of dollars in lower healthcare costs. For colonoscopy alone, Connecticut residents save $6.4 million in one year when they received care in the Ambulatory Surgery Center. When you visit the OHS website, the cost comparison tool there shows that our centers are often 50% less than other providers.

The ability of ASCs to provide care at a fraction of the cost has always been centered on focusing resources on quality and patient care. In functioning, more of an extension of the physician

office, as opposed to an institutional provider. Surgery centers have focused strategically on investing and equipment and highly-trained staff, resulting in more efficient, easily accessible, community-based, patient-centered care. It returns patients to work and their daily activities faster. This all saves healthcare dollars.

Unfortunately, Connecticut Institute of gross receipts tax on ESDs, the most punitive form of taxation, I think, in the context of what we've been talking about here when you're looking at what drives healthcare costs. And it has made it increasingly difficult for surgery centers to provide the level of care that they've been historically known for, forcing them to make choices about purchasing new equipment and maintaining staff.

This situation has only been exacerbated by the pandemic when elective surgical care was halted and when we started required the extensive use of testing, added PPE, increased time between patients and other initiatives to keep staff and patients safe from COVID-19. As responsible providers, ESDs we're happy to undertake these and other safety initiatives, but they also come at a cost to our industry.

This brings us to our concerns with Senate Bill 1006. Specifically, Section 5, which includes additional new extensive reporting requirements from the financial aspects of agencies. The data points regarding utilization charges, prices, payments, costs, revenues and other information deemed relevant under the Bill is extensively broad and really sort of suggests a one-size fits all approach, which we don't really think is the smartest way to approach it. Given the ESDs are always the lower-cost provider and already report extensive data to the State as part of the patient identifiable data reporting system, that includes

every detail of every patient encounter, we would oppose this additional burdensome reporting.

As you weigh the impact of this Legislation on the healthcare delivery system, please keep in mind that ESDs are highly-regulated small businesses that are reimbursed at a fraction of the cost of other providers. The surgery center -- I'm sorry.

DAWN MARZIK: That's your time.

LISA WINKLER: Okay. The Surgery Center tax really has stretched the limit of surgery centers who are now taxed both as small businesses and healthcare providers. We do not have IT systems and staff, and we really operate in a much more streamlined approach. We commend the Agency for its efforts to control costs and expand access but believe the added burden identified in this Bill is somewhat counterproductive for our industry.

Connecticut should to be looking at reducing or moving the tax and working in partnership with ASCs were a necessary part of achieving the goal, the cost-savings goal outlined in the Bill but find the approach extremely problematic, so --

REP. WOOD (29TH): Lisa, I'm sorry to cut you off.

LISA WINKLER: No, no, we certainly welcome the opportunity to work with you as you develop this and I'm happy to take any questions.

REP. WOOD (29TH): Do we have any questions from the Committee? Lisa, thanks so much for coming on. Next, we have Sheldon Toubman, followed by Paul Pescatello.

SHELDON TOUBMAN: Good afternoon, Representative Wood and other Members of the Committee. My name is Sheldon Toubman. I'm a staff attorney at New Haven Legal Assistance in the Benefits and Elder Law

units. I mostly all represent Medicaid clients. I've written testimonial, I'll hit the main points.

I understand, obviously, the desire to address rising healthcare costs but Sections 1 through 9 of Section 106 or not the way to do it. The Committee needs to understand what is completely ignored by the proponents of this Bill and OHS, and that is that Medicaid, which is included in this Bill, is already a great cost control success. An average annual rate increase over the last four years of 1.35%. Obviously, if insurance in the commercial world we're doing it as well, there'd be nothing to talk about. But unfortunately, Medicaid has been roped in.

Section 1 is about payment reform and that sounds perfectly innocuous. The language is "*Healthcare delivery and payment models are going to be encouraged*", under the Bill. But what that really means at -- in OHS-speak, as well as in SIM, which was the predecessor really before OHS came into existence, really means imposing some kind of financial risk on providers, so providers have a direct financial incentive to restrict the cost of care of their own patients' healthcare. And that can go from shared savings to downsize risk to full capization (sic), and the SIM program has pushed all of those. OHS is pushing all of them. And it's always claimed that money will be saved the right way by incentivizing of -- you know, not providing unnecessary care. But in fact, that's not what the model is. The model is the provider gets keep more money if they lower costs, no matter how they do it. And all the measures that are always advertised as the solution, are always weak and they either have no or weak enforcement.

So what happened with SIM was that there was a proposal to impose those kinds of models, those payment reform models and all the payers, but it was difficult to impose that on commercial insurance. So

what happened? Our folks in Medicaid, they were the ones who got saddled with the shared savings program which is highly problematic and quite controversial.

So now, under this Bill, Section 1, OHS would have extraordinary power to actually direct these problematic financial risk models. Section 2 through 9, of course, are about the cost caps Ellen already talked about the really lack of success in Massachusetts. But I also think we have to talk again about the fact that this proposal of cost caps always assumes it will be saved the right way by reducing unnecessary care, driving down costs, but it can be done entirely the wrong way. The model doesn't prevent it from happening. The quality measures are really weak, with no enforcement.

And so once again, sure you can save money, but it comes from clients. But as with SIM, in the end, it is Medicaid who may pay the price. We're already doing great on costs. There's nothing to having Medicaid in any part of this. But OHS has made clear, they don't want to separate Medicaid. And what that means is once again, Medicaid may pay the price thru drive -- allowing the savings in Medicaid to credit towards the savings not made on a personal side. I'll wrap up.

But I do want to just say that this is really problematic in general. It's not the time to do it. You can have the Executive Order go into effect and see what happens.

But lastly, we need to understand the case of Medicaid. That Medicaid, it's been a great success. It is also probably illegal to give this power to OHS because federal regs make clear that DSS as a State Medicaid agency may not delegate -- This is the reg, "*may not delegate to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules and regulations on program matters*", meaning Medicaid so --

REP. WOOD (29TH): Thank you very much for your comments. I'm sorry to interrupt. Do we have any questions from the Committee?

SHELDON TOUBMAN: Thank you.

REP. WOOD (29TH): Sheldon, thank you very much for your thorough testimony. We appreciate you coming. Next up is Paul Pescatello, followed by Wyatt Bosworth.

PAUL PESCATELLO: Yes, hi and good afternoon. Again, Paul Pescatello. I am Senior Counsel at the CBGC and Executive Director of the CBIA's Bioscience Growth Council. I'm here today to speak in opposition to Sections 10 through 15 of SB 1006.

At the outset, I want to underscore what a laudable it is goal it is to work to reduce healthcare costs. As a corollary to that, I'd like to underscore what a small proportion of healthcare classed prescription drugs represent. Since *World War II*, the share of healthcare costs attributable to prescription medications has remained remarkably stable at between 10 and 14% of overall healthcare spending.

To a large degree, the focus on prescription medications is misplaced. Prescription drugs could be fixed at their current prices and 86 to 90% of healthcare costs would still be unaddressed. Indeed, without addressing the other drivers of healthcare costs inflation, doctor's visits, hospitalizations, surgeries, outpatient care, insurance, administration, healthcare costs, inflation and will continue to rise unabated.

Importation of Canadian drugs is fraught with at least six critical obstacles. Each of them in some way stems from the impossibility of ensuring the safety of imported drags. First, the United States

has created the world's most secure prescription drug supply chain. It tracks and traces medicine from a drug's manufacturer through various intermediaries to pharmacies and patients to protect patients from counterfeit and unapproved medicines. And it protects them from adulterated medications. Medicines whose dosage has been altered such that its concentration is less than the original formulation. Sometimes having no active ingredient, whose purity has been compromised, whose formula has been tampered with such as the medicine ends up bound with substances like arsenic or even drywall compound.

Each juncture in a closed US system is a checkpoint for the FDA and other regulators. Importation breaches breaks open that system and leaves it vulnerable to tampering. Second, the complex regulatory scheme of SB 1006 seems to almost concede how severe the safety risks are with respect to drug importation.

How the Connecticut Commissioner of Consumer Protection could demonstrate that imported drugs meet, quote "all applicable Federal and State standards for safety and effectiveness, comply with all federal tracing procedures, and ensure that Canadian pharmacies, Canadian drug wholesalers, Canadian laboratories, all meet a host of safety requirements, including all applicable track and trace measures." That's not only impossible, it's highly problematic and very costly. That's our third point. Lowering the cost and complexity of one state, Connecticut, to set up a regulatory compliance system to ensure safety of imported drugs could very well erase any cost-savings.

While the aim of SB 1006 is to reduce costs, the Bill in some sense not to address for those costlier drugs, a large molecule --

DAWN MAZRIK: Could you wrap up your comments, sir.

PAUL PESCATELLO: Sure. It doesn't address large molecule biologic drugs, infused drugs, intravenously injected drugs, many of these are many of the most expensive drugs, including most cancer and autoimmune drugs. If 1006 would import more than just drugs, it would import Canadian - Canada's drug price control regime and drug price controls. And price controls generally never work, they always resulting in shortages.

Finally, I'll just say that there's the stark fact of the math. How a country of about 38 million could have a difficult, if not impossible time, supplying a country of 330 million. Canadians face shortages of as much as 2,000 medications, right now, and the Canadian Government itself is opposed to importation programs like those embedded in 1006. Questions?

REP. WOOD (29TH): Questions? Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Paul, for your presentation and thank you, Madam Chair and --

PAUL PESCATELLO: Well, I was rushing through it, so --

REP. DATHAN (142ND): I don't -- No, you did great. Thank you. Just a quick question. We were talking a lot about -- You talked a lot about drug importation and that's something that I know, you know, our Committee looked at really carefully in 2019 and 2020. You know, it is a challenging problem we have in our country, that the US is actually funding drug costs for the rest of the world by, you know, all of the R&D that we do in our country. And we're funding quite a bit. So my question to you, based on your experiences, what can we do as a country to help lower the cost of drugs?

PAUL PESCATELLO: Well, that's a really good point. And it's really -- it's really a national problem. Not something a state can deal with. I often, you know, when asked this kind of question -- this line of questioning. It's really an international relations problem. In some sense, we need to work with other developed countries, Europe and Japan to pay more for their prescription drugs because they're not -- you're right, they're not paying the R&D where we are -- and we benefit from that R&D. And so that's the bargain we've made. We benefit so much from that R&D and from those drugs, they we are willing to foot that cost.

REP. DATHAN (142ND): Well, I wasn't looking to, you know, make sure that we raise the cost on the rest of the world, but you know, I think there is some merit. We need to figure out how we can make drugs more affordable in this country. And whether it's a you know, benchmarking, which I think is an interesting idea, but I think it's going to be a big problem and you're right, it's maybe not something that a single state can do. But I think it's something, you know, we need to try to do to make it cheaper for our residents. So thank you so much for your time today and your answers.

REP. WOOD (29TH): Thank you, Paul. Thanks for coming. Next up we have Wyatt Bosworth, followed by Joseph Quaranta.

WYATT BOSWORTH: Good afternoon, everybody. Can you hear me?

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

WYATT BOSWORTH: Great. My name is Wyatt Bosworth. I'm an assistant counsel for CBIA, the Connecticut Business and Industry Association. Chairs Wood and Lesser and Ranking Members Hwang and Pavalock-D'Amato. Thank you for the opportunity to testify today. CBIA supports Senate Bill 1006, the Bill

builds upon the great progress that OHS has made over the last year through its implementation of the Governor's Executive Order, Number 5, by codifying a cost growth benchmarking plan into State Statute. Lowering premiums on the individual marketplace through a reinsurance program providing independent annual audits of the State partnership plan and reforming the way assessments are levied on health plans throughout the State.

So benchmarking. As I said, this Bill is essentially a codification of Executive Order Number 5 from last year. CBIA has supported OHS's efforts to begin developing a cost growth benchmark in compliance with the EO and we support this effort to make it a permanent program in the Agency. Exposing the true drivers in healthcare costs will not only pressure carriers and providers to abide by the State established benchmark, but the data collected will also provide tremendous value for all of you on this Committee. So that you can truly develop public policy that's narrowly tailored to address the root of the healthcare cost program.

CBIA supports Section 23 of the reinsurance section tasking OHS to seek a 1332 with the Federal Government to establish the program. We also appreciate the Bill's requirement that state funds in lieu of assessments will be used, as it pertains to the State partnership plan and the transparency.

We support Section 24 of the Bill that will improve public transparency and accountability, as it relates to the State partnership plan. Under current law, the SPP is required to have an independent actuarial firm determine the adequacy of premiums relative to experience and total costs and report those findings to the healthcare costs Committee and the General Assembly. This section goes a step further and actually requires the auditors of public accounts a true independent entity to annually

conduct that audit and report its findings to you all in the Governor's Office.

Lastly, CBIA supports Section 26 of the Bill that would require future assessments proposed by the exchange to receive both a public meeting with public comment, as well as a majority approval from the Insurance and Real Estate Committee. And this is due in part -- I spoke to you all, just a few days ago, we are very concerned about future assessments. You heard Susan Halpin talk about the carriers being at a breaking point. Our small businesses are at a breaking point, paying close to $600 a year in assessments fees and taxes.

And you know, requiring this extra step of public comment and legislative approval will help ensure that future assessments receive the utmost scrutiny and review. So with that, I'll take any questions, thank you.

REP. WOOD (29TH): Thanks, Wyatt. We have a question from Senator Lesser.

SENATOR LESSER (9TH): I thank you for your testimony and through the Chair, just a couple of questions similar to the questions I asked early of Senator Kelly. Senator Kelly proposed that the reinsurance program established pursuant to this Bill pegged at $80 million. I just wanted to know if CDI have suggested a way for paying for that.

WYATT BOSWORTH: That's your job, Senator.

SENATOR LESSER (9TH): You know, I'm not testifying in support of the Bill, you are.

WYATT BOSWORTH: I know. I know. But it's all of you who control the budget and the Appropriations Committee. I think the answer to your question philosophically, I think the State Government and CBIA thinks the State Government and the taxpayers

at large should be subsidizing this program in lieu of picking winners and losers and the fully-insured and self-insured in individual markets.

SENATOR LESSER (9TH): That you would support a generalized tax increase to pay for the $80 million?

WYATT BOSWORTH: I'm not saying a tax increase. I'm saying prioritizing funds and taking advantage of the more than $10 billion flowing into the State as a result of the COVID Bill coming in. That's a policy decision you will have to make. We're simply just stating that the money coming from the budget is more advantageous and better with federal matching than continuing to levy assessment and fees on our small business members.

SENATOR LESSER (9TH): So I appreciate that. But we, you know, we're getting -- we may be getting a one-time infusion of revenue, but the language in the Bill isn't for a one-time expenditure. It's for a year-on-year expenditure. So you're saying at a time when Connecticut faces massive long-term fiscal challenges, that you want Connecticut to embark on an $80 million annual expenditure without -- But other than a one-time revenue from that, is that correct?

WYATT BOSWORTH: I don't know where this $80 million figure --

SENATOR LESSER (9TH): Probably said in your testimony earlier.

WYATT BOSWORTH: Yeah. I'm -- Senator, I'm just going by the Bill and the Bill caps that amount at 20.2 million, which is what the Wakely Report showed as being the maximum amount of a state contribution to get a 5% reduction in individual premium so I'm going by that $20.2 million number.

SENATOR LESSER (9TH): So now that's [inaudible] Wakely Report and I'm glad you brought it up, because the Wakely report took place -- it was written two years ago and it was an interesting report and I read it, you read it, you all read it. But it was about the healthcare environment that existed two years ago, before the pandemic and importantly, before the American Rescue Plan that just passed by Congress. The American Rescue Plan eliminated the 400% cliff.

You're telling me that you think reinsurance will lower prices, out-of-pocket costs for individuals purchasing health insurance exchange passage of the American Rescue Plan?

WYATT BOSWORTH: I think you bring up a valid point and I forgot to mention this in my testimony. We need another Wakely Report done. We need another independent actuarial analysis, because the ACA subsidy landscape is going to vastly, vastly change as a result of this federal Bill. You know, more than $43 billion is going to go towards the ACA in the Bill, and like you said, Senator, you know, those with incomes over 400%. Subsidies will be determined by reducing that 10% cap to eight and a half percent cap. And subsidies will also greatly increased to those on the Exchange.

That's not to be said, though, that reinsurance can work within that existing program. I think it's a good program to have on the ground running given the fact that this federal money is set to expire in two years. And we quite frankly don't know the state of healthcare as it will be in 2022. That's --

SENATOR LESSER (9TH): I got the idea, right. We're in the middle of a healthcare crisis now. We could, you're right, we could assume the Congress sunsets the existing law in two years. I think that's an important conversation. That's why the Bill that we passed that out of the Committee earlier today

includes the option for reinsurance as one of a menu of options. But it doesn't lock us in. And the question I have about a bill the locks us into a program, that to me seems obsolete, right. If everyone is subsidized on the exchange. If there is no 400% cliff. Then by passing reinsurance, not only are we put opening up an $80 million hold on the budget, but I think we're likely to raise out-of-pocket costs for people on the Exchange, which is the -- I think the opposite thing what you're trying to do. What am I missing?

You lower premiums, you lower premiums on the Exchange for the subsidized population. Unless my math is totally wrong, you lower the federal subsidy, you actually put -- will likely, in many cases, if not all cases, wind up raising the effective premiums that a customer would actually pay. And you would raise the overall healthcare expense.

But I don't think there's anything -- there's no way and there's no reason to think that this would actually load -- Why don't I just give $80 million dollars to lower -- to buy-down deductibles. But reinsurance in this context seems to flunk the sort of the basic structure of the *American Affordable Care Act*.

WYATT BOSWORTH: Yeah. I mean, I don't necessarily disagree with you, Senator, and I think that's why it's important that another analysis needs to be done once we obtain those dollars from the Exchange and start to understand the real impact for Connecticut residents, that purchasing insurance through the Health Exchange, I can't, you know, I can't talk on hypotheticals about how the reinsurance program will work on a bill that was literally signed today. But I can tell you that you know healthcare costs will still be a problem, especially for those making well above the 400% level. You know, those middle-class residents who

make 60, 70, $80,000. They'll see a reduction. How much of a reduction they'll see is still --

SENATOR LESSER (9TH): There's no way they won't necessarily see a reduction, so there was a reduction into the American Rescue Plan. But under this -- under this proposal, right, they're going to be capped -- on the American Rescue Plans, going to be capped at eight and a half percent of their AGI, right. That's going to be their whole total percent, and if you capture that, regardless of your age, so -- What -- Where are they going to see savings? How are they going to see savings, if we do -- If we do a giant reinsurance? Where is that going to be achieved? What does that -- I understand that that will save the federal government money, but how is it going to save my constituents in Cromwell and Rocky Hill and Newington.

WYATT BOSWORTH: Yeah. Well, I mean the way the reinsurance program is designed is it implements an attachment point that will allow insurance companies to have the pool subsidize anything above that attachment point. And we know that the cost of healthcare is growing exponentially. We know that catastrophic events will still continue to become more expensive. So that issue is not going away. The thing reinsurance addresses are those -- are those costs that insurers and payers incur and I don't see that issue going away as a result of more subsidies on the Exchange. Granted, the reinsurance, you're right.

You know, if another Wakely Report is done, because the subsidies are expanded, because more people can capture more advanced premium tax credits, we're likely to see that federal pass-through funding, you know. Which is now about, you know, a little more than a one-to-one match on the state funding, probably decline a little bit. And that may result in us needing to allocate less State funding to the

reinsurance program. But the issue of catastrophic claims destabilizing individual groups and health plans is not an issue going away. And we've already had 16 states passed similar programs to fix that very problem. They passed them but they passed them prior to the passage of the American Rescue Plan, when the specific problem of the unsubsidized population that reinsurance was intended to address, that all happened on Tuesday. So I don't understand how on Thursday, you can -- you know, you're not alone. I'm not singling you out. But you and other folks were testifying in support of reinsurance. It's not clear to me how this lowers health insurance prices for anybody on Thursday. Thursday, you've got me. I -- understood -- you can tell me that people at 40% are more important that people at 200% of pocket. That's a value -- people can disagree on that, like it's a reasonable point but on Thursday, this Bill seems as obsolete as the dodo bird.

WYATT BOSWORTH: Well, let's find that out and let's commission another report.

SENATOR LESSER (9TH): Shouldn't we study that before it was -- shouldn’t we study that before we put $80 million in a program that doesn't seem to work?

WYATT BOSWORTH: I think it would be prudent, given the radical change in the *Affordable Care Act* that literally came into law an hour and a half ago. You know, I think that the 2019 and '20 Wakely Reports are out of date. So yes, I, you know, I would agree that we need additional study on this issue to find out the true facts. I don't disagree with you on that, Senator. I agree with you 100%.

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

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

SENATOR HWANG (28TH): Thank you, Madam Chair. Mr. Bosworth, my compliments to you for offering a contrasting view to some Members of this Committee. And eliciting, dare I say in some ways, a combative nature of this debate. You must be making some impact. So I want to applaud you in that regard. And let me, let me give you a chance to kind of shout out to CBIA, who you represent, in its representation of thousands of small, midsize and large businesses and hundreds of thousands of employees for you to testify and give their viewpoints.

One of the challenges is the fact that, you know, some of the proponents of Senate Bill 842 talks about how small businesses and many of our businesses are clamoring for it. And I remember when we had first the discussion, literally almost about three weeks ago, when you kind of challenged the survey results that was purportedly represented by Control Limbo, with a survey that CBIA did and followed up with some scientific background in which small businesses had significant concerns about a State-run health insurance program. Could you kind of elaborate with this audience, even though it's been a long day, the importance of representing small businesses?

UNIDENTIFIED SPEAKER: Madam Chair.

REP. WOOD (29TH): Yes, sorry.

SENATOR LESSER (9TH): I'm sure. I know that this has been a long day for many of us and we've had a robust conversation about many, many bills and many ideas, but just a point of information. Should Members confine themselves to questions about the bills before us?

REP. WOOD (29TH): That's a great point, Senator. Please, talk and ask questions related to the Bill at the Public Hearing. Thank you.

SENATOR HWANG (28TH): Thank you, Madam Chair. And I'll get right to that then. Thank you. So we were talking about reinsurance. And we're talking about money allocated. And I kind of found that kind of funny that the -- that my colleague said, it's this Bill is dead as a dodo bird. But the fact is reinsurance is a concept that is practiced in many other sectors. And obviously, still very much in consideration under the Governor's proposed plans, which I will not discuss. But in regards to Senate Bill 1006, reinsurance is a component to reduce costs. Now we talked about the $80 million, whether it be at 80, 60 or even 100, the fact is, we are looking at possibly utilizing innovative ways to take tax burdens off our residents and also leverage federal tax dollars that come to our state from many of our residents that pay into the federal.

It is a worthwhile initiative for us to think a little bit out of the box to utilize reinsurance. Would that be a fair statement?

WYATT BOSWORTH: Yeah, and you know that you've heard from people earlier. You know, the State spends billions of dollars on healthcare every year. We have a great robust expanded Medicaid Program that does a lot of good work for a lot of people in need of coverage in this State. You know, I think from CBIA's perspective, we're just, you know, we're cautious about picking winners and losers with assessments and inflicting any more financial burden on them through targeted taxing. And you know, we know from the Wakely Report that the more you assess for a reinsurance program, the less federal pass-through funding received. So that, you know, that's a policy decision you all will have to make is whether you feel that specific insured groups in the

State should be subsidizing lower premiums for another specific group. Or you think the tax base at large should play a role and get as much federal pass-through funding as we can possibly obtain. And I would just urge the latter, along with the carriers and the other insurance brokers that spoke here today.

SENATOR HWANG (28TH): Great. Ad you also heard from colleagues that talked when questioned in regards to where the $80 million coming from, and even if the federal allocation funds don't materialize and even if it expires as a one-time payout in two years and those are all merited conversation pieces that we need to evaluate. But what you also heard was the fact that, if we talk as though healthcare is an absolute critical human right, then indeed, we as a legislative body should appropriate money to be able to utilize a tool that will lower healthcare costs.

And we've said that in this Committee. We've said that from Republican leadership that talked about it. As a contrast to $140 million plus, that we just voted on in the General Assembly in an emergency certification bill that says "Okay, we promise to put 140-plus million for your pilot funds because we believe in that." And it passed on a bipartisan basis. Why are we not making that kind of a thought process to making a financial commitment as a tool that we could use that has been proven to reduce healthcare costs and health insurance costs, rather, why are we not willing to do that? Instead, boldly going ahead with a system based upon its current actual numbers when we can get them, is running a deficit. And the fact is posing many challenges, why wouldn't we want to use that tool to be able to create a system that's sustainable down the road?

WYATT BOSWORTH: Can I just say I concur with you, Senator. I mean you hit the nail on the head. This is a policy decision that I think all of you have have done a great job raising this year, about how

we should fix our healthcare costs problem, and we should pay for it. And you know, CBIA quite frankly believes this is the most responsible way to at least spread the burden amongst the largest possible base, you know, to result in you know, a five, ten percent reduction in the marketplace. We just think that's a good public policy decision compared to more assessments and taxes that will be targeted and inflict a much narrower range of insured individuals in the State. And also put more pressure on the insurance industry that supports tens of thousands of jobs and is reaching a breaking point with those type of assessments. So I guess I'll just leave it there, Senator.

SENATOR HWANG (28TH): No, thank you, Wyatt. I know the day is long and but, you know, I appreciate sticking to the germaneness of Senate Bill 1006. But I must say that the interconnectedness of three different bills that are being considered, all focus on these important issues, and that as we deliberate, I think we should look to include the best elements of all the bills, instead of taking one over the other. And that unfortunately, is not the process that we undertook today.

So I appreciate your thoughts and I hope that you and CBIA will be continually engaged in this process moving forward. So I thank you for your time and CBIA's contributions and our businesses in the State of Connecticut and thank you, Madam Chair.

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

REP. NUCCIO (53RD): Sorry, Madam Chair. It took me a second to find the button there, going back and forth. Good afternoon, Mr. Bosworth, how are you?

WYATT BOSWORTH: I'm well. How are you, Representative?

REP. NUCCIO (53RD): Thriving. So there's a couple of things here that I think that you mentioned, and I would like to get your input on. As I've asked a couple other people on here. Well, first of all I would like to just kind of give a little bit of background and history on the entire reinsurance process in the State of Connecticut. We actually have a piece of legislation. We were using -- we had a reinsurance legislation long before PPACA even was dropped about. It was a program that actually did its job and worked pretty and that legislation is actually still on the books in the State of Connecticut. It has never been repealed, even though it was suspended when ACA came into place.

Then, as we have seen, and this is actually been a phenomenon across the country, reinsurance was out there for a long time. PPACA came into play and everybody suspended their reinsurance programs. And then, as the prices increased and people couldn't afford it anymore, reinsurance programs within reinstituted. Whether it was the 1332 waiver or just states coming up with their own version of how to fund the Exchange. So this is not a new thing, and to think that this infusion that we got right now from the Federal Government is going to fix our health insurance problems, I think is kind of folly to think that in the next two years, this funding is going to automatically fix everything that we know is wrong with the ACA.

So the idea that reinsurance comes on and off of books, I think it's a valid conversation and I obviously think that it's better to socialize that hit across a wider populace. So I sincerely agree, in that sense, on there, whatever the number ends up being, 20 million, 30 million, 80 million. And looking at the widest base to spread it over is the least amount of harm, so I value your insight on that.

But what I really wanted to ask you is the piece again that I focus in on the most in on this particular Bill here is the value of the benchmarking. And what is CBIA's position and how they feel like the value of benchmarking is actually going to be able to help the market overall in their areas.

WYATT BOSWORTH: So, thank you, Representative. Great to see you again. I think, at a bare minimum, benchmarking does a good -- setting aside the benchmarking and the Performance Improvement Plan and that process that Ellen Andrews had great feedback on, I think at a bare minimum, what the program does is it consolidates a wide range of healthcare data. It makes it easily accessible, right. You can go on to the APCT website right now and look at data and reports can be generated off that data. And it's data that's necessary for this Committee, the Public Health Committee, the Human Services Committee, to really target reforms to specific sectors. In areas, whether it be the payers or the providers or the pharmaceuticals, inpatient, outpatient, so we can really start to target reform.

Now there's -- you know, there's differing opinions about whether the Massachusetts model was a silver bullet. You know, the Governor says that it's reduced total healthcare expenditures by $5 billion from 2013 to 2016. People like Ellen Andrews, you know, and other well-known, well-read healthcare advocates in the country will say, "Well, Massachusetts was already experiencing a downturn in healthcare costs before benchmarking exists." And it may be the first, it may be the second or maybe a combination of both, it's such a new experiment, we're certainly going to find out.

We also know that Delaware and Oregon have already proposed benchmarks for their states and will begin implementation in the coming year. So I think Connecticut is in a really unique position to, you

know, not only collaborate with these other states to figure out best practices. But also continue collaboration with stakeholders in the community we know through Susan Halpin's testimony that the carriers have been supportive of this. They want to play by the rules that OHS is setting. We've got to figure out how the hospitals feel, how the pharmaceutical companies feel, the input they may have. the business community like CBIA. It's really a global effort to take this program that's been jumpstarted successfully by OHS. And I think the news that came out of the Governor's Office today just adds more credibility behind that problem.

And I think it'll just take constant communication with stakeholders with this Committee, with other Committees of Cognizance to really get this program up and running. But codification is a necessary step because, you know, I'll give you an example. OHS didn't feel like they had the authority under the Executive Order to collect Workers Compensation claims, right. So they asked for a bill that's in the Public Health Committee that would essentially give legislative approval to collect that data. And we've been working with OHS. We have a number of property and casualty businesses in the State. And we've been trying to work with them to find the best possible means of getting that data into the hands of the agency. You know, the Executive Order also says nothing about enforcement mechanisms. It says nothing about PIPs or penalties or hearings.

So I don't know enough about the Program but I, you know, I certainly have questions about whether OHS feels they have the authority under the EO to actually hold carriers accountable through PIPs once the benchmark is up and running, So it's really important that we codify this as soon as possible so we can really set OHS up for success rather than patchwork fixes throughout the next couple of sessions.

REP. NUCCIO (53RD): I just want to thank you for bringing back bringing me back to about 22 years ago when I was just a baby in the industry. I haven't heard PIPs in a long time. So that's definitely -- I hadn't even thought about how that would work, so thank you for giving me something else to look into. But I'm a firm believer. I don't believe in silver bullets. And you know, it's a mess. You know, it's just a mess. So to me, if we look at what Massachusetts did, and we look at what other States are doing, you know, you have the ability to look at the pioneers in front of you to be able to pick and design a plan that works for you, knowing that you're going to have to just as we see with reinsurance, you're going to have to flow and ebb and you're going to have to find what works and what doesn't work. Suspension of some and addition of others.

So overall, I think we're moving in the right direction. If we can try to combine all these different things and come up with a good plan, use the data that we have and modify it to go forward to really focus in on reduction of costs.

So thank you for the conversation, and thank you for throwing a word back that I hadn't heard in a long time.

WYATT BOSWORTH: Thank you, Representative. You used the term 'cherry picking' in a positive fashion today. Usually, it's in negative fashion recently, so I concur with that. I think there's -- there are a number of good proposals in the, you know, the three bills that we've seen before. You know, I want to help be a part of some bipartisan package that we can show Connecticut residents that we got together, got creative, got innovative and really delivered relief to them. This shouldn't be a partisan issue here and it's too big of an issue to be partisan. I appreciate your work and everyone else on the Committee's work on tackling this issue this year.

REP. NUCCIO (53RD): I would love nothing more than to fulfill that dream and have a bipartisan combined bill that does that. I happen to really like cherries, and I even like the bruised ones, so you know we'll take all of them. Thank you.

REP. WOOD (29TH): Thank you, Wyatt. Next up is Joseph Quaranta, followed by Kathy Flaherty.

JOSEPH QUARANTA: Thank you, Madam Chair. And I thank you for the opportunity to testify today in support of House Bill 6585, AN ACT CONCERNING ASSOCIATION HEALTH PLANS. My name is Joe Quaranta, a primary care physician and I practice in Branford Connecticut and I own my own practice. I'm also the President of the Community Medical Group, which is an organization made up of over 240 independent medical practices, almost all of which would qualify as small businesses under our health insurance definitions.

I'm here today speaking in support this Bill to help provide independent practices, as well as other small businesses, opportunities to help navigate through the health insurance market that has been so challenging and struggling to us. As a small business owner, we have seen our health insurance costs go up dramatically year-over-year with little recourse except to revert to the group rates that we are facing in the small business market. What we would like to be able to do is, as we do for many other things in our organization is to help our small businesses come together and help navigate a complex issue together instead of having to do it independently.

The opportunity to form an association health plan would allow our practices and other small businesses that also share common interests and resources, to try to procure health insurance benefits that fit their business needs at a lower cost, and also at a

substantially reduced administrative burden for their practices. Because not only is it the escalating costs of health insurance that puts a strain on small businesses, it's the extra administrative burden that each individual group has to manage these different plans is challenging.

I would point out that, in my opinion, I am not in support of nor to ever support association health plans that market insurance coverage that is diminished in any way from the standard state minimums. And we actually would support that association health plans have to provide insurance benefits that are consistent with the State mandates across the board. And I think that's an important point to make.

I also acknowledge for the record that I know that this Committee is looking at other opportunities to help support small businesses through other options, like the public options and we need to support it to the extent that the public option would help support small businesses in doing that.

However, though we still want to speak in support of this option, which we have supported for many years, to give small businesses an option to control their own destiny for their health insurance, for their employees and for their members. And do it in a way that's financially responsible and in a way that helps preserve our ability to stay independent.

And I close with one final comment. We speak of this not as a matter that's related to our health insurance, but it really is a matter related to our existence. The number one reason that we see our small independent practices either closing or being bought out by larger entities, is because of the increasing administrative burdens they face in maintaining a small business. And the increasing costs that they are forced to absorb. Health insurance in a year-over-year basis is the number

one increasing cost that we face over time. And if we don't find a solution for certainly our practices, but I'm sure many small businesses, we will continue to lose small businesses in this State.

And for the healthcare industry that continues to mean that our small practices will either close or be absorbed into large integrated delivery systems. And I think that has important ramifications for the healthcare industry in general.

So I thank you for the time today. I would encourage you to consider supporting this Bill and I'm happy to answer any questions that anybody may have. Thank you.

REP. WOOD (29TH): Thank you, Joseph. I think you hit up a great point there by describing the cost of doing business as a small businessowner. And how sometimes looking at being bought out is your only option. So I appreciate you hitting on that. Any questions from the Committee? Not. Thank you, Joseph. Next, Kathy Flaherty, followed by Maggie Goodwin.

KATHY FLAHERTY: Good afternoon, Representative Wood and Members of the Insurance and Real Estate Committee. My name is Kathy Flaherty. 'm the executive director of Connecticut Legal Rights Project. We are a statewide nonprofit that provides legal services to people who are eligible for mental health services from the Department of Mental Health and Addiction Services. And I'm here to express my opposition to the first nine sections of the Bill for the reasons that my colleagues, Ellen and Sheldon, have already represented. And it's a concern when you have an agency that is not the Department of Social Services, which is the single State Agency in charge of Medicaid. Being potentially given a whole lot of power to influence the policy decisions in the payment strategies for

Medicaid, when Medicaid is already saving money and really kind of has the best results in the nation.

Our clients rely on Medicaid. They not only have mental health conditions, a lot of them also have co-occurring physical health conditions. People with disabilities are the high utilizers of healthcare. Doing something that, in terms of cost growth that benchmarks on that, could potentially limit access to care for the people who most need healthcare, is problematic. They're not putting the quality benchmarks in for another two years, Like, why are we putting off looking at quality? You know, our office has experienced the cost of rising healthcare and I testified at another committee on another bill about that. But those risk models, the shared savings, it incentivizes providers to potentially reduce care. We don't know if that will happen.

And one of the things that the State has a tendency to do is when they claim they're getting stakeholder input, they don't get that at the beginning of the process. They decide what they're going to do, usually in consultation with high-paid consultants, they start down a path, and then they come to us later to get sign-on for that. You know, that's why SIM got shut down because when they finally decided to come to the community, the consumer said, "This isn't acceptable." And just repeating that pattern, I think, is a little problematic. I would encourage you not to do it. So that's the opposition to the first nine sections of the Bill. Thank you.

REP. WOOD (29TH): Kathy, thank you very much for your testimony and your testimony in previous ones, I think, having strong consumer protections in any new healthcare reform bill is a priority of this Committee and I appreciate you bringing those to light and all the information that you've provided. Any questions from the Committee? Thank you, Kathy.

KATHY FLAHERTY: Thank you. I know you've had a long day.

REP. WOOD (29TH): We're really good at long days. Next up is Maggie Goodwin, followed by Ellie Smith Fagan. And Ellie is our last speaker.

MAGGIE GOODWIN: Hello to the Committee. My name is Maggie Goodwin. And I'm an LCSW and a member of National Association of Social Workers coming today. I'm submitting this testimony in opposition to Sections 1 through 9 of SB 1006, which would give enormous new authority to the Office of Health Strategy in the areas of one, imposing payment reform models on the entire healthcare delivery system, which would directly financially incentivize providers to restrict access to healthcare for their own patients.

And two, in closing global costs caps on how much money can be spent on healthcare, including on Medicaid Connecticut. I come to you as a retired social worker who worked and lived in the Commonwealth of Massachusetts for 30 years. And also I have spent two of those years only in managed care, for a managed care Commonwealth of Massachusetts company. All I will say about that is that I made more money at the managed care company than I did in any other of the administrative or clinical positions that I held in many nonprofits clinics community health centers.

So from that perspective, I'd just like to say that change that -- this change in Section 1 through 9 of SB 1006 -- And to say it's a misguided effort from my perspective, to save money by financially incentivizing health professionals to restrict access to medical services and medical care by sharing with those providers a portion of the money saved on those unprovided services. I provide -- I maintain this is not an appropriate approach to healthcare delivery for the State of Connecticut.

And would urge that you would not -- These people would not be forced to, or directed by OHS, to participate in such an effort.

I suggested these financial incentives for providers to limit care provides puts providers in an untenable position and proposes a real threat to equal access to care. Particularly for low-income Medicaid recipients, black and brown Medicaid recipients and those Medicaid recipients with complicated and complex medical needs. The changes suggested would place, as I see it, an unfair burden on the health care providers by putting purely financial considerations in the middle of the health care provider and patient relationship. That doesn't belong there. Clients are not well served when their medical provider is pressured to prioritize consideration of cost at a high priority.

It is also not right to institute this change at this time in OHS. It is under the cover of COVID. And thus, will be blindsiding many in the medical community and the healthcare community consumers because we are in the middle of a national disaster. Many healthcare providers are occupied other places. I suggest that we need -- you need more input from consumers and these providers and that hasn't been gotten at this point. People aren't here today. The surgery folks were here. But I feel I'm speaking for a number of other providers. That this is not the right time to give OHS the power to direct providers to participate in these new models, rather than just maintain their monitoring role.

I, an NSW Connecticut and many of those private providers and nonprofit providers and our consumers, are asking that the broad powers granted by the change in Section 1 through 9 for OHS be removed from SB 1006. I believe this is a misguided approach in regular times. But right now, during COVID, it's not appropriate. This is not the time to change, while many consumers are struggling to maintain

their health and many of our healthcare providers are under more stress than in their other work lives. This would provide an undue administrative burden to many, many nonprofits and clinics.

DAWN MAZRIK: If we could ask you to wrap up please.

REP. WOOD (29TH): Perfect timing, Maggie. Thank you so much for your comments. We really appreciate the great insight. Any questions from the Committee? Seeing none, our last speaker is Ellie Smith Ferguson. Fagan, sorry. Is Ellie on?

LOGAN COTTER: Madam, there's no one else in the waiting room.

REP. WOOD (29TH): Okay, great. Any other speakers? Great. Thank you. Thanks to the staff. Thanks to Dawn for keeping us on track, we really appreciate it.