CHAIRPERSONS: Senator Matthew Lesser,
Representative Kerry Wood

SENATORS: Anwar, Cabrera, Hwang, Maroney

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

REP. WOOD (29TH): Great. Good morning, everyone. Welcome to the Insurance and Real Estate public hearing on March 18th. We are going to convene the public hearing. My name is Kerry Wood. I'm the Representative from the 29th District, serving Rocky Hill, Wethersfield and Newington. At this time, we'll pass it over to Co-Chair, Senator Lesser for comments.

SENATOR LESSER (9TH): Thank you, everybody. This is our last public hearing of the Insurance and Real Estate Committee. It's also a very long public hearing. So please bear with us, we have an awful lot of folks who are here to testify in support of a great many Bills. I'm excited that my leader and an old friend of ours is -- have joined this as the first speaker this morning. But we have a lot to hear -- to get to, and a lot of important business before us today. So with that, I'd like to thank the members for being here and turn it back to the Chair.

REP. WOOD (29TH): Thank you. And Senator Anwar, Ranking Member, do you have any comments?

SENATOR ANWAR (3RD): Thank you, Madam Chair. No, but just wanted to listen to everybody's perspective. Thank you so much, Madam Chair.

REP. WOOD (29TH): Thank you. And Ranking -- on the House side, Representative Robin Comey, I'm sorry. Do you have any -- do you have any --?

SENATOR ANWAR (3RD): Thank you. No, thanks for all your work. We're gonna plow through the rest of these Bills. And I'm looking forward to hearing the testimony. And I thank everybody on the Committee for their commitment to hearing this work. Thank you.

SENATOR LESSER (9TH): Madam Chair, could I just do one more thing if that's okay.

SENATOR ANWAR (3RD): Yes.

SENATOR LESSER (9TH): No, I would just note that due to the Senate session on Tuesday, we will have to pick -- we will likely pick an alternate day Monday or Wednesday for the purpose of JF Bills. I know that that's not the usual committee practice and I apologize the Members for the inconvenience just simply due to scheduling process.

REP. WOOD (29TH): And I apologize, Representatives Comey, is my Vice Chair. And do we have -- I don't see our Ranking Members on. So at this time, we will jump into our speakers. Our first speaker here today is Senator Marty Looney. Marty, the floor is yours.

SENATOR LOONEY (11TH): Thank you, Madam Chair. Good morning, Chair Representative Wood and Senator Lesser and Vice Chairs and Ranking Members and Members of the insurance and Real Estate Committee. It's a pleasure to -- before the Committee this morning to testify on a number of Bills. And especially to be with my close friend and collaborator on so much good legislation over the years, Former Republican Senate Leader Len Fasano, who's going to be testifying on some of the -- some of the same Bills.

So just to begin with, lists of Bills that I wanted to what to speak about Senate Bill 1045, 1048, 1049 and House Bills 6622 and 6626. As, frequently, the

6622 would protect patients from formulary changes during their policy term. And it's really unfair, that if a patient buys a health insurance policy that includes prescription drug coverage for a specific drug, that the health insurer can change the formulary during the policy term and exclude that drug. In fact, some people are attracted to policies only because of certain coverages, and they may have chosen the policy because of that coverage and then have risk having the rug pulled out from under them during the policy period.

So there are times when a physician, a patient knowingly choose a drug, for instance, that has some documented side effects. But despite these dangers that appears to be the best course of treatment for that patient, and an insurer records could say contact with physician to share any safety concerns that have rather than denying coverage, as a first step.

Senate Bill 1045 would provide a number of innovative protections for patients. So first of would create a presumption that treatment that's ordered by a physician is medically necessary treatment, and this would physicians to practice medicine and limit the ability of the health insurers to interfere with patient treatment by making medical decisions, which they're not qualified to make.

Generally, in most contexts, in the law, the burden of proof is placed on the party that has the relevant information and knowledge. And Senate Bill 1045 would bring appeals of adverse determinations in line with most areas of the law theory. Here, the insurer is the only party with knowledge as to why a claim was denied. And in appeals of adverse determinations, neither the patient nor the provider, know why the payer declined to come for service. So it's a matter of civil legal justice.

Despite this reality under the current framework, the burden of proof on these appeals is on the patient and the provider. In fact, prior to a Public Act 12-102, which Senator Fasano and I worked on together back in that -- nine years ago now, the patient and provider prior to that didn't even have the right to access the record that the insurer used to make the decision. And that practice was changed by that law.

In addition, an insurer is not licensed to practice medicine, and its judgment as to what's medically necessary for a patient should really, really be weighted far less than that of the treating physician. The insurer could still, of course, deny claims under the framework, but it would have to prove that the treatment was -- that denial was justified and there was some problem with that treatment, and that it was not medically necessary.

So that's a -- in addition, it's -- if an insurer has concerns about the treatment practices of an in-network provider, that concern should be addressed with the provider and the patient should not be used as a pawn caught in the middle here. Also, Senate Bill 1045 would strengthen patient protections of vis-à-vis the insurers use the step therapy. While there are legitimate uses of step therapy too often is implemented in a manner that interferes with patient care leads to insurance preventing physicians from providing the best care for patients.

And we -- the protections in the Bill this year apply to behavioral health as well as chronic diseases. And that's an important expansion. Then in 2014, Public Act 14-118, AN ACT CONCERNING REQUIREMENTS FOR INSURERS used that -- Senator Fasano and I worked out together back then, that created certain patient protections regarding insurance carriers use of step therapy. But there have continued to be situations in which a carrier step therapy policies prevent the patients from

receiving the treatment that their healthcare providers have decided is the most appropriate. In some cases, this is delayed effective treatment that can leave patients with diminished health outcomes.

Again, a couple of years ago and four years ago now, Public Act 17-228, AN ACT CONCERNING STEP THERAPY FOR PRESCRIPTION DRUGS PRESCRIBED TO SEEK -- TO TREAT STAGE FOUR METASTATIC CANCER recognize that these continued patient struggles in furthers and further regulated the use of step therapy in certain cancers but not in a broadly applicable way. So the use of step therapy continues to be particularly problematic for various chronic diseases, including behavioral health and cancer patients. And Senate Bill 1045 would enable the physicians to be able to best provide treatment for their patients.

In addition, that bill would create a more stringent definition of clinical peer in the appeal process for adverse determinations by including peer-to-peer conference that the healthcare is required to offer. And requiring that the clinical peers use to evaluate adverse determinations reviews, the certified specialists in the same sub-specialty would result in more accurate and appropriate determinations and would also require that the peer that is provided for the peer-to-peer conference have the authority to overturn the adverse determinations. Otherwise, you have a series of non-conclusive bureaucratic hearings, and the result remains in limbo.

So this would benefit all parties involved and make our healthcare system more effective. So at this point, it's my great pleasure to turn it -- turn it over to my friend and colleague, Senator Fasano, who provided such leadership, this and so many other issues during his 18-year tenure in the State Senate.

EX-SENATOR FASANO: Thank you, Senator Looney. First of all, let me say it's a pleasure to have

sort of sort of be back into the building. I miss it a lot. I got to tell you, in all honesty. But I think Senator Looney covered a lot of the 1045 and other Bills. I just want to add a few things.

First of all, in 1045, with respect to the burden of proof. Basically, Marty is right when he says legal justice, but it's also practical Ajar. The insurance company certainly can rely upon the fact that they denied certain drugs to patients -- one, we're interfering with the patient-doctor relationship; but number two, they recognize that doctors have a limited amount of time dealing with patients. So I think Senator Anwar knows a lot about this from his -- wearing his other hat, but they have a limited amount of time.

And if a doctor has to keep on following every patient for the burden of proof to determine and prove to an insurance company, that the medicine is the appropriate for their patient, they know there's only a limited amount they'd be in the insurance company knows there's only a limited amount of patients that a doctor can put that effort for. And that's simply not fair. This is about health -- healthcare, and doctor-patient relationship. And if they have an objection, they can raise the objection. But then they have to prove the objection is unfair, they recognize the Ajar that doctors can't follow through on all these. And that's why this is being done this way. And we need to change. It is only the most -- dealing with family -- there's somebody in the background complaining about my speech here.

But there are people who are going to be treated unfairly, and doctors will not be able to provide the best medicine. And that's what this is about. 1040 -- also 1045, if the child turns 26, leave the person on the insurance until the end of the calendar year. I would add, we do that in the State of Connecticut. When my daughter turned 26 in June, she was allowed to stay on the healthcare plan for

the State of Connecticut until December 31st, so that she may have to switch halfway through, and that makes sense. So that should be adopted as well. That as soon as the child turns 26, wait for the end of that calendar year, and then the person makes the change. So we just be adopting state policy that we have in our state contract. In 1049, basically, that just allows the deductible to calculated on calendar here, which would give the opportunity of people to make fair choices so that their plans don't change mid-year. Once again, it's just equitable.

The other one that is on there that I don't believe is Senator Looney's mind, which is a House Bill 20 -- 6626, Senator Looney have some time ago billing for emergency rooms. That is you go into emergency room and a patient at an -- or a doctor at a network, you can't get surprised by a bill.

I would -- I would add that that emergency surprise billing is now being looked at in Washington D.C. and is going to be modeled pretty much after the Language Center Looney and I started here in Connecticut. What this does, it limited to or extensive to ambulance services. We've heard a lot of issues with respect to ambulance services, where people are getting these huge bills. So we want to have the surprise to also apply to those emergency transports. I'm not going to go through the rest of it. I think Senator Looney covered a lot of the information here. And I think this these bills are a step, which this committee has endorsed over the years to improve healthcare to patients and also improve doctor-patient relationships that we all value so much as a public policy.

REP. WOOD (29TH): Great. Thank you so much. I just want to say to the Committee that when people can't log in, I forward my link. So when people log in, you see Representative Wood, it's because I'm sharing my link. So Senator Hwang, you are not Representative Wood, if you just want to change your

title. Any questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And I will say I've often wondered how Senator Looney and Senator Fasano were able to cook up so much Legislation; I can see that they're in the kitchen right now. So -- where they will share their bipartisan recipes with all of us. But I just wanted to thank you both for the both the suggestions that we're hearing today, but also for the long work that you both have done to strengthen consumer protections in Connecticut. We've worked with both of you in the past as the great many items.

I don't know if you have more information you can share about the changing definition of clinical peer that you're requesting. That was one question. And the other was about the frozen formulary building know that there were some questions about how to do that. In the past, we just didn't know if they were, I think Senator targeted different approaches I didn't know you had a specific suggestion for us to how to -- how to tackle an issue.

SENATOR LOONEY (11TH): Let's just -- I think it is an issue that sometimes there may be a clinical period that might be assigned by the insurance company for review, maybe in the same specialty, but not necessarily the same subspecialty as we want to make sure there really is an apples-to-apples meeting here that these first two physicians talking are actually experts in the same sub specialty area, not just the same general specialty.

SENATOR LESSER (9TH): Great, thank you.

REP. WOOD (29TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you, Senator Looney and Senator Fasano. It's so good to see both of you together again. And Senator

Fasano, we miss you as well. And if you change your mind, it would be a blessing for our state again. I just wanted to mention about this issue with -- that you have alluded to in 1045 about some of the challenges with the medications. It's really impacting the well-being of our patients, and especially in the healthcare facilities, but also the impact on the patients and the side effects.

And as many of the patients who are on the medications are or the older age group navigating the system is having an impact. So I wanted to thank you for this well-thought out legislation and the wisdom around it. And in some of the other legislations that the two of you have worked on together. So it's such a blessing and refreshing to see the leadership that you have both shown and the work that you're doing to -- still doing to help the community at the grassroots level. Thank you so much.

EX-SENATOR FASANO: Thank you.

REP. WOOD (29TH): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. I apologize for being late in the Zoom world that we have. But it is absolutely fantastic to see both senators together. It seems like the good old days. I wanted to acknowledge that, and I apologize for coming in late. But, obviously, the good work that you all did in 2014 regarding the step therapy. Where have you seen that progress? And where do you see your Bill right now, taking that as a continual basis to provide quality patient care and giving decision-making back to the physicians, rather than, in some cases, the insurers?

EX-SENATOR FASANO: No, I will say this, we know in this building, you can't take a huge leap, right? Everything is done incrementally. And that's the best -- and that's how Senator Looney had approached all these healthcare Bills. You have to deliver

incremental. And that's the reason why this is year, what, six, or eight.

SENATOR LOONEY (11TH): Yes, yeah, yeah.

EX-SENATOR FASANO: Because we always felt that you need to ease in the change. A dramatic shift doesn't work. And if you've been building long enough, you know, each time you do something, you see how it works, it's accepted. And then you try to push it the next step. And that's what these Bills have done over the years, is show that we do have an idea of a plan, ultimately, but you get there in a step progression. And the feedback that we're getting, you know, there's going to be certain industries were going to push back because that's their nature. But after it's in, the Bills that this Committee, as well as public health have passed, as Senator Looney had put forth as well as others, have been accepted. And there's been no negative ramifications. And that's because we're doing it very slowly.

SENATOR LOONEY (11TH): By my dad, I think what we've been doing as Senator Fasano said incrementally over the years, is a strong argument against term limits, because it takes a while to do these things sometimes and to build on them incrementally. We've been working on these things since 2012, when I was a majority leader and Senator Fasano was the Deputy Republican leader at the -- at the time. So some of it has a lengthy germination period. And as he -- as he said, you have to build consensus gradually.

On this step therapy issue, again, that legislation that we passed in 2014, was focused on, yes, in some limited areas of step therapy, we want to expand that. And we -- the main concern about some of the mandates of reusing step therapy is that it delays the most effective treatments in some cases over in -- against the judgment of the treating physician who may know that patient well enough to know that

the -- what the -- what is being suggested in terms of step therapy, as preliminary treatment is not appropriate in this case, and should be able to go to something different sooner.

SENATOR HWANG (28TH): No, and I appreciate that. And Senator Fasano, I want to tell you -- share with you that my gratitude and appreciation for your leadership and mentorship in me means the world. And --

EX-SENATOR FASANO: Yeah.

SENATOR HWANG (28TH): And you are a continuing example of that, that even as a private citizen, that you continue to engage in public policy. And that may be a lesson for all of us that may go through the cycle of public service, that even we're no longer in office, the commitment to your community to making our state better is always present within you, so I want to acknowledge and thank you on that. Now, where are the hospitals on these conversations? And I apologize if it's been said already. You know, we looked at the insurers, but I look at healthcare from an entire ecosystem. And one of the biggest impact points are our hospitals. And as a source of providing these critical care and decision making process, can you share with us, you know, what the engagement and what the need is for the hospitals to play a part in this as well?

SENATOR LOONEY (11TH): Well, I would say that I'm sure you'll probably hear from them today in one way or another in regard to some of these Bills, I think there are probably some that they're certainly support about, because they have been concerned about the insurance mandates in areas where they believe that they represent the interest of physicians and the -- and patients, they're probably be others that they may not be as pleased about.

But, in general, I think that what we have tried to do is to create greater fairness for everyone. In some cases, we take steps that says, in past years, we identified some areas where we bought that hospitals were, perhaps, making profits in areas that were justified. So that for instance, the issue of trying to find a site neutral payments, that's an issue, I think that's somewhat controversial. But it is true that certain treatments since provided in certain settings are far more costly than in other settings. I imagine that's a -- that's something that the -- that the insurance industry would most likely support because of they are paying a lot more for coverage in certain areas than they are in other settings.

EX-SENATOR FASANO: You know, we have Bills -- certainly saying we have Bills that -- there's not gonna be somebody who's gonna be totally on our side on all the issues or totally against us on all the issues because it's driven by -- you know, there's a money issue involved as well as patient healthcare. So I think Marty summed it up perfectly by saying the hospitals are gonna be in favor of some of these and not others and the insurance companies do me a favor some these but not others.

SENATOR HWANG (28TH): Absolutely. And I think that fits perfectly well with one of the -- one of the ideas that we're contemplating in, in the General Assembly and in this Committee is the idea of benchmarking -- being able to use comparable data points to make sure that one facility is not charging disproportionately different from another. So it is a concept that I think Senator Looney articulated very well, addressing one of the biggest problems in regards to cost containment. So, again, I want to thank both of you. I'm sure there's other people love to talk to you. But I, certainly, am so happy to see you senator Fasano. And you look great, and maybe there's a testament for maybe life after the General Assembly. So thank you very much for joining us today. And again, thank you, Senator

Fasano for many, many years of public service. The State of Connecticut owes you a great debt.

EX-SENATOR FASANO: Thank you.

SENATOR HWANG (28TH): Thank you, Madam Chair.

EX-SENATOR FASANO: Thank you.

REP. WOOD (29TH): Representative Meskers.

REP. MESKERS (150TH): Thank you, Chairman -- Chairwoman Wood. I want to thank the Senators. I cleared this before I want to take a shout out to my mom, who turns 90 today, God bless her, Representative Meskers. Stuck between St. Patrick's and St. Joseph's Day, so [inaudible] Looney and Fasano are there in front us. God bless you -- both of you for your work.

I wanted to speak particularly to the issue you mentioned about the formularies and to address the issue which I think was personalized to me in the last two years with a constituent who came to my house after I'd been out. I'd canvassed aggressively. I spoke to a lot of people and the -- and the particular individual, you know, I want to keep privacy of the person -- of the -- of their names is a person suffering from multiple sclerosis.

And, you know, it's a progressive disease and they're stabilizing moments in it. And it requires and the medication is particular to I guess it's whether it's the bios of the -- of the medication that stabilize a person's position. And she came to me with a strong advocacy for this, because for exactly the reason you mentioned, so to personalize it, she had selected the insurance, the medication was covered. And she said, "I need to know that that medication is going to be available for the life of the policy. I can't afford to have the formulary change," because the impact on that formulary change is a marginal or significant

decline in functionality under multiple sclerosis. And what happens is, she told me in the diseases that it's progressive. And when you move the baseline with a change in medication, you don't reset back up, you basically stabilize. So when she gets kicked out of one level, the chance that she has a significant drop in her functionality, and that becomes a new baseline is a reality. So I want to tell you that I wanted to personalize that story in that people need to know that they can get the drugs that they -- when they pick up a -- at a policy, because it's for the efficacy of that drug, and kicking them out is or changing the formulary midstream is not the right thing to do. So I really want to thank you for that.

EX-SENATOR FASANO: You know, and to that point, your answer, it's a bait and switch, right? By this policy for this and then after you're in, we're going to change it. And nothing stops the insurance companies are going to balk at this. But there's nothing that stops the insurance company from calling the doctor up and saying, "Hey, we've got another drug. And this is what we think it is." That conversation to take place between the insurance company and the doctor, the doctor makes the ultimate decision for the patient. And that's fair, but to do a bait and switch just really is not fair to your point.

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

REP. NUCCIO (53RD): Thank you, Madam Chair. Good morning, again, Senators. How are you?

EX-SENATOR FASANO: Good, you?

SENATOR LOONEY (11TH): Very well. Good morning.

REP. NUCCIO (53RD): Good. Thank you very much. So you have a lot of Bills here and a lot of stuff that you were talking about. And for the most part, I

don't really have a lot of questions about the majority of them. I'd like to kind of focus my questions in on 1045 and on -- oh, boy which was other oh, 1049. So I'm going to do the easy one first with 1049. The deductible on a calendar year, do you see that as something that would happen, regardless of enrollment date of a or the start date of a plan?

EX-SENATOR FASANO: Do you want to take it?

SENATOR LOONEY (11TH): So I think we're talking about the -- basically the 12 -- a 12-month -- 12-month period. So that we want to make sure that patients aren't subject to multiple deductible costs in a relatively short period of time. And a -- and being in a position where they may be prevented from meeting their deductible because of the shift and yet they would have paid overall enough to meet what would normally have been a deductible.

REP. NUCCIO (53RD): So I'm assuming you mean if they change jobs or something because any policy -- any policy is a policy calendar year. So regardless of it's a -- you know the majority of policies in the State of Connecticut are one policies. The next biggest bump is a seven-one policy. And then the next is a 10-one policy. And those are all decisions made by employers on what their effective dates are going to be. But regardless, even if it's a 10-one policy, that policy is for 12 months, so their deductible would be from 10-one of the current year to 10-one of the next year. So from what I heard, it sounded like you were talking about a one-one deductible calendar year, regardless of enrollment date. That's what I'm trying to figure out.

SENATOR LOONEY (11TH): Right. I --

REP. NUCCIO (53RD): There's no there's no possible way for somebody to pay a deductible twice in one calendar year unless they change jobs.

SENATOR LOONEY (11TH): Right, but that's a concern is trying to provide some relief from people who for whatever reason, they may be in a situation where they wind up having a highly significant amount of out-of-pocket costs in a short period of time. Because of a -- because of policy change. And this we know as the hardship in a number of cases.

REP. NUCCIO (53RD): Okay. So -- but a policy change because of a job or a policy change because of an employer. I don't know that I've ever heard of an employer changing a plan midyear to another company because they're contractually obligated for a 12-month period. So I guess what I'm getting -- I'm confused because if you have a 7/1 period enrollment date, and you decide that you want to have your deductible by 1/1, that is a pretty much a crossing -- a nightmare from an insurance perspective because that person could have a policy effective 1/1.

SENATOR LOONEY (11TH): Yeah.

REP. NUCCIO (53RD): And I don't know how you would administer a prior company or prior policies from somebody else for the first seven months, the last six -- the last, you know, five months, and then say, but 1/1, your deductible is going to start over. And then if they leave that company -- insurance company to go to another one, you're back in the same situation. So, deductibles are on policy years. So I guess my question is, are you aiming that all policy years be a 1/1 and no off cycle policies? Or I just don't know that -- what's your -- what's your -- what you iterated in your beginning there was is something that is doable in the market without extreme cost and administration like malarkey?

EX-SENATOR FASANO: I thank your point.

SENATOR LOONEY (11TH): I think that's it --, there's certainly a point there. But it is -- it would apply to a relatively small universe of plants, only those defined -- decided tactical plans. I think that's the effort to try to provide some relief for people who are in that category.

REP. NUCCIO (53RD): Right. And -- but even high deductible plans, which I would actually argue are probably a bigger majority of plans, especially considering 80% of -- 70% to 80% of plans in the State of Connecticut are ASO, and most of those are high deductible. The -- I guess, the only way I see that somebody would have to pay a deductible twice in a 12-month period, if they change jobs. And I don't think you can tell one company that they have to eat the deductible and the other company doesn't because somebody paid something somewhere else, and they made a decision to change their job. So I'd be interested to talk to you about the language that you have in here. I understand what you're trying to accomplish. I just don't know that this piece of legislation would actually do that, I guess. So glad to sit down and talk about it. But I think I've -- I think that's enough on that one from me.

On 1045, this is a pretty complex Bill with a lot of different things in there. And I wanted to focus in a little bit what I believe it was a Senator Lesser started with the change of the clinical peer language being from similar to same. That kind of loops into your medical necessity also, because, typically, clinical peers are used to help determine prior authorizations and stuff like that. So is this ask then that an insurance company would have to have availability to every specialty of every doctor to review every prior authorization or every claim of medical necessity, because that is a structure that I don't know how anybody could ever actually implement.

SENATOR LOONEY (11TH): So I think the incentive is to try to make sure that the peers truly -- is truly

a peer. Otherwise, the peer review process, or the peer consultation processes, is not as accurate as it should be because it is supposed to be somebody who really is competent in the same not general area, but is the same -- in the same -- in the same subspecialty.

REP. NUCCIO (53RD): So my only real concern with that is if any insurance company does not have available accessibility to a provider that provides every single type of service that we can have imaginable, you are going to be building in a significant delay in prior authorization process. So that's a -- that's something -- I think there may be some fine tuning to the original language that's there. But changing from similar to same, I think you are going to have a lot of Legislative on intended consequence on that, just from the perspective of prior authorization, and the amount of time that it takes.

And that kind of got me into the medical necessity piece that you had. So medical necessity is an important tool. It really is. And is there -- is there a way we can do it better, probably on all sides? But medical necessity was built into the insurance realm because of abuses and as a protection to insurers, and also as a way to contain the cost of healthcare for providers who prescribe things that are, are excessive or not needed. You know, if you can get an X ray rather than jumping right to an MRI, you know, medical necessity is not the -- is not the bad guy here, fine tuning, looking at things, maybe changing some of the expectations of medical necessity they are. But my concern is, the more you tinker with it -- you know, if you understand insurance's role on this, it's to try to contain the costs. Like I said, you know, there was a reason that it was put into place. So I'm a little concerned with making it harder for medical necessity to be -- to be determined.

And I -- and the step therapy, I understand, I absolutely get. And I know, in Connecticut, we're already legislated that it's 60 days. But a lot of that to gets back to the employer deciding the benefits that they want to offer. You know, insurance is a contract between an employer and an employee, and insurance companies administers so I think there's room in there to talk. And then you had one comment, you said that "Doctors have less time. They have -- they don't have the time to track their patients and their care plan. And that the burden of proof should be on insurance. And I would challenge that as doctors have less patients than insurance companies have members." And ultimately, it's the doctor's responsibility to understand and track their patient's treatment plan. You know, if there's something that needs to be validated, I would -- I myself, I would want my doctor to do it and not my insurance company. So that burden of proof there on who has to have the burden of proof of medical necessity? Again, I think there's -- I'm little concern with the language mixed in there, and making sure that we're actually protecting all of the partners in this -- in understanding the actual roles of what they are.

EX-SENATOR FASANO: So, the -- so -- sorry.

REP. NUCCIO (53RD): No, go ahead.

EX-SENATOR FASANO: So, you know, there's no question that ideas cost containment that's, obviously, have to be balanced against medical care and public policy. That's the skills that I looked at.

REP. NUCCIO (53RD): Right.

EX-SENATOR FASANO: And what I was seeing is not -- if a doctor prescribes a -- I was talking to a heart doctor out of a major hospital the other day about this, because he was calling me off saying that, for some reason, he was getting a lot of medicine as

prescribed by -- for his patients seem rejected as not being covered by the insurance company. And he said to me, "You know, Len, here's the problem." You call -- you call the insurance company and say, You know, why are you doing this? Send me the stuff, you get the stuff you call them in 45 days, they get back to you, you send more stuff, you're still -- you're chasing something that they know, you don't have time to chase. And if I've got to do that for 12 patients, that's all I'm doing all day long, I'm not getting patient care. I'm fighting a bureaucrat insurance company over an issue that I have to figure out, "I'll give you the stuff but I got to figure what their issue is. And then I get to prove almost a negative to them. Why don't they prove to me what their real concerns are, let the burden be with them and I react to it? As opposed to me reacting to they're saying no, on some study.

And his argument was sure; you're tracking your patient as a doctor, no question about it. But when you're being denied a drug and you've got maybe 500 patients, because you work for a hospital, and you're the cardiologist for that hospital. And so, yeah, all sorts of people coming in out of the hospital every day, and the medicines being rejected and so it's up to you to take on the burden of 10% of those patients to go through the insurance company is extraordinarily time wise not the best interest of using a doctor for that. So they say, "Well, then I have to hire a nurse to or some practitioner to chase it all down." But that doesn't really get you very far. Now you're adding more costs for the hospital that we all pay for.

So why not, if someone is complaining, why not make it, as I think, Senator Looney, said the legal procedure generally followed throughout all our cases. And what as lawyers, you have an objection, state your objection, make it clear, put the burden on them, and then let the doctor react to that burden. But the way it is now, it's too scattered on and the odds are -- and the insurance companies

know this. The odds are you're not going to fight all of them because you haven't got the time. So you got to pick two or three is a doctor and the rest you got to just say, "It is what it is". I hope it does good policy, in my view,

REP. NUCCIO (53RD): I 100% see where you're coming from. And I guess maybe that's a good delineation to make. If you're talking about this from a -- from a prescription drug perspective or a formulary perspective, then I see that. I can agree with you on pretty much most of what you said there from our formulary or a -- or a drug perspective. You know, I think -- I don't know a single person who hasn't had issuance of a drugs, and the -- then they try something different. And you know, this one works, but now you get a 51 to get there. And I absolutely agree with that. My concern is when the language is written, vaguely, and it now covers medical necessity, and every aspect or burden of proof on every aspect.

EX-SENATOR FASANO: I'm with you. I understand. And if you want to know that language down to, you know, a drug issue and see, you know, once again, it's these urges. So --

REP. NUCCIO (53RD): Yeah.

EX-SENATOR FASANO: And see other flies, I think --

SENATOR LOONEY (11TH): Yes, Senator.

REP. NUCCIO (53RD): I would definitely be in favor of that, because that would also help us contain the cost of drugs, which, you know, understanding that sometimes the drug that they want you to try is a more expensive drugs than the other drugs. So, absolutely, if we could narrow that language down to be more honed into the drug formulary or the drug aspect of medical necessity, I definitely think there's language there that we can work on, that would accomplish what you want to do, without

broadening it so wide, that it starts to hit all medical necessity and prior authorization. So I appreciate that. And I'm the new girl. So I don't know how I would even go about doing that with you. But I would very happily sit down to look at trying to find a way to improve that language. And thank you very much, both of you for coming in and answering my questions, I appreciate it.

EX-SENATOR FASANO: Thank you.

SENATOR HWANG (28TH): Thank you.

REP. WOOD (29TH): Thank you, Rep. Nuccio. Next up, Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. And I wanted to start with a disclaimer. I do not work for an insurance company. I'm a physician and I look at things from a lens of consumers. I think the language the way it is, is accurate and appropriate from the consumer's perspective. Look, here's the reality, what happens. I will give you some examples. And then I will go a little bit deeper into it, and I would respectfully ask that we do not change the language and water down, because that will just tell the entire purpose of saving or taking care of our consumers.

My Secretary a few years ago left who have been working for me for 16-plus years. And she left because she was on hold on the phone literally the entire day just to get approval -- prior authorization of a rescue inhaler, the most basic inhaler for respiratory asthma patients to get a rescue inhaler, and the insurance companies would make her hold on the phone for 45 minutes. And it was either me on the phone to get the basic rescue inhaler, or it was her. And then and she said, "Look, I wanted to greet people, I wanted to dress and smile at them. And I'm listening to this music on the insurance company side." So this is the bureaucratic disaster that has been created because

some of the people give up and they say to the patients, "Sorry, we can't do it, go buy your medicines from Canada, and you will not be able to do anything." And that's what's happening. And that is actually a financial benefit from an industry that has actually mastered some of these technologies to restrict people from getting the medications.

The other thing about the burden of proof is the physician, the clinician who has spent many years specializing in that area is rewriting a prescription. So they have already -- he or she has already made a decision about what the patient needs. There is industry that is saying, "No, we refuse to give it." So the burden of proof should be the one who is not giving it rather than actually putting it back on the clinician and then trying to claim that while they still have to prove that they needed is not accurate. And I think Senator Looney and Senator Fasano, you're on the right track. The burden of proof is supposed to be on the insurance industry side because the physicians have already done it.

Other thing is that if you talk to the neurosurgeons, you talk to ophthalmologists, retina specialists, they would have their medications, some of the things, and then are refused by a retired family practice doctor, retired surgeon who actually is an M.D. or a D.O., who's actually spent -- well, sorry, we can do it because he does tell you the or she carries the name of an M.D. at the end of their name except they don't have the information and the depth of what is going on at the current time. And that's part of the challenging thing that we have seen the industry and then that is actually just filling a check box, "Yes, there was a doctor who said no to you."

And then -- and you're absolutely right Senator Fasano, for a cardiologist, for an arrhythmia issue and a medicine that they need for the arrhythmia,

they're not looking at the cost of medicine, they're trying to look at how they can save the life of that patient, because the arrhythmia is going to kill that patient. And having to wait and fight with somebody who does not even understand the impact of that specific medicine, it is unfair to the patients, and it's life threatening to the patient.

So I believe the way you're viewing this legislation is going to save patients' lives, and then give them time to be able to spend it with their loved ones and also allow the clinicians to see more patients. So I just wanted to put my perspective and thought in there as well. And, again, and I start with the disclaimer that I don't work insurance companies I don't plan to, because I think that I'm more interested in consumer support. Thank you so much.

SENATOR LOONEY (11TH): Thank you.

REP. WOOD (29TH): Thank you both, Senator Looney and Senator Fasano. That was -- thank you for your time here this morning.

EX-SENATOR FASANO: Thank you very much.

SENATOR LOONEY (11TH): Thank you so much to the Chairs and Members of the Committee. This Committee does very important work on an annual basis and much of its work has been recognized nationally over the last several years as being at the forefront of consumer protections and making good healthcare insurance policy. So thank you very much.

REP. WOOD (29TH): Thank you. Next up, we have Senator Berthel, followed by Representative Borer.

SENATOR BERTHEL (32ND): Good morning.

SENATOR LOONEY (11TH): You wanna leave? Are there any more questions for us? I guess we're done.

SENATOR BERTHEL (32ND): Chairman Lesser, Chairman Wood, Ranking Member Hwang, Ranking Member Pavalock-D'Amato and Distinguished Members of the Insurance and Real Estate Committee. I am State Senator Eric Berthel. I am testifying today in support of Senate Bill 1007, AN ACT REQUIRING HEALTH INSURANCE AND Medicaid COVERAGE FOR THE TREATMENT OF SEVERE OBESITY. I have submitted my written testimony, which I would encourage you to please take a look at and I will not read that to you, because you can all, at your leisure, take the time to do that.

What I did want to share with you today -- and this is I think the third time that that a Bill of this legislative intent, if you will, has been proposed. First of all, I want to thank you for creating a Committee Bill and incorporating the language from my original bill of Senate Bill 90 into this. I'd also like to thank Senator Anwar, for your interest in this Bill again, this session. As a physician, I know that you encounter -- you encounter in your practice individuals who are suffering from the disease that is obesity.

But I sit before you this morning, not only as a legislator, but also as an obesity survivor. I am a patient who has previously had bariatric surgery. It was a procedure that dramatically improved and changed my quality of life. Obesity has officially been classified as a disease by the federal government it is not the surgery that corrects -- morbid obesity is not glamorous surgery or something that people do, because they just want to feel better.

The end result in reality and in practice is that individuals who undergo proper bariatric and metabolic surgery end up getting their lives back. They get rid of many of the common comorbidities that come with obesity, things like diabetes, hypertension, other forms of cardiovascular disease, can all be properly mitigated and even reversed as a result of successful improper bariatric surgery.

Today, you will hear from many doctors, who I know are signed up to testify before you, they are the medical experts with respect to how this surgery changes lives and improves outcomes. And I think based on the written testimony that they've submitted, you're going to hear about their results, not only with children and adults and seniors, but also how COVID has affected people with morbid obesity, people of color are victims of higher incidence of comorbidities because of morbid obesity. And I think all of this will prove to you, at the end of the day today, that this is something we should be doing Connecticut is one of the few states in the nation that does not require coverage for bariatric and metabolic surgeries.

And I would encourage you to -- you will get a fiscal note back on this for sure. I know Senator Lesser and I have talked about that in the past. And, Senator, thank you as well for your continued interest in the -- in the bill. But I think that when you look at the -- you look at what will ultimately come back as a -- as a fiscal note, and you look at how this positively changes and affects lives, and the long-term cost savings, when we can possibly prevent a stroke, we can prevent reliance upon certain medications that are very costly going forward for treating those comorbidities, you'll see that there's actually a pretty good return on the investment. So thank you again, for a few minutes of your time. I think I may have gone over my three minutes. Thank you for the indulgence, and I'm happy to answer any questions of the Committee. Thank you to the Chairs.

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

SENATOR LESSER (9TH): Thank you, Madam Chair. And thank you, Senator, for coming back before us with this proposal. And you and I have worked on this in the past. And I thought it made sense previously,

but it's impossible to ignore the crisis of the moment the fact that we are in a global pandemic, and the overwhelming evidence that severe obesity is a risk factor for COVID-19 -- at COVID-19. So making sure that we're giving doctors the tools that they need to serve their patients and make sure that they are safeguarding public health seems like a worthy goal and something we're focused on these days.

I know we're gonna hear from an awful lot of members of the medical community today, and it's going to be a long hearing for us. But I'm glad of our bipartisan work on this issue of in the past. And I know that there's a fiscal note, but perhaps we may be able to tackle this here. So thank you for coming back before us and I look forward to hearing from the relapse -- the doctors who -- and patients who are going to share their stories, and thank you in particular for sharing your story. I know it's important and powerful and hope to work with you on this.

SENATOR BERTHEL (32ND): Thank you, Senator. And I will tell you that one of the individuals who is -- who has submitted written testimony. I believe he signed up to speak with you this morning is Dr. Neal Floch from Norwalk. He lives down along the shore. His written testimony provides all of the scientific and statistical information, as it relates to the -- among other things as relates to the impact of COVID-19 on people who are suffering from morbid obesity. So I would encourage the Committee to take a closer look at his written testimony, in addition to whatever he may say before you today, but thank you for your support and understanding of this very important piece of legislation.

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

SENATOR ANWAR (3RD): Thank you, Madam Chair. Senator Berthel, third time is a charm.

SENATOR BERTHEL (32ND): Yes, Sir it's going to, hopefully.

SENATOR ANWAR (3RD): Yes, Sir. Thank you for your advocacy on this. And thank you for your persistence. I think the last time around was the COVID that got this Bill stop better. Like I've said before, this excellent Bill much needed. And there is a cost. Every time, if you are going to look at it from the lens of how much is it costing us, we should look at how much is it going to cost us if you don't do this. And that's where -- there's so much saving in the chronic illnesses that are there. I -- who have witnessed numerous patients get their lives back passionately agree with you. And I want to thank you for your leadership in this effort. And I look forward to supporting it.

SENATOR BERTHEL (32ND): Doctor, thank you very much. I appreciate that. And I look forward to working with you and the Committee to do what we have to do to get the legislation passed. Thank you for your support as well. I appreciate that very much.

SENATOR ANWAR (3RD): Thank you.

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

SENATOR HWANG (28TH): Thank you, Madam Chair. And welcome, Senator Berthel. And thank you for your courageous advocacy of this important issue. And as you know, there's always a cost benefit analysis, right? And before this Committee this year, we are addressing the concerns in regards to healthcare and insurance costs in our state. But I want to take a step back and what I've learned from you, as a colleague, it is the fact that you have educated me that obesity, challenged by the societal perception and the stigma, is not an issue of, you know, a lack of willpower of individuals. It's not an issue of cosmetic when you're looking at bariatric surgery.

It is a health and well-being issue. And what I also learned from you is the fact that not only is it an issue of a cost to do the surgery, but also the savings that will result from the other bits of health challenges that you described earlier.

So it's really important that when we do this cost benefit analysis, and for those that challenge the fact that we may be yet imposing another health mandate, I think this may be one that significantly is a value added for those that are looking to take control of their health, and it's never easy. That being said, What are your thoughts in regards to your personal experience from a cost benefits and health benefits basis of what you have gone through?

SENATOR BERTHEL (32ND): Senator, thank you. And as my good friend, I appreciate the -- your question this morning, and sharing your -- the relevance of our relationship as Senators and a lot of the time we spend together in our caucus and what have you. And thank you for the question. I -- you know, I'm pretty open about my experience, because I'm so passionate about wanting to do what's right here and helping others who currently don't have access to bariatric and metabolic surgery procedures.

But in direct response to your question, when I -- when I -- prior to my surgery, I would -- I was looking at what would have been now in my life, you know, four or five years ago, probably being a diabetic, probably being hypertensive on medications to treat that, that we're really just treating the symptoms and not the cause. And that's where we're occasionally -- medicine can go -- can go off the -- off the track, if you will.

Because if you don't actually get to the systemic cause of something and fix it, then you're not necessarily changing the quality of life, you're not changing outcomes, you're just helping someone to survive in that moment. And that would have been, for me, probably a very different quality of life.

And in a longer term, maybe 10 years or five years from now, it might have taken my life. And that's something that should -- that a lot of people face and a lot of different medical conditions that they have.

But for me, it was a profound change. And a -- it gave me my life back, quite honestly. And, and it is a -- let me be perfectly clear, it's a challenge every day, it's not a one-time-fix-all kind of -- kind of procedure, nothing is. It's something that you have to be -- that, as an individual, I have to be cognizant of and aware of and conscious of, for the rest of my life, in order to take advantage of the gift I was given, which was a change to my anatomy, to fix a disease. So yes, the return on the investment is large, much larger than the initial cost. And it absolutely takes -- it takes that kind of foresight to look at this and say there's initial costs today. But the long-term benefit is really amazing.

SENATOR HWANG (28TH): Well, absolutely, and you are an incredible role model in that perspective. But you said a key word that sometimes we need to fully understand this issue and why you're looking to have some financial support through the insurance products that we all buy is, ultimately, you said this was a disease. This is not in -- a reflection of people's lack of willpower, is not a cosmetic means of making a change. This is a medical procedure to address an illness, and an illness that is not -- and, you know, wished upon by many -- by people. So does that change the pivot for you as an experience?

I mean, as a -- as an acknowledged fiscal, conservative advocate, I know you respect the taxpayer dollars and insurance premium dollars, I know that. But what does that mean to you when you start repositioning this is not just simply helping people with lack of willpower -- keep looking for cosmetic improvements.

SENATOR BERTHEL (32ND): So, right.

SENATOR HWANG (28TH): But it is a disease.

SENATOR BERTHEL (32ND): Thank you for the question, Senator. That is absolutely 100% correct. There's a stigma that's attached with people being overweight and being obese. And I think that the stigma goes down to this, boils down to this. You look at someone who walks into a room who's overweight. And whether you think this consciously or subconsciously say, "Wow, that person just can't control how much they eat. And that's why they're so big."

And I can assure you having been that guy that it's not a matter of not being able to control it. If you look at -- and I think -- I think there's a couple of people signed up to testify before you today that are the medical experts, doctors that actually deal with the metabolic side of obesity. That will tell you that this is a psychological issue. This is actually the way their genetics are programmed. They -- and how they how they overeat.

So the ability to go and make an -- and a -- change the anatomy -- anatomical change gives that person a tool, if you will, is that's how it was presented to me. It's not going to necessarily cure me of the desire to eat too much. But it prevents you from doing that. Okay? And that's part of what bariatric surgery does and metabolic surgery does.

And that's where good medicine and good practitioners come into play. And they're so important. And you're going to hear from some of them that they can provide the tool, but they also have to provide the education and the support while going forward. And some of that may require the use of some pharmaceutical products in the long term to help the -- help the individual control the disease. It's not a one-time one fix.

But to your point, this is absolutely not something that is done for glamour. This is not getting the facelift or having a chin bones made higher or whatever, you know, cosmetic surgery, this is something that truly saves lives. And I am a living example of that sitting before you this morning. And I think that there are many others out there -- I don't know if we have any other patients that will be testifying today, but I'm living proof that it works. And it gives people an opportunity to take back control of their life with good medicine, proven medicine. And as I said before, the return on the investment is tremendous over time, and it does change people's lives.

SENATOR HWANG (28TH): And I appreciate that. And then I thank the Chairs for the indulgence of time. But it's not only just a physiological impact, there's a mental health impact as well. And it's not just the mental health of you as an individual, as you have taught me so much. But it is also the mental health perspective of how others react to you.

SENATOR BERTHEL (32ND): Sure.

SENATOR HWANG (28TH): And we have to acknowledge, as we talk so much -- so much this year in this building, and rightfully so about the perception and bias that we have in our culture. We also need to acknowledge that we have bias against people's body shape and sizes, and that we also need to recognize that it forms and shapes us.

So that being said, what you have demonstrated as a colleague, but also an individual that have the courage to step up and be a role model for so many others, that may be contemplating this to take this step forward for their better health is something that I greatly admire. And I'm so glad that you and Senator Anwar, on a bipartisan basis, is working on making this go through the process.

But also, I want to acknowledge that for those that may be concerned about the cost benefit analysis of health mandates, this one in the long run, may end up saving healthcare costs. So through you, Madam Chair, I want to thank you for the indulgence of the time with Senator Berthel. But I'm truly impressed. And always, always proud to call you a friend. So thank you.

SENATOR BERTHEL (32ND): Thank you, Senator. Thank you, Senator Hwang.

REP. COMEY (102ND): Thank you very much. I'll be jumping in right now to Chair the meeting. So our next -- Rep. Farrar, you're up.

REP. FARRAR (20TH): I think Representative Delnicki was before me, so I yield to him.

REP. COMEY (102ND): Okay, that's very nice. Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Madam Chair. And thank you, Representative, for yielding. You know when I first met you, Senator, I never would have guessed that you had that issue. And then I went back into my memory bank here. And, literally, I can remember the first time I met somebody who I hadn't seen in probably a year, year and a half that went through the procedure. And when I saw them, it was a totally new person with a high amount of energy, with such a positive outlook on things. It was amazing. And I've got to tell you, there has to be a tremendous savings in the long run. Just avoiding diabetes in and of itself would easily pay for the front end cost of having the surgery, not to mention other maladies that you can end up with.

But to see the emotional and physical well-being in and of itself, was truly amazing -- with a friend of mine years ago. And, of course, to hear you testify

here so enthusiastically about the -- in essence, a new lease on life.

SENATOR BERTHEL (32ND): Yeah.

REP. DELNICKI (14TH): And that kind of energy and stamina and positiveness in and of itself proves the point. And I wholeheartedly support it. I know we've had the conversation in the past, that I truly hope we can get that law passed and that coverage provided, because I do believe, at the end of the day, it will save a substantial amount of money when it comes to healthcare costs, not to mention the benefit to you, and to friends that we all have that have that surgery, and how it benefits them, and society as a whole. And then I thank you for coming forward.

SENATOR BERTHEL (32ND): Representative Delnicki, thank you. Thank you for your kind words. Thank you for sharing your perspective on that. And I agree with you, I appreciate your support. And thank you. That's -- I think all of that is very -- is spot on. It really, really makes good sense. And I appreciate your support of the Bill as well. Thank you.

REP. DELNICKI (14TH): And, again, thank you, Senator. And thank you, Madam Chair.

REP. COMEY (102ND): Representative. Representative Farrar. Senator, thank you for being here. As new Legislator and new to this Committee, I'm really thrilled to see this Bill, and I appreciate you coming before us. And as someone who has worked on a whole range of preventative mechanisms at the community level to change, really, as you noted at the outset, the systemic causes that can be at the heart of obesity in our communities, I appreciate you highlighting that in your testimony.

I think what I just wanted to ask you about since some of my colleagues have really eloquently allowed

you to share your story is I just wanted to ask you a bit about, you know, how we, in our state right now, might compare to other states and what we can learn from other states and how they've approached this very issue. That would be helpful to me, especially seeing and hearing from you for the first time. Thank you so much.

SENATOR BERTHEL (32ND): Sure. Thank you, Representative. Congratulations on your election to the General Assembly. And thank you for the question. So I am -- I am absolutely not the expert with respect to other states. But I can tell you what I do know from a general standpoint.

I believe from the last time I looked at this, Connecticut is one of eight states in the nation that does not provide or does not require insurance companies to provide coverage for bariatric and metabolic surgery. So Connecticut, generally, is a leader in -- no, in healthcare and medical coverage for procedures, and I think some of the doctors that will come before you this morning and I'm certainly into the early afternoon, will be able to state much more eloquently to that.

But I guess I would say to you that since you have a -- some awareness and cognizance with respect to how programs like this and coverage like this affects community and what have you, that it's time for Connecticut to make this change and to bring some good additional medical coverage to our residents.

You know, as a point of reference, we have parts of our coverage under various state programs that include paying for metabolic and bariatric surgery. So at some point in time, a decision was made to include that as part of -- part of our state-sponsored plans. And it was -- I'm certain done for the right reasons -- all the same reasons that we're talking about today.

But I hope that the people that come after me this morning and testify will be able to, perhaps, write you a little more detail to in answering your question, but I thank you for your comments as well. And again, welcome.

REP. FARRAR (20TH): Thank you, Senator. I appreciate your brief commentary on that. And as you said, we don't want to leave our Connecticut residents behind. And I appreciate your advocacy, and I really look forward to hearing from others today about this important issue. So thanks for being with us.

SENATOR BERTHEL (32ND): Thank you, Representative.

REP. COMEY (102ND): Thank you, Representative and thank you Senator Berthel for sharing your story. I know that the worst is stop at all at the surgery and that it is an ongoing -- an ongoing job -- second job if you want to call it to meet --

SENATOR BERTHEL (32ND): Indeed.

REP. COMEY (102ND): To maintain -- to maintain that of the health of your -- of your -- of your body. So thank you so much and we will go to if we have any other questions on us.

SENATOR BERTHEL (32ND): All right, thank you very much. Thank you for the opportunity to speak with you this morning.

REP. COMEY (102ND): Okay, so next we are going to extend this. It's been a little bit over an hour. We are going to jump in with Representative Borer the next and then we will rotate into the public. The next person after Representative Borer will be James Kritzman, followed by Ted Doolittle, and then we will open for now. So Dorinda, I think --

REP. BORER (115TH): Yep.

REP. COMEY (102ND): Go ahead.

REP. BORER (115TH): So good morning, everybody, Senator Lesser, Representative Wood, Vice Chairs, Senator Anwar, Representative Comey, our Ranking Leaders, Senator Hwang and Representative Pavalock-D'Amato and all these and Members of the Insurance Committee, thank you for allowing me to testify in support of Bill 6623 today regarding acknowledgement of claims for property damage. Currently, there are timeframes for which you are required the insurer to report damage to your home. And I'm gonna use the example of -- which we saw a lot of in 2020, and three hits your home.

You have 60 days to notify the insurance company and provide proof of that claim. And then you work out what the -- what the damages with the insurance company. And then on the back end, the insurance company has a certain timeframe once you agree to an amount when they have to pay you out. So there are no timeframes in the middle of that process. So as the insurer you would report the damage within 60 days. There is no timeframe of which the insurer -- the insurance company needs to acknowledge your claim, or needs to resolve and agree to the amounts of your claim. So, technically, that process in the middle can take an extraordinary long time. So you can report your claim within 60 days, but it can be a month -- it could take a month for the insurance company to come out, assess, acknowledge and agree to the amount of that claim before they agree to pay it out.

So the National Association of Insurance Commissioners has recommended the timeframe for those steps and a number of states have adopted those timeframes. And what they are is after you provide proof within 60 days, the insurance company has 15 days to acknowledge your claim. And they have 21 days to resolve what the value is of those claims. And then the time paying you out -- paying you were paying you out begins.

So we have folks that incur significant loss and financial damage. But that timeframe is waiting for the insurance company to respond and let you know that that -- those damages will be covered is a waiting game. And they're left, you know, in the dark, no pun intended, not knowing that the insurance company has accepted their claim and what the value of that claim will be. So it's very consumer friendly. I think it's very reasonable timeframe for the insurance companies to adopt your Connecticut, as they have adopted in so many other states. And I know -- you know, I look back at store -- my day, and I know the insurance companies were --

REP. COMEY (102ND): I guess not.

REP. BORER (115TH): Overwhelmed. But like our utility companies, they need to be prepared, and they need to have assessors in the queue and they need to be able to go out, assess that damage and be able to respond to it timely.

REP. COMEY (102ND): Thank you very much, Representative. Do we have any questions? Seeing none, I will say that, yeah, we as representatives, you know, as we hear from our constituents all the time when there's big storms in our community, and it's taking forever for them to sometimes -- they have to move out of their home. And then -- and then it all depends on them fixing --

REP. BORER (115TH): Right.

REP. COMEY (102ND): And moving back in and add a couple of those with the [inaudible].

REP. BORER (115TH): It's -- I think just the acknowledgement gives them some assurance that, "Yes, you've received my claim, yes, you're going to pay for my claim." And then they can get started on the work. You know, if you have a broken window or

roof damage, and you're trying to figure out how you're going to pay for that, at least some assurance that is acknowledged it's going to be paid for and you can start to work in and get going on repairing your home. And so, we saw several of our constituents in this situation back in the fall.

REP. COMEY (102ND): Thank you so much. And thanks for bringing this pro consumer Bill forward.

REP. BORER (115TH): Okay. Thank you, everybody.

REP. COMEY (102ND): Okay, thank you. So, next we're going to go to Members of the Public, as we do after we hit the hour mark. We have Dana Kritzman and Harold Kritzman as a double -- a double whammy here. Welcome to the Insurance and Real Estate Committee.

HAROLD KRITZMAN: You again I mean -- hi. I'm Harold Kritzman of Newington. I'm going to introduce my wife, Jan Kritzman of Newington who's gonna do all the talking.

JAN KRITZMAN: Greetings Chairman Lesser and Chairlady Wood, and Members of the Insurance Committee. My name is Jan Kritzman. I live in Newington. I'm an eight-and-a-half year breast cancer survivor. And I'm a patient advocate for dense breast tissue awareness and the early detection of breast cancer. I support H.B. 6626, especially sections 24 through 27. Here's a terrifying statistic. Connecticut is number two when the nation per capita in cases of breast cancer. Some years went number one, 3,500 plus newly diagnosed cases of women annually, plus some 250 men. Now let's talk about Section 24 first.

You see, the essence of this Bill is to provide with the early detection of breast cancer, it's only logical to conclude that the earlier information and awareness is taught the better. I suggest that this information to be part of the state of Connecticut

guidelines for health education in the schools starting as early as perhaps middle school when girls become women develop breasts to notice changes in their bodies. I think it's a good time to start teaching them about breast self-exam, and, by the way, young men to learn about testicular cancer and self-exam also.

In class, I would receive uniform standard lessons with an opportunity for Q&A with a qualified educator. All of these diseases are known to occur at a very young age. And also I have particular concern for young women of color, because it's very important in several medical journals recently that quite young, they develop breast cancer, often triple negative, which is the most difficult to treat. Outreach and early detection in this demographic are a critical importance.

Another suggestion, how about more funding for community outreach programs, for example, this project in Bridgeport. It distresses me no ends that I'm here testifying on breast cancer Legislation for Connecticut without my mentor and life-saver the late Dr. Nancy M. Cappello, PhD of Woodbury, Connecticut, Founder, with her husband Joe, of AreYouDense.Org. Nancy passed away in 2018 from complications from the treatment she received 14 years prior for the lead stage 3C breast cancer.

Our mission, with the help of you, our Connecticut legislators resulted in 2009 with mandated notification first state in the nation to women of the breast tissue density, with five milligrams in height, small early stage breast cancers, and urge the need for essential follow-up testing with breast ultrasound or MRI. By the way, 40% of women have dense breast tissue. This Legislation, as I do, have dense breast tissue saved my life.

Today, I'm asking you, my Connecticut legislators to repeat your enlightened legislative performance of 2009. H.B. 6626 will expand insurance coverage,

from the screening to both screening and diagnostic testing, with no out-of-pocket costs. For the record, breast tissue density notification became federal law in 2019. Because of Nancy's state-by-state global efforts --

PETER MURSZEWSKI: If you could summarize your testimony.

JAN KRITZMAN: I am -- 10 more seconds. Now granted, other states have some bits and pieces of H.B. 6626. But Connecticut would be the gold standard elimination for early detection breast cancer Legislation, as well as recognition of other predisposing conditions, which we'll see in other sections. would have any out-of-pocket costs for essential follow-up testing. Is there any other questions you'd like to ask me, I have to -- yep.

REP. COMEY (102ND): Thank you. Thank you, Jan, thanks for your testimony. And, you know, Connecticut being the gold standard, and something that certainly -- that saves lives would be certainly something we can all get on board for. I'm going to open it up to the Committee. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And, Jan, how -- it's good to see you. Full disclosure, you are constituents of mine. And I know that you worked as well with Representative Wood, Representative Turco on this really important legislation. So it's good to see you. And, yes, you are a force of nature. I -- if we had a lot of trouble saying no to your requests in the past, then you are a one heck of an advocate for all people [inaudible] facing breast cancer. I want to thank you for all that you do. You mentioned a few things. And some of them do go beyond our cognizant as a Committee, we obviously focus on insurance coverage. And that's what we can do -- some of the things about education. Now, we -- a little bit trickier for us to address in this Committee. There

are other Committees that are probably more focused on that aspect.

But I, specifically, wanted to ask you about the issue of diagnosis versus screening, because, you know, I like to talk about some of the important work we've done -- the bipartisan report we're gonna expand mammogram, breast ultrasound coverage. And then we get some surprise and sort of upset phone calls from folks who thought that their procedure was covered and discovered that it wasn't. In some cases, it's because they have insurance is not regulated by the state because it's health insured plan or is Medicare. In some cases, you know, it's because of this diagnostic versus screening issue. So can you tell us a little bit more about that and why some things are covered or some things aren't?

In 2019, I -- Representative Dorinada Borer actually contacted me because she knew I had some knowledge about this. And the Bill was proposed in the past in 2019 to cover just screening, mammograms, ultrasounds and MRIs. And that's a lot of confusion, I think began with that because if coding isn't properly, if coding was for diagnostic ultrasounds and so forth, and we've got a surprise Bill but wasn't covered. So this happens quite a bit. And I was talking to my -- Representative Gary Turco, and we discussed it. And I said, "I've got to come back again, this session to point out that screening and diagnostic testing for mammograms, ultrasounds, and MRI has to be -- the law has to include diagnostic also." And I think that would eliminate a lot of the confusion. And it will definitely help in detecting early stage breast cancer.

And take note, you know, there's no prevention for breast cancer and there's no vaccine and there is no work speed. And the only tool we have in the toolbox really is early detection. And this Bill, which is far and wide, to provide this. I want to [inaudible] if that's okay with you for the

insurance company lobbyists who may be interested. Early detection may involve, very simply lumpectomy and radiation. It's not really simple, but it's -- how should I say? That's early stage treatment of most often.

Cost to the insurance company or maybe $30,000 dollars to $60,000 dollars for testing and for doctor visits and medication and surgery and the radiation, late-stage detection, like stage four, which is a terminal diagnosis, that shortens lifespan, involving most often, what they call slashed poison and burn, clinical trials and more clinical trials, chemotherapy, scans more scans own maybe about $0.5 million dollars. So ignoring the vast difference in the cost between early and late diagnosis is very bad business. Insurance companies, you have to listen. Don't be pennywise and powerful, the bottom line is early detection, not only saves lives, but it saves money.

For the record, I hate pink. Never was my call. And I get exhausted talking about breast cancer all the time. But if it will help pass H.B. 6626, I will wear shocking pink. And I will never stop advocating for this most life-saving mission. So give a damn, get a mammogram because all breasts matter.

SENATOR LESSER (9TH): Thank you, Jan. I don't have a whole lot to add to that you are a -- you are a force of nature. So thank you for gracing us with your presence and for doing what you're doing to try to save lives.

JAN KRITZMAN: If anybody wants to be on the other side of this, my son-in-law bought this for me a while back and they're my shocking pink Everlast boxing gloves, and I'm willing to use them against any -- against of this Legislation. We're Connecticut. We have to be the gold standard. We have the number one girl's basketball team, I want

the number one protection from women of early-stage breast cancer.

REP. COMEY (102ND): Thank you, Jan. Thank you so much. Will you come back at the end of the day when we're tired and we need a little pick up?

JAN KRITZMAN: This is -- this is very important. I have one more thing and then really if you have any questions, I will -- I will be quiet. This is a picture of Nancy Capella, the late Nancy Capella. She did not invent dense breast tissue. She invented dense breast tissue awareness. This is a picture of Sandy Casinello, my breast friend. She is stage four breast cancer, is 45 years old. And she'd been battling this for five -- seven years. And I want -- and she wants very desperately for women to get early-stage diagnosis, unlike what she's had to go through. And the girl in the middle. I don't -- I don't know who that is. I think maybe somebody said it was me.

REP. COMEY (102ND): Thank you, Jan. Representative Nuccio.

REP. NUCCIO (53RD): Thank you Madam Chair. Good morning, Mrs. Kritzman. I absolutely love your energy. And you may not like pink but you look darling in it, so.

JAN KRITZMAN: Oh, I look like this when I wake up in the morning, I can't help it.

REP. NUCCIO (53RD): I can only aspire to be as wonderful. This is -- this is funny. This is something that I kind of came to legislate -- to late -- Legislature and instead what -- I was a little frustrated with the Bill that was passed in the -- in the prior Legislation because it only affects people with fully insured insurance. And it doesn't mandate it across the board. And I know there's about a million and two reasons why it is like that and I'd be looking to try to find a way to

get around it because I am too one of your members of your group with the dense breasts and I have issues myself when I would go for my required mammogram and every single time they want me to then go for an ultrasound. And then, they wanted to go for another mammogram, another ultrasound.

And then quite honestly, I never could do it, because I could not afford the cost of the ultrasound, and then the second mammogram, and then the second ultrasound, it was thousands -- it was a thousands -- it's 1000s over a thousand easily. It was for all of those extra things. So I just go once a year, and keep track of the items that are of concern. And, you know, just go for it. Because that's how -- that's how it is. So, I'm definitely a supporter of trying to find a way. And I fight with myself on this because I'm always trying to find ways to keep healthcare costs down. And I love that you brought up the cost of identification early, and the cost of identification late because I think that's what we have to do. We have to look at the ROIs on these things.

And I know people don't like to talk about ROI when they're talking about healthcare. But if we can definitively show this is going to save us money in the end. You know it -- there are some people that are emotion-based and some people that are fact based. You can swing the fact based people that way. And then the emotion comes along with it. So I just want to thank you for what you're doing and for putting a little pep in my step to try to go back and fight a little bit harder for this and to make it a more broader reaching piece of legislation that doesn't just cover the 30% of people who have fully insured but as a -- as a full insurance, wellness and health initiative.

JAN KRITZMAN: May I say something?

REP. NUCCIO (53RD): You can say anything you want, dear?

JAN KRITZMAN: Oh, thank you never you. Never skip a mammogram or an ultrasound, never. COVID-19 this past year, a lot of women say, "Well, you know, I don't want to go out and I don't want to go to already mammogram radiation center, and I might catch COVID. And I don't want to get a mammogram and be wearing a mask, and I don't know how safe it is and blah blah blah, so I think I'll skip it." Now they're gone two years --

REP. NUCCIO (53RD): Yeah.

JAN KRITZMAN: Without having a mammogram, without being tested. And early breast cancers -- do you know what an only breast cancer can do in two years? It can come early to very late. For example, I was -- I have been going to the same radiology, mammogram radiologist in 25 years, starting when I was 40 until I was 65. When I was 65 -- this is eight and a half years ago -- the radiology technician said to me, "Oh, you know, don't have to get an ultrasound, you have dense breast tissue." And I said, "I think I've been here for 25 years. No one mentioned that to me. Is that -- and is that a problem?"

"No, no, it's very natural, 40% of women have dense breast tissue. The problem is we can't see anything on your mammogram, because of the density." It's like looking for snow like in a snowstorm.

REP. NUCCIO (53RD): Yeah.

JAN KRITZMAN: "So please come into the next room and get an ultrasound, it's a different contrast." So I went into -- I said, "What's an ultrasound?" Because you'll see. I went to the next room and I had an ultrasound. And guess what she found? A very tiny, early-stage breast cancer -- very aggressive breast cancer.

Fortunately, I was one of the lucky ones. But, you know, we can't face breast health purely on being lucky. It's got to be mandated legislatively, that the woman doesn't have any obstacles not burdensome, having to meet your $7,500,000 dollars deductible to get proper testing, both screening and diagnostic.

REP. NUCCIO (53RD): I agree. You know, and I think -- I think there's medical necessity that can show that. Because as you said, you know, I'm one of those people who well, "You got to come back for an ultrasound." "Yeah, well, you know, I also got to pay the bills." So I'm not out-of-pocket.

You know and it's hard because it's a -- so you do. You're right. It's just like anything else you ration it. How often can you go? And it's not every -- you can't go every six months, and this and this. So, you know, I -- 100%, I understand what you are. I'm an advocate for your cause in this. And I hope to speak to you in more detail at some point about it. Thank you so much. I really appreciate you coming and testifying today.

JAN KRITZMAN: Thank you. It's my -- it's my most important mission.

REP. NUCCIO (53RD): Yeah.

REP. COMEY (102ND): Thank you, Representative Nuccio. I share -- I share a lot of your stories of -- your similarities with your story. So thanks for sharing that. Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Jan, I do love your energy. And I want to compliment you. And it is all about early diagnosis and constant testing and prevention, right? So I really -- the stories you're hearing right now are important for people to hear and to make the extra effort to go get tested.

The other thing I wanted to acknowledge and thank you is the fact that that I want to compliment Harold. Harold's right on the side. He -- you know, he made the intro, but it's a total team effort. And I can see the kind of effort that you both put out, it's inspirational. So I want to thank both of you. And as a husband and as a father of a daughter, these are important issues for men as well, to ensure that their loved ones are -- there are -- continued to be healthy and not be just absolutely impacted by the illness of breast cancer.

That being said, I also want to acknowledge your mention of those with metastatic and stage four, cancer. I think we have to do a much better job in recognizing the unique challenge of that, as well has to emphasize additional research support, to support individuals that are impacted by that. The courage of those individuals, as you mentioned, your friend, have displayed are just -- it's hard to describe. But having been influenced and then impressed by so many of those courageous women, it really is important for us to address that as well. And I appreciate you mentioning that. So, Jan, you're full of energy, and you've given us some of it. But more important, you shared an important message. So I become a huge fan after this exchange. So thank you very, very much.

JAN KRITZMAN: You're very welcome. And another thing I'd like to say, if you folks get behind me on this and pass this Legislation in Connecticut, gold standard in the nation, I take it this piece of Legislation to Congress, and I get -- I don't know, an invitation or I get through whatever to get to as many Senators and Congressmen as I can meet in the lobbies, in the hallways, and I will tell them all about my breast, that stops them dead in their tracks. But I say, no, no, no, I'm not going to show you my breath. I'm just going to tell you about them. They're extremely dense breast tissue, and so and so on. And this is what we found in Connecticut as with the gold standard.

SENATOR HWANG (28TH): Jan, you're making me blush, okay? So stop right there. That being said, I think it's important, as we said, the other poll of -- people would testify like Senator Berthel. We need to do a cost benefit analysis, right? Because the idea of prevention is, you know, penny wise, and a better approach -- the cost savings. So, I think -- I think you will bear out and as you've advocated so effectively, the initial costs, the habits of testing are so important for the enormous cost that that people may have to endure not only from a financial costs, but the emotional, is incalculable. And I want to say again, Harold, you're a smart man to support this lovely lady, and you're a smart man to stand right beside her. So, Jan, thank.

JAN KRITZMAN: You know, we're newlyweds. We've only been married for 54 years.

SENATOR HWANG (28TH): God bless you. Happy anniversary.

HAROLD KRITZMAN: Thank you.

JAN KRITZMAN: Thank you.

HAROLD KRITZMAN: Thank you.

REP. COMEY (102ND): Thank you very much, Jan, and Harold, and we hope to see you back here soon and to -- and to do your cause justice. So -- and I appreciate your direct to ask, so it's very productive. So thank you so much. Have a nice day.

JAN KRITZMAN: Thank you.

HAROLD KRITZMAN: Thank you.

REP. WOOD (29TH): Okay. Next, we are going to Ted Doolittle. After Ted Doolittle, we will go to Joan Lunden, and then to Representative Turco. Back and forth, thank you.

TED DOOLITTLE: Thank you very much.

REP. COMEY (102ND): And welcome back.

TED DOOLITTLE: Oh, good to be here. Thanks so much for having me. I am with the Office of the Healthcare Advocate. My name is Ted Doolittle, and I'll be testifying today regarding Bill 1045. I also am accompanied today Madam Chair by two attorneys from my office, Adam Prizio. And Adam Prizio will be speaking to Bill 1049, as well as SEAN KING, and SEAN KING will be speaking to Bill 1041.

First, for those of you who don't know, the Office of Healthcare Advocate is a state agency. We offer free expert assistance to anyone who is having trouble with their health insurance, we can help with claim denials and so forth. So anybody who is out there who has an issue with their insurance or a friend or a loved one, we'd be happy to assist you for free. please contact us at the office of the healthcare advocate.

I want to associate myself with the comments on Bill 1045 in the burden of proof with regard with Senator Looney and Senator Fasano. I just want to mention that, again, my name is Ted Doolittle. Senator Looney's name is Marty Looney. Senator Fasano's name is Len Fasano. My insurance company knows me as Theodore. Senator Looney's insurance company would know him as Martin, and Senator Fasano's insurance company would know him as Len.

And that's just to say that the -- our treating physicians know the first thing about us. But, frankly, our insurers and the insurance doctors operating in other states who have never examined a patient adopt. They know me as Theodore. They know Senator Looney as Martin and so forth.

It was mentioned quite rightly, earlier in this hearing, that the role of insurance is to contain the costs. I would submit to this Committee that our costs are two to three times the cost of any other advanced economic nation. It's been a 40-year record of not being able to contain costs. So we really do need to try to look at this in a new way.

With respect to utilization review, that is review of medical claims and so forth. Let me mention that utilization review is a cost -- a very heavy cost that is almost unique to this country. So in terms of trying to get the cost down, we need to rethink, as a community, the way that we negotiate prices that includes actors -- minor actors, like the patient, but also the insurance company and the providers.

I would mention that I don't think that this burden of proof -- this idea to shift the burden of proof if a denial want -- the insurance company wants to deny a claim on the insurance company is actually revolutionary. I believe is evolutionary. And in fact, I believe it goes right along with many things that the industry is working on right now, such as centers for excellence, which is a program where, for instance, an employer like Walmart will require all of its folks who are getting hit transplants to go to a center of excellence. Well, that claim is not going to be denied, because that's a trusted provider that Walmart has selected.

There's folks will be familiar with tiers, where if you might have a lower copay, if you go with a -- with a tier, a preferred provider, that, again, is a provider that's been vetted by the carriers and is a more trusted provider, the reversal of the burden of proof goes right along with those innovations. And says that, let's take the status of our good treating physicians seriously, "Let's treat their judgment as the default judgment, let's presume that as valid." In fact, I would encourage this Committee to think along the lines of I've been

calling even deeper than reversing the bureau proof. But what I've been calling plans -- new types of plans, building on centers of excellence and tiered providers that I call "no denial health plans or low denial health plans". And that would involve minimizing the number of actual individual claims that get reviewed, and instead reviewing the patterns of practice of individual providers.

If you spent hundreds of dollars reviewing one claim, that's an expensive endeavor, if you're looking at your providers and determining which ones need education, which ones have had many, many claims that need to be reviewed, and, perhaps, rejected, then you could educate that provider. And if you educate that provider and change their practice pattern, you haven't -- you haven't saved just one claim, you saved many claims. If you educate that provider, and they don't change a practice pattern, you can escalate and go up to termination and kick them out of the network.

But, anyway, again, I want to be brief. But I do want to associate myself with the comments of Senator Looney and Fasano. The reversal of the burden of proof is appropriate. The consumers have paid for the insurance, and they are using presumably vetted in network providers. And my comments, by the way, in universal burden of proof, it should, in my view, probably be limited to in-network providers, who have been vetted and are trusted. If there is a way as Representative Nuccio was groping for or thinking about earlier to narrow it down and do a baby step rather than going full hog on reversing all offerings of proof, I'd be open to that. But those are my comments. Happy to answer any questions. As I say after me, I would like Adam Prizio to direct some comments to 1049 to and Sean to direct his comments to 1041. Thank you for your time, Madam Chair.

REP. WOOD (29TH): Thank you, Ted. Senator Lesser, would you like to ask the question about this? And then we move on to his colleagues?
Shall we go forward with everything?

SENATOR LESSER (9TH): I have a -- I have a question for Mr. Doolittle. Hey, I will hold the question for later or what -- you tell -- you tell -- you're the Chair, so you tell me when would be appropriate.

REP. COMEY (102ND): Okay, well, let's go forward in an effort to -- they don't -- I only see your hand up in an effort. Let's do Adam and Sean, and then we will we -- will hit -- take them all with questions, one, two, three. Thank you.

SENATOR LESSER (9TH): Sounds good.

REP. COMEY (102ND): Go ahead. Go ahead, Adam.

ADAM PRIZIO: Thank you, Madam Chair, Senator Lesser, Representative Wood, and Members of the Committee. I'm -- I'll be brief, but I'm testifying and support of 109 -- 1041, the Bill to regularize high deductible health plan deductibles to a calendar year.

And we will -- the Office of the Healthcare supports this Bill, because it simplifies -- it simplifies things for consumers who, honestly the concept of a deductible is one that is -- you know, we see a lot of consumers who have challenges understanding how a deductible interacts with their coverage, and anything that can be done to simplify it is beneficial. We also appreciate this Committee's attention to high deductible health plans, generally, and the way that they serve as barriers to care. This Committee -- I'm sorry -- the full Legislature convened a task force, which concluded its work last year, looking at some of those issues of high deductibles and barriers to care.

And I want to raise to the Committee's attention to proposals which also affect the high deductibles and which connect with some of the concerns that were raised by Representative Nuccio earlier on this bill. The specific issue that we were talking to her that was being discussed was people who change a healthcare plan partway through the year, and how that causes the deductible to reset.

So a majority of the High Deductible Health Plan Task Force supported two ideas to address this, to sort of establish some fundamental fairness for people who maybe have met a deductible or have contributed significantly to a first deductible. And then either they change jobs or they lose a job or they, you know, maybe they were having a subsidized plan on the exchange, and then they start a job, the deductible in their new plan starts at zero. So they have to meet two deductibles in a plan year.

So the taskforce examined the ideas of either prorating the deductible so that, for instance, if you start on July 1st, just to make it simple, your deductible would be prorated to half of the calendar year, or half of the plan year. And then that would give people who have already put skin into the game, which is the purpose of the deductible, a little bit of the benefit of having already put that skin into the game.

And then the second idea was similar, which is to give people a credit for the money that they've already contributed towards the first deductible in the -- in the second plan. We've thought that this would not affect a ton of people, but it does significantly affect those who it affects because high deductible health plans are -- you know, deductible by significant many thousands of dollars. And it's not fair to ask people to meet to high deductibles in a plan year.

It's also worth raising to the committee's attention that a very small number of people actually meet their deductible in a plan year. The recent -- a Access Health Committee meeting shows that for almost all of the plan designs, the 75th percentile or higher of consumers in the northeast have an annual out-of-pocket contribution that even comes close to the deductibles for most of the plan designs in Connecticut.

So we support the regularization of the high deductible to the -- to 1/1 of the calendar year, but also want to raise these two other ideas as ways to address some of the additional issues surrounding that. Thank you.

REP. COMEY (102ND): Thank you very much, Adam. And we will hear from Sean. Sean, give some comments?

SEAN KING: Thank you, Madam Chair. Thank you, Senator Lesser, Representative Wood, Members of the Insurance Real Estate committee. I appreciate the opportunity to share the stage with my colleagues this morning. My presentation is on S.B. 1041, which is addressing healthcare sharing ministries, and looking to put some type of regulation in place about access to those types of health coverage arrangements, that don't really exist in great market share in Connecticut, but potentially growing here in Connecticut.

I just want to highlight at first that under federal rules, healthcare sharing ministries have a fairly narrow definition. Among those parameters, they have to be tax-exempt organizations, they must be grounded in religion or faith where the members share a common set of religious or faith-based beliefs.

They have to have been in existence since December 31st of 1999, to actually meet the federal definition of the healthcare sharing ministry. And they have to subject themselves to an and an annual

independent audit that that they make publicly available.

As I mentioned, there's a -- there's a limited number of these types of organizations that exist across the country. Very few of them that that presently, operate in Connecticut, one sources has mentioned to us that there's maybe 5,000 members of healthcare sharing ministries in the State of Connecticut, at the current time.

These particular coverage arrangements are not technically insurance. They are not subject to regulation by the State of Connecticut at the moment. There are no rules in place. The insurance department does not regulate true healthcare sharing ministries in the State of Connecticut. And so without any regulations of that nature, they're free to sort of operate according to their own rules that they set up. Again, they're grounded in faith-based and religious beliefs. But they don't have any of the normal requirements that insurance companies have, in terms of having to provide certain coverage of essential health benefits of preventive services, of emergency care, things like that.

They have opportunities to discriminate against people in terms of whether or not they may be enrolled in the healthcare sharing ministry, whether or not they may cover certain things based on their health condition, instead of following the federal rules where those types of discrimination are not permitted.

In fact, these arrangements are not -- they're not contractual arrangements at all, and healthcare and sharing ministries really don't have any obligation to pay any type of claims at all. It's all subject to the discretion of the folks who are part of the ministry who make those decisions on what to cover and what not. And they describe this not as coverage but as sharing of expenses among their members.

Our offices received complaints over the last couple of years from members of these healthcare sharing ministries fall into two buckets. One is complaints that we received from folks who belong to, what I'll call, a legitimate healthcare sharing ministries that meet the federal definition that I described before where, perhaps, they did not -- they had a claim that they thought would get paid. But it wasn't shared by the healthcare sharing ministry. And they come to realize that, as I described before, the ministry doesn't really have any sort of legal or contractual obligation to pay for those claims at all.

And so, these are things that they may not have realized at the time that they were shopping for these plans or enrolled in these plans and things that weren't adequately explained to the members prior to their enrollment. And they end up having to learn the hard way, in some cases, that's what they thought they were signing up for isn't exactly what they were getting.

We've also received some complaints from folks who belong to an organization that presents itself as a healthcare sharing ministry. But it's currently subject of a cease and desist order by the insurance department and the insurance department has alleged that this particular organization does not meet federal definition of healthcare sharing ministry and is, in fact, operating as an insurer operating improperly as an insurer in the State of Connecticut.

And that -- that's the subject of some further proceedings before the insurance department that are -- that are still pending. But I just mentioned that to highlight the fact that there are other actors out there that are acting as healthcare sharing ministries, but, perhaps, may not be actual healthcare sharing ministries under the federal definition. The reason why I do that is just the

height -- is just to call your attention now to the text of the Bill, and some of the concerns that we have about the actual text. And as we look at, it's really Section 4 of the Bill that said, appears to be an attempt to regulate healthcare sharing ministries, the way that it read -- it kind of looks like it's really only regulating the broker community and kind of putting some limits on those folks' ability to assist consumers who are interested in healthcare, sharing ministries in getting them enrolled in earning a fee for it. And as part of that assistance, hopefully, they -- that brokers would also educate consumers.

And so, if this bill were to pass, as written, some of our concerns include the fact that -- that's number one, consumers would still end up having access to healthcare sharing ministries without having adequate education, about the risks involved -- the real world risks that are involved with enrolling themselves in this type of plan because now, they would not have the ability to seek professional advice from a broker, or somebody similar, to make sure that they learn as much as they can about their options and what they're buying and what they're not buying.

We're also concerned about the loosening of the definition of the health care sharing ministry that that's contained in this language. Because in essence, Section 4 defines the health care sharing ministry, basically, as any organization that calls itself one, without putting further parameters on it, like having a common set of religious beliefs, being an actual tax exempt organization having to subject itself to an audit. None of those requirements are in this definition and the concern there is that it invites other potentially nefarious actors to create these types of arrangements that, essentially, again, provide nothing in terms of the guarantee for protections for consumers in the State of Connecticut. And that leads me back to the example of the entity that is currently subject to

the cease and desist order for the insurance department.

That organization, under this definition, would be free to act as -- have been acting and probably would no longer be subject to any cease and desist order. And this would expose its members and, potentially, other new members to a lot of financial hardship if some of their requests for sharing expenses were denied on a discriminatory basis or any arbitrary basis whatsoever.

You know as an alternative to what's been proposed, our office would prefer, probably, to see more direct regulation of actual healthcare sharing ministries, requiring them, again, to fit the federal definition of what a health care sharing ministry is, and imposing some parameters on how they operate in terms of mandating -- they cover certain essential health benefits like the a federal -- like the ACA does, prohibiting them from imposing pre-existing condition exclusions, those types of things, you know, try to have them regulated, maybe not equivalent to insurance companies but on a par that protects consumers, make sure that they, their consumers who are interested in these types of arrangements have adequate notice about what they're buying and what they're not buying, what the limitations are. So those are our suggestions for, potentially, modifying this Bill, as a way to provide further protection for consumers who are interested in joining healthcare sharing ministries. Thank you for your time.

REP. COMEY (102ND): Thank very much. Your [inaudible] is very helpful. We'll go on to some questions for the three of them [inaudible]. Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair, and good to see all three of you and for your work on behalf of consumers. I'm going to confine my questions, actually to Mr. King's testimony

regarding the health care sharing ministry Bill. Because -- you know, I guess I see it very different. I think this was a very narrow products prior to the Affordable Care Act, where I think a throwaway sentence in the ACA has been taken as licensed by a new industry to spring up and sell insurance -- unlicensed insurance to consumers.

And I know that the Office of Healthcare Advocate has gotten a lot of complaints about this. I know Department of Insurance has, and I know that I have personally heard from constituents, who have been sold insurance by these so-called sharing ministries and have been harmed by it. And so, I guess the first question I had, Sean, you used to suggest that these are not, in fact, insurance products. I agree that they are not licensed insurance products.

But in 2019, the Department of Insurance found that they are, in fact, insurance products that the companies are holding themselves out. I -- you go on the websites, the companies and you see them advertising provider networks, you see them talking about premiums, you see them talking about all sorts of insurance see terms. But the one thing that they don't do is provide any of the consumer protections or any requirements actually pay the cost. That to my mind that is holding yourself out as an insurer, and that's something that the Department of Insurance is down. And I was just curious, you know, in what -- it -- do you disagree with the Department's finding? And if so, what benefits do these provide to consumers the way they're currently contract?

SEAN KING: Thank you, Senator Lesser. I appreciate the question. I don't know that we disagree with the Department of Insurance in the -- in the sense that, you know, if an organization is, in fact, holding itself out as providing insurance and they have a Web page that looks like insurance, I think -- I think we may be speaking about it the same entity that I described earlier in my testimony that

they were concerned about, but I'm not sure that -- and this may be a better question for the Insurance Department itself, I'm not sure that they consider those health care sharing ministries that are subject -- that falls squarely within the definition of the Federal Rules, whether they consider those particular entities subject to regulation under current statute and current regulation, although they could be, if that was the preference of this legislature to establish some of those rules.

SENATOR LESSER (9TH): And the Bill before it doesn't outlaw health sharing ministry, that is not a thing that the Bill dodgers seeks to do. I understand it prohibits insurance brokers from selling non-insurance products because I think there is -- I have -- I can speak, from personal experience talking to my constituents, there are an awful lot of confused consumers out there who see insurance products and they are sold then, in some cases, by licensed insurance broker.

So the Bill does not outlaw minutes -- the ministries but it does limit the ability of people to -- you know if you wanted to come up with a GoFundMe to share your health expenses with friends, colleagues, family members, co-parishioners, that is a thing that you can do. You can set up a ministry for the purpose of sharing health expenses under this Bill. But the Bill -- the bill -- and Bill does not seek to outlaw that. That's correct, right?

SEAN KING: That's my understanding of the way that the Bill read. Yes, Senator, thank you.

SENATOR LESSER (9TH): But it does prohibit licensed brokers from steering consumers who are seeking insurance into a product that does not provide any of the consumer protections you talked about, or even a promise to pay any expenses at all. And the problem I'm hearing is one after another after another, I'm hearing consumers walk into a doctor's

office, and they think they have coverage. And they turn out, they don't have coverage. Because there's no contract, there's no requirement that these companies pay $1 dollar, for anything. And they get stuck with a surprise that I had a constituent who's actually in the paper, who wound up getting stuck with a with hundreds of dollars for a COVID test because it turns out that her healthcare in ministry, which he thought was an insurance company, just decided they don't want to pay for voting. And, you know, that happens every single day. So I guess I'm not sure why we would treat these folks with any -- with can -- gloves or with any of those any fewer restrictions that apply to, you know, to other products in the insurance market.

SEAN KING: Yeah, thanks for that comment, Senator. I don't know that it isn't necessarily wise to treat them any differently than an actual insurance product either. The only thing I can think of is that because of their roots in religion and faith, that there may be actually some limitations on a state's ability to do so. But in the interest of protecting consumers, who may not know the difference between a healthcare sharing ministry and a regular insurance product, our office would advocate, you know, putting regulations of those arrangements on parity to the extent possible with an actual insurance product, put them on the same level playing field. That's the best way to protect consumers from these arrangements to the extent that that's permitted under federal law.

SENATOR LESSER (9TH): So thank you for that. And that's actually very helpful and through you, Madam Chair. Then I have a question because I don't if you review some of the testimony, we have a small amount of testimony in support other ministries, but they have some -- I don't know if you've reviewed any of that, but some doing a little bit of research, it appears that the majority of the testimony we got was in support of new rebrand of the -- one of the companies that was subject to the

2019 cease and desist letter. So I guess they've changed their names, and are now marketing this prohibited practice through a new -- through a new business. And is that -- is that your understanding? I'm looking at -- try to Google the evolving names of these ministries, but it turns out that it's the same -- the same company that existed in 2019 that ran afoul of the of the enforcement arm of the insurance fraud.

SEAN KING: Senator, I did -- I did review briefly some of that testimony. I did not explore the origins of the particular ministry that they mentioned in that testimony, so I -- unfortunately, can't really speak to that at this time.

SENATOR LESSER (9TH): And is there any value that you see to having licensed brokers or licensed insurance professionals scaring customers to unlicensed products about which there have been a number -- a large number of consumers?

SEAN KING: Yeah, as I -- as I tried to articulate earlier, it's a little bit of a double edged sword. We would, obviously, prefer not to have consumers steered to those unlicensed products. They should -- they should be enrolling in products that are, you know, subject to -- again, subject to the same rules that says insurance product have to play by, in terms of consumer protections, especially. But to the extent that somebody may come to a broker and express some interest in one of these products, we would hope that brokers would be allowed to educate the consumer who is interested in that about what it is that healthcare sharing ministries offer and do not offer, so that they can be fully aware of the risks, of going that route before they enroll in that type of an arrangement.

SENATOR LESSER (9TH): Just being - drilling down here, do they offer anything? There's no promise to pay. So they -- if they --

SEAN KING: Correct.

SENATOR LESSER (9TH): If it don't -- if you're paying premiums to a company, but they're not paying you for anything, right, if there's no promise for him to pay you back, a nickel, what do you get?

SEAN KING: We --

SENATOR LESSER (9TH): Can you say $500 dollars to the company? And they say, "Hey, we've got this provider network, we provide healthcare, etc. And there is no promise for them to pay you a nickel." What am I doing?

SEAN KING: They -- to be fair, it -- folks who are in these arrangements often do receive contributions towards their health care costs from the healthcare sharing ministry. But it's a matter of complete discretion for the folks who are running the ministry to determine whether or not to pay and how much to pay for a particular service. So there's no contractual obligation that exists under these arrangements.

SENATOR LESSER (9TH): So -- and then I think you described earlier as, you know, a religious organization, and this is an act of faith that people are engaged in. And I, obviously, we all have enormous respect and deference to bonafide religious activities, people can access their faith however they want to in this country. But when a product -- I mean if this were a case where a minister or a priest or a rabbi or an imam were going to their congregation and saying, "We're going to come up with whatever the equivalent of a GoFundMe, take care of members of our -- of our flock." That would be one thing.

But that's not what it looks like, when you have an Insurance Brokerage that's in the business, a for-profit business, in the business of selling insurance to people saying, "Hey, we've got

insurance regulated by the Department of Insurance, they're -- go through all of the rigmarole of that." But now they're in the business of pastoring To Connecticut resident, it's to me it seems odd that you would go to an insurance brokerage for faith-based practice. It does -- to me, there's a -- there's a connect -- I mean I -- you know I -- those two things seem like they're juxtaposed and that raises questions as to whether or not that is actually what's happening when you're calling up your insurance or -- because I don't usually call my insurance broker for the great life questions about here and the hereafter. I ask him about insurance questions. And so that's why I'm talking a little bit eyebrow when you're telling me that it is a faith-based operation because you know, you're a faith leader for that, you don't go to your insurance broker. You know some missing stuff.

SEAN KING: Well, I guess to your point, Senator, I -- I'm not entirely sure how individuals find themselves in a position where they are enrolling in one of these particular health plans. In some cases, and my recollection of folks that we've spoken to, they're just out on the internet shopping for low cost insurance, right? And for whatever reason, a Google search pulls up health care sharing ministry. They read something about it, it looks like it cost less. And so they decided that they're gonna sign up.

I, frankly, am not sure how much -- how many folks end up discussing it with a broker. Or how often somebody goes into a broker and says, "You know, these health care premiums are killing me, you got any other ideas?" And then a broker turns around and says, "Well, there's these health care sharing ministries."

SENATOR LESSER (9TH): [inaudible] there's no, unlike regular insurance, there is -- you are paying a premium, just like you are in any other insurance company, that I'm in a regular insurance company,

you know, you're getting your money back if you get sick. And with the -- with these, is -- they're not. And the reason they're not is because they are religious communities that are supposedly focused on obligations to one another.

And it's just -- you know, unless the unless the brokers are all graduates of Divinity School, it seems like they're just selling folks unlicensed insurance products. And like I just -- maybe I'm missing something. I just don't see -- I don't see why we would want to connect those two things, unless they really are, what I suspect they are, which is unlicensed insurance.

SEAN KING: Yeah, I mean, I understand your point. I guess that -- I guess that the knowledge gap that exists is just, you know, what really is happening on the ground in terms of how people end up in these insurance arrangements. I don't -- I mean, I do -- I think I agree with the idea that, you know, we would want to limit, again, how much brokers are steering folks towards these arrangements as a potential alternative to regular insurance. But I'm not sure how much more deeply I can answer your questions, Senator, I apologize.

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

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

REP. NUCCIO (53RD): Thank you, Madam Chair. My question is for Adam. You had -- you had mentioned something about the high-deductible health plan. And I was hoping maybe we could kind of get a little bit more information. So the high-deductible health task force you she said addressed the issue of the copay, if somebody leaves a job. And you said the two options would be prorating the deductible and then a credit for money paid in for the second plan. You had also mentioned something that I didn't get

to write down 100%, that very small number of people need their deductible that I agree with. And then you said something about the 75th percentile in New England. And I was wondering if you can first start off with maybe repeating that so I can get it down?

ADAM PRIZIO: Yes, I'm happy to do that. And I can be a little bit more precise. The March 12th of this year meeting of the Access Health Plan Benefits and Qualifications Advisory Committee was presented with data that included the out-of-pocket expenditures for, I believe, I said New England, but I want to -- I wish to prep myself, for members in the North East region, the -- and the data -- and I'm happy to submit this to the Committee after this meeting to submit the presentation. The data shows out-of-pocket expenditures for consumers in the gold, silver at various costs -- cost share variations and bronze plans. And for each of them, it's -- if you have to exceed the 75th percentile of expenditures, meaning for almost every plan, you're spending more than three quarters of people in that -- at that -- you know who bought who bought the plan at that metal level to even come close to the deductibles that are being proposed for the different metal levels this year, which is merely a way of put --

REP. NUCCIO (53RD): Is that --

ADAM PRIZIO: Putting a figure to the claim that folks don't tend to meet their deductibles.

REP. NUCCIO (53RD): Okay. Because you're saying two things there that aren't the same in industry, one is out-of-pocket max, and then one is deductible. So was it -- do know what they were delineated?

ADAM PRIZIO: This shows the out of -- the data is for the maximum out-of-pocket annual costs.

REP. NUCCIO (53RD): Okay, I'd like to see that --

ADAM PRIZIO: Which you're -- and the deductible is it --

REP. NUCCIO (53RD): Yeah, they're separate. But I'd like to see that data to understanding. So I think that's interesting. I'm not a fan of high deductible health plans, never have been, but want to get back to the question regarding the deductible and splitting it. So if somebody changes -- the deductibles are set by employers, not by the insurance companies. So if somebody is at job A for half of the year, and they pay, you know, $2,000 dollars of their deductible there, and then they go to company B for the other half of the year, I'm trying to understand what the -- what the mechanism is, because company A will have paid -- will have gathered that deductible against the expenses that they directly have to be paid to a doctor, and then they go the second one. So what was the mechanism that they were using to take like the money that was already paid at one business to another business, to apply towards their deductible, because then company B their deductible part is not going to be met? So I guess I'm just trying to track the dollars on how they're doing that. I was wondering if, you know, if they got into the mechanism for transfer of the money from a -- the paid expenses from one to another?

ADAM PRIZIO: No, I can say that, you know, these were sort of discussed at a -- at a higher level of -- as a concept that would relieve this pressure on the consumer. And my recollection is that the test scores did not get down into the specifics of the mechanism. I'm also -- you know, I think, I'll leave it at that. Yeah.

REP. NUCCIO (53RD): Okay, yeah, I think that there's a -- there's conversation to be had there. Because the whole point of the deductible is after you need this amount, then your company starts to pay their portion of those expenses. So if you're

going to use what somebody paid at company A to company B, company B is going to be responsible for the expenses quicker than the other company because you didn't meet the deductible on their side. So they're going to be paying quicker, you know, then the other -- I think it's just that -- that might be a contractual thing. And I think that may actually be a fiduciary thing also because -- but I'd -- all right, you don't -- if you don't have the answer --

ADAM PRIZIO: Right.

REP. NUCCIO (53RD): If they did not come up with an answer, but just an idea, then I can accept this.

ADAM PRIZIO: Thank you.

REP. WOOD (29TH): Thank you very much. All set, Representative Nuccio? Thank you. Go ahead, Representative Wood.

REP. WOOD (29TH): Thank you, Representative Comey. Next up, we have Joan Lunden, followed by Dave Jones. Is Joan Lunden on?

CHRISTINA PEN: I just saw some other set of panelists, so she should be.

REP. WOOD (29TH): Okay.

JOAN LUNDEN: I am on. Has any -- okay, there you go. I think I've been muted or something. Hello, everyone. I really appreciate this opportunity today to speak to all of you on the Insurance and Real Estate Committee about Bill number 6626. The reason why is because I heard those words that no one ever wants to hear, "You have cancer." It was in June 2014. I was diagnosed with stage two triple negative breast cancer.

And on the day of my diagnosis, I had had a 3D mammogram, you know, the latest and greatest and it was clean. Fortunately, only because I didn't send

on a story and knew to do this, I followed that mammogram was an ultrasound. And that ultrasound showed that I had a tumor back against my chest wall that hadn't been seen on the mammogram. And why did that happen? Because dense breast tissue, which I learned That I had, shows up white on a mammogram, just like cancer. And as we've already heard today, therefore, it can easily mask a tumor.

Thankfully, due in part to the tireless efforts of the late Nancy Cappello, it is now mandatory for all women to be notified if they have dense breast tissue. Nancy's the one who fired up the advocacy in me, took me to Washington to testify before Congress and FDA hearings because getting these tests and getting them early, it's so important for women.

Right now, mammogram screenings are still the most effective way that women can protect themselves against breast cancer. But the costs that are associated with the test can be overwhelming to some women. As a breast cancer survivor, who had my cancer found in an ancillary test, I know how important all of these tests are. And I also often hear from women who find it difficult to bear the expense themselves. And, therefore, they forego these important diagnostic tests and end up with late-stage diagnosis cancer. And when a woman is worried about whether she has breast cancer, this isn't the time to be weighing the pros and cons of her finances. And this is why insurance companies should cover the cost of screening and diagnostic exams so that breast cancer can be found early at a more treatable stage, and thereby limiting late stage diagnosis with the exponentially higher medical costs. In the seven years since my diagnosis, there have also been a lot of new tests and cancer treatments. So there are now tests for women with early-stage breast cancer, which can study our biomarkers to --

JALMAR DEDIOS: Excuse me.

JOAN LUNDEN: Yes. Yes?

REP. WOOD (29TH): Go on. Please continue.

JOAN LUNDEN: Okay, which can study our biomarkers at the time of diagnosis. And that allows oncologists to determine which therapies will work best. And that means we can eliminate a lot of the chemotherapy and a lot of the aggressive, expensive treatment. And, of course, that also means that we can save lives. And that is why I ask you today to pass Bill number 6626, which would expand insurance coverage for both screenings and diagnostic mammograms, breast ultrasounds and MRIs with no burdensome out-of-pocket costs. This Bill can help protect your wives, your mothers, your daughters and yourselves, because every woman should be able to benefit from all the new advances we have, without having to make sure that her health fits into her budget. I thank you for the consideration and for allowing me to testify today.

REP. WOOD (29TH): Thank you, Joan. We have questions from the Committee. Representative --

JOAN LUNDEN: Sure.

REP. WOOD (29TH): Lesser -- sorry, Senator Lesser. I'm apologize.

SENATOR LESSER (9TH): Quite all right. Well, it's good to see you. And it's not every day that we get a long time, a Good Morning America host in front of this Committee, but appreciate your work being a voice where all of us around the country who are battling breast cancer and appreciate your strong advocacy and gracing us with your presence. So I don't really have a question. But I do know that it is really important to see you and to have state legislators like ours doing what we can to support -- ensuring that health insurance covers the health

care that so many people, so thank you very much, Madam Chair. And thank you, Joan, for your time.

JOAN LUNDEN: And I must just say I'm a Connecticut resident. And I'm so proud that our state has really been kind of the gold standard when it comes to this. Nancy Cappello reached out to me when I was diagnosed. And I have -- I must say, I mean, I'm a journalist who asked medical doctors to questions and I didn't know about the risk of dense breast tissue. I just -- I didn't know it was a thing that I should be worried about. And it was only because I was sent to interview a breast cancer expert, Dr. Susan Love and, you know, between changing the light she said to me, "You know, you do get all your annual mammograms, don't you?" And I said "Yes, I said. And there's -- they're always nerve wracking because they always call me back in for more pictures. And that's the moment that a woman says, "Wait, wait, wait, wait. Did you see something bad?" And they would always say to me, "No, it's just hard to see anything because you have such dense breast tissue."

And with that, Dr. Susan Love said to me, "Oh, my gosh, then you have to also be getting ultrasounds." And had I not been sent on that interview; I wouldn't have known to get that ultrasound that day. And I'm not being dramatic. But I probably wouldn't be here getting this testimony today, because I was diagnosed with a very aggressive kind of cancer, triple negative, which didn't have any treatments at that time, other than a year of aggressive chemotherapy.

And when I realized that I didn't understand the risk of dense breast tissue, which all -- you know, just under 50% of women in America, have dense breast tissue, I realized that there was a real need to go out and educate women. But this to me what we're talking about today, from your standpoint, you have to look at it as an expense issue, and the expense of taking care of women with metastatic

breast cancer, who got their breast cancer diagnosed in late stage because they didn't have any of these diagnostic tests early on when we could treat them, it just makes no sense at all from an expense point. The more we can find women's breast cancer early on, the less insurance companies will have to pay for that long, expensive kind of medical therapy to try to keep women alive later.

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

JOAN LUNDEN: My pleasure.

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

REP. MESKERS (150TH): Joan, I want to thank you for your testimony. You probably don't know it. But we've probably been chasing each other for a number of years. I grew up in Mamaroneck, and now I represent Greenwich on the shoreline. So I thank you for the advocacy. I already mentioned -- it's funny I mentioned and through a shout out for my mother, who turns 90 today. But when I was in high school, she was diagnosed and had a radical mastectomy. And today she joins 90. And when I think about the importance of the healthcare in avoiding the risks, I mean, you know, she suffered horribly, and thank God, she'd been a survivor of it. But anything we can do to preventative medicine, I think, is so important and to make the testimony you did, it meant a lot. So thank you very much.

JOAN LUNDEN: And if I just may take just a moment, one of the things I will tell you that really set me on this path of advocacy is that my father was a cancer surgeon. But back in the 50s and early 60s that -- where we didn't have chemotherapy, we didn't have radiation, all there was radical mastectomy. And I always thought I would grow up to be a doctor just like him because people use all this stuff is on the street, and they do hug him and they'd --

they thank him for saving, you know, their wife or their mother or daughter. And to me, that's what I wanted to be. But I went to work in a hospital that he had helped to found. He was actually killed in our private plane coming back from speaking at a cancer convention when I was only 13. And I learned pretty quickly that I -- scalpels were not going to be part of my career.

But in becoming a journalist, it became my passion to disseminate information to help others stay healthy. That was kind of my way of carrying on my dad's legacy. But when I was diagnosed with breast cancer, that was like an opportunity dropped in my lap, to really take the baton from my dad and go out and help other women who were diagnosed with cancer. And I've been all over the United States speaking. And I have found that most women when I would go into a luncheon didn't know anything about dense breast tissue. So, you know, this is important education. And I know that's not your mission here with this particular Committee. But, again, the more women we can get diagnosed in early stage and the more we can find out and have -- let allow them to have an ancillary test, since you can't always see breast cancer on a mammogram, if they have dense breast tissue. It's the smart thing to do, in addition to the fact that it's the human thing to do to save lives.

REP. MESKERS (150TH): Thank you very much again.

JOAN LUNDEN: Thank you.

REP. WOOD (29TH): Thank you, Representative, for sharing that. Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. Miss Lunden, thank you for joining us. Personal stories are really the most powerful. And thank you for taking your time to share your thoughts and experience. And it is important that women of all ages and husbands, sons and support significant

others need to understand that it's a total team effort. And --

JOAN LUNDEN: Okay.

SENATOR HWANG (28TH): It's the support and the encouragement, the allay of fears. You know, you saw Mr. Katzman -- Kritzman, who was a big supporter, he was as happy as could be, but he was smart right beside her. But can I ask of you, you began your testimony by saying the words that none of the people want to hear is you have cancer. It -- it's a jolt, and it's something that that I don't think anybody ever wants to be a club of. But can you share what you did afterwards to resolve that the redirected focus that you were going to go through, the painful chemo and whatever was necessary with a triple neg -- the, you know, the triple stage two triple negative --

REP. MESKERS (150TH): Rep. Meskers --

SENATOR HWANG (28TH): If I may, just if you could share what your role was --

JOAN LUNDEN: Sure.

SENATOR HWANG (28TH): As you went through that difficult journey?

JOAN LUNDEN: Well, I think it's actually an important question, because, you know, here I was a journalist, but I had actually not gone through this journey with a friend or relative. So I didn't really know that much about it. And in fact, when I went to meet with my breast cancer surgeon, Dr. Barbara Ward, right there in Greenwich Hospital, so amazing, she saved so many women's lives. And she said to me, the kind of doom and gloom, "Well, I have to tell you that triple negative breast cancer." And at first I thought, "Well, that's good, at least have negative to three things." And then she informed me that that meant that I didn't

have any of the three normal kinds of breast cancer for which there was targeted treatment. And this meant that I was going to have to undergo months and months and months of aggressive chemotherapy, and then radiation, and surgery.

And so, I went to one oncologist and got one kind of diagnosis, which was kind of the standard of care. And then I went to another doctor and got a very different kind of suggested treatment. And that is the one I went with because I felt that it was really the latest and greatest. And it wasn't necessarily the standard of care. Fortunately, in the past seven years since that diagnosis of mine, which left me, you know, in a year of treatment, you know, you may have seen me on cover People Magazine bald. And I admit that the first question I said to her, "Chemotherapy, does that mean I'm going to lose my hair?" But, you know, when you go through that kind of aggressive treatment, I just realized immediately that I needed to share my story. I think every time one of us shares our stories, other people learn, whether you're on a committee like this, that can actually do something about it, or just with women all across America. They started learning from what I was going through.

And since that's seven years ago, diagnosis, the treatments that have come down the pike, the new tests that we now have, I mean, we've had more advancements in research in the last five years than we've had in decades. And so, now women can avail themselves, of these new tests if they just get in and get that mammogram. And if we just make sure that every woman understands that if the mammogram can't see her cancer because of dense breast tissue, that she needs that ultrasound, or that MRI that found my cancer, the ultrasound did, then we can help these women. They can then get this new test, which studies their biomarkers, but that test is only good if it's at an early stage of their breast cancer.

So, again, the importance of getting all these women in and getting that early testing, not only are we going to save so many lives, and we're going to save women from long, horrible treatment for metastatic breast cancer, but we're going to bring down the cost of health care, which is so incredibly important to this country.

So to me, I mean, I'm not here as an advocate on a lot of different levels. And I went and testified in Congress I walked the halls of Congress with Nancy Cappello. And you know Nancy was the same as me. She didn't know she had dense breast tissue. She didn't know that was important. Consequently her breast cancer got found at a late stage. She dealt with metastatic breast cancer. And, finally, you know was taken so young, because she was just like so many other women and didn't understand what needed to be done.

So we can help every woman from here on out if we just get them screened whether it's for screening or diagnostic and that's really important. And if they need that that ancillary test, if they need that ultrasound or the MRI, let's make sure they're covered, because I have too many women who reached out to me all the time that say, "I couldn't afford it, so I didn't get tested. And now here I am now. I had to go in and I'm getting diagnosed in stage four." It makes no sense at all.

SENATOR HWANG (28TH): Sorry, the mute button and Zoom is always tough to get ahold of. It was -- it was important that you said, everyone right, because, obviously, the barrier of testing cost, as well as traveling convenience is a prohibitive, then there's a psychological aspect.

JOAN LUNDEN: Yeah.

SENATOR HWANG (28TH): That there's some people just say, "I'm too busy," or they just don't want to know. I mean I know it sounds silly to say that,

but I -- I've learned and heard that as well. But when you say everyone, it's important that this Bill considers being able to provide the aspect of testing some of the mobile testing units that we've advocated in our cities to be able to get access to communities that may not normally have --

JOAN LUNDEN: Yes.

SENATOR HWANG (28TH): Access to these kind of pre-testing. So it's really important when you say "everyone" that this kind of insurance coverage affords everyone in our society to get to the coverage. Because there may be a socioeconomic divide if you put these barriers to testing at costs, right? Because -- and then you talked about the genomics, which is another methodology that technology has afforded us, but without support and financial offsetting --

JOAN LUNDEN: Yeah.

SENATOR HWANG (28TH): You're not going to do that test, right? So --

JOAN LUNDEN: You're absolutely right.

SENATOR HWANG (28TH): So I really appreciate and applaud you using your celebritydom to testify in front of us beyond all the other medical experts and stories that you know, I was so touched by Representative Mesker wishing his mother Happy Birthday but also his willingness to share what impact that she has on him in regards to health care priorities importance. So, happy birthday to your mother as well, Represented Mezker. But when you talk about your celebritydom, not only are you talking to us as a legislator, but in this broadcast you are touching people who would otherwise not want to listen to us because sometimes I don't want to.

JOAN LUNDEN: Yes.

SENATOR HWANG (28TH): Right? But you're able to kind of articulate that so that someone says, "Oh, Joan Lunden is on the Committee, let's go watch her," that they could hear the story and, perhaps, be motivated to get tested to not only do the mammogram to say, we can do the ultrasound. And for other people to see, "Well, she went through it and look at her as vibrant and as beautiful, as ever." You know what for those that may have been impacted by breast cancer, they have the belief, to know that they will get better. And you also accounted for -- and I don't know if you mentioned about the metastatic cancer --

JOAN LUNDEN: Yeah.

SENATOR HWANG (28TH): Process, it is a difficult story for many of us --

JOAN LUNDEN: Yes.

SENATOR HWANG (28TH): To want to acknowledge, but I have seen such incredible bravery of women at that event stage in metastatic. And I don't know if a lot of people understand is the fact that there is no cure.

JOAN LUNDEN: Yes.

SENATOR HWANG (28TH): There's management. But the courage that those women and their family and loved ones go through, and knowing that there is no cure is something that I have been touched by. Because in these kind of vitriol world where pettiness seems to sometimes take precedent, those are people that value every precious moment that they have.

So I can't say enough how much I appreciate being able to meet you but also you taking the time so that other women and other families as they go through this experience know that they can connect with you and do what's necessary for their best health. So Ms. Lunden, thank you so, so much, I

really appreciate the opportunity to interact with you.

JOAN LUNDEN: Thank you very much.

REP. WOOD (29TH): Next question is from Representative Farrar.

REP. FARRAR (20TH): Thank you, Chairman. What a pleasure to have you and I just wanted to comment as a solidarity, as a fellow women with dense breasts I hear you. I know so many friends and family in that same circumstance, and I have to say to your point if, you know, one of the things I've heard and I'd be curious what you've heard as well, is for those of us that go for our first mammogram, which I was in that circumstance, a couple years ago. And to tell you the truth, I started, I mean a grandmother, a few years early because my wonderful on passed away, after many years to a fight with breast cancer. And that's why I started as you notice, you know screenings early, but when I had the conversation with my doctor I about pursuing that follow up test, even with these you know potential genetic factors right that I have. You know, there was still that additional costs right that I had to look into and to some was brought up before. It wasn't just calling my insurance company was calling the provider, you know going back and forth several times.

JOAN LUNDEN: Yeah.

REP. FARRAR (20TH): And I think, you know, I'd be curious to hear, I think, in my case, you know, you kind of I saw firsthand how much effort really went into what was a necessity to get this follow up test and really understand, you know, what the financial and, you know, barriers were for me and my family and I'm just wanted to hear from your perspective. You know what you've seen in particularly for unheard of, particularly for women who are finding this out for the first time and those barriers that

can get in the way of them really pursuing that test, because I know for myself, it took a while you know to figure that out and to really make sure that I could pursue getting that follow up testing that was needed.

JOAN LUNDEN: You know there's so many barriers of getting women tested and I'll just lay a couple of them out, I, personally, I went, because I know as opposed to, however I didn't think I was ever going to be that you know one in eight women that will be diagnosed with cancer in their lifetime, because I didn't know of any breast cancer in my family. And, had I known that less than 15% of women diagnosed with breast cancer ever had a family history. I would not have felt so immune so while it's really important that we know our family history it's also important to know that just because you don't have it in your family does not mean that you can't get it, and besides that back in the day.

This used to be a situation where, when women got breast cancer, they wouldn't tell everybody, I mean, I know, women who have not told their children that they went through radiation and a lumpectomy and, you know, now that their children are older, I mean I've gone to them and said, you must tell. These young men, because when they get married you know when they have children it's not only up through the mother's line of heredity it's up through the husband, the father's line as well that tells you what your risk is.

So the second thing is that you know it's been -- it's been shown that women don't want to the number one reason women don't go to the doctor is because they don't want to take their clothes off and step on the scale. I think, maybe we need to take skills at a doctor's office is just get women in there. There's also cultural barriers, you know, and we have found -- it's been found that in certain areas of the U.S. that there is a reluctance to go in and have your breast examine so just to make something

known. Dense breast tissue cannot be determined by how your breasts look or feel if you have lumpy breast that does not equate to dense breast tissue, it can only be found on a mammogram. And, you know, we've seen mammograms recommended that they'd be started at 40 years of age, for a long time, and many do a 35 year old kind of screening before.

And then in the last two years, we saw The American Cancer Society kind of bend to pressure to move that back to 45 and saying that if you're over 50 you should only have it every two years that's a terrible recommendation. Because we are seeing women diagnosed with breast cancer younger and younger and younger. And I hear from women all the time in their early 40s being diagnosed with breast cancer, so if we followed that recommendation to wait until 45, I mean don't their lives matter, you know, from 40 to 45. And the idea of waiting every two years, if you had an aggressive cancer like mine, that would be a deadly recommendation.

So we need to start those testings at 40 years of age, and if you have any kind of family history or any kind of risk factor involved, you will very likely need to be tested and screened far earlier than 40 years of age. So our whole effort here should be not to try to not pay for this or to delay testing. In order to bring down the cost of health care when it comes to women's breast cancer, we need to get women tested sooner and take away as many barriers, as we can, and certainly the financial barriers are the ones that really hit women, the most. So we got to -- we got to let women know that they can come in that they can get tested, it will be paid for and they will do everything they can to try to find that earlier because otherwise it's the healthcare industry, it's the insurance industry that's going to pay, you know, so much more later on. It's what ROI -- the ROI makes no sense whatsoever, not to test earlier.

REP. FARRAR (20TH): And to your point, I was one of those women who was, you know, diagnosed in her early 30s, right? And --

JOAN LUNDEN: Yes.

REP. FARRAR (20TH): To your point, you know, you -- you know you are really in a scenario, as you said, that it should be about preventing breast cancer --

JOAN LUNDEN: Yeah.

REP. FARRAR (20TH): In our lives in the lives of our friends or family or Community Members, and I also appreciated your comment particularly on, you know how this is really about making it as affordable and accessible and as easy as possible, I mean that's what we want healthcare --

JOAN LUNDEN: Yep.

REP. FARRAR (20TH): To be for all of ourselves, but as you noted so many folks, who might have greater barriers to care and I just want to thank you for being you your authentic and passionate self and I'm grateful for you taking time to be with us today.

JOAN LUNDEN: Thank you.

REP. WOOD (29TH): Joan, thank you for spending time with a Committee and sharing your story. We appreciate your testimony.

JOAN LUNDEN: Bye, bye. I appreciate it.

REP. WOOD (29TH): Next up we have Dave Jones, followed by Representative Gary Turco.

DAVE JONES: Thank you very much, Madam Chairperson, Members of the Committee, I just want to make sure you can hear me. My name is --

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

DAVE JONES: Thank you, my name is Dave Jones and I appreciate the opportunity to testify before you today. I served as California's Insurance Commissioner for two full terms from 2011 to 2018, and in that role led the California department of insurance and was responsible for regulating and insurance marketing, which ensures collect over $340 billion and premium manually. The views I'm expressing today are my own, but I serve as the Director of The climate Risk Initiative at the U.C. Berkeley School of Law. I'm testifying today and supportive Senate Bill 1047. Climate change poses physical and transition risks and potentially liability risk to insurance companies and as California's insurance, Commissioner, I concluded that climate change in particular poses transition risk to insurance companies' investments in oil, gas, coal and utility.

As the United States through market decisions technological changes and policy decisions transitions away from reliance on fossil fuels, in order to address climate change, investments in fossil fuel enterprises face a significant risk of declining and value or becoming stranded assets. One of the responsibilities of an insurance superintendent or insurance, Commissioner, is to make sure that insurance companies are investing in ways that hold value so that reserves are available to pay future claims, so the transition risks associated with climate change, in particular, have significant potential implications for the value of investments held by insurance companies. As a result, I required insurance companies transacting insurance in California to report to the California Department of Insurance annually. Their investments in oil, gas and coal enterprises, as well as utilities. Department, then made public the insurers fossil fuel investments by insurance company in an online searchable database, so that consumers investors and other regulators could have insight into the exposure of insurance companies reserves to

transition risks related to those fossil fuel investments. The purpose of this disclosure requirement, again, was to give my department, as the insurance regulator, but also the insurers themselves greater insight into what they were holding in the fossil fuel sector and a better ability to address the transition risks associated with those investments.

In 2020, the United States commodity futures trading Commission issued its seminal report managing climate risk newest financial sector, this is the first time a U.S. financial regulators look comprehensively across the entire financial sector, the United States, including the insurance sector at ways in which climate risk are posing systemic risks to the financial sector, as well as risk to individual financial enterprises. That report recommends that state insurance regulators require ensures to disclose and address climate risk and that insurance departments at the state level take up as a part of their ongoing supervisory practices consideration of an addressing climate risk. S.B. 1047 requires ensures to report disclose fossil fuel investments, as well as their underwriting the fossil fuel industry and will provide the state's insurance regulator with information to evaluate ensures exposure to climate related risks on both sides of the insurers balance sheet. S.B. 1047 also supports, including climbers' considerations and the Department of Assurances supervision of ensures, whether it's a capital adequacy requirements or supervisory tools such as enterprise risk management and own risk insolvency assessments. This is critically important. So I appreciate the opportunity to testify, and urge your support for S.B. 1047, happy to take any questions that you might have.

REP. WOOD (29TH): Thank you. Any questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair, and I'm still trying to figure out where my raise hand function is only a year into operating Zoom. Mr. Jones, thank you so much for your testimony, this is a fascinating issue, and I know that the Connecticut's Insurance Department has been long at the forefront of trying to scrutinize climate risk was industry is more on the front lines of climate change, and I think any other and Connecticut Insurance Department, I think, understands that and it worked with partners in places like California and also Washington state where there are really visionary insurance commissioners who are looking to try to understand that. And my understanding is that we're well behind as a nation our partners in Europe where there's been a lot of action on this front.

Some of the -- a lot of sort of the pushback we received from the industry has been not on the subject is, I think the industry understands that Climate change poses a huge risk to their underwriting, to their ability to do business but there's been some question about a uniformity. And so I just wanted to know if you had a chance to look at the language that we have in sort of understand how we can work -- how we can best work with organizations like NAIC to sort of move this conversation forward. But also, you know champion or domestic insurers, like the Hartford who really taken a bold steps to try to address this issue, but how do we sort of standardized the reporting, while also working to make sure that what we do is uniformly applied across the country?

DAVE JONES: That's great, Senator. And I do want to acknowledge the Connecticut Department of Insurance and your insurance superintendent's partnership with me and my department and administering the NAIC disclosure survey. The challenge with that survey is it's now about 11 years out of date. And what you're proposing in this Bill would enable your department to embrace

disclosure frameworks that have evolved considerably since the NAIC first put together its climbers disclosure survey, for example, the task force on climate related financial disclosure, which was an industry formulated framework is now recognized internationally as the leading standard for climate risk disclosure has been taken up by a number of global ensures, banks and other financial institutions, so your legislation enables the Connecticut Department, both to lead, but also to embrace disclosure frameworks that are more universally applied and would enable Connecticut to continue to position itself as a leader within the NAIC FDIC in trying to encourage more uniformity across states in this regard. So I think the legislation does a very good job of setting an expectation, with regard to what the department needs to do but also giving the department the latitude as standards evolve as standards evolve, and also to pursue greater uniformity in reporting across states.

SENATOR LESSER (9TH): And would you -- would you agree and through you, Madam Chair, would you agree that while there are a lot of states and non-state actors -- were asking for disclosure, they uniformity reporting is accurate may be a benefit to the industry in terms of understanding reporting guidelines and understanding how to best understand their own risks. This is something that could be a potential benefit to insurers, as they are scrutinizing around risk but also in managing regulatory compliance.

DAVID JONES: Absolutely. There's no question that what the -- what the Bill does in in requiring disclosure is a benefit to the individual companies, as well as the sector as a whole. What I found when I was California's Insurance Commissioner in required disclosure was that many companies didn't know what they were holding on their books. They were relying on third-party investment managers. And this really elevated to the C suite of the

company the issue of climate risk, and how it might manifest on their -- on their balance sheets. And so, we got a lot of favorable feedback from companies. And I think also, if you look at what's happening internationally, global insurers are embracing not only disclosure, but commitments to address the risks facing both on the underwriting as well as the reserving side. So I do think it's a benefit to the industry and the sector as a whole.

SENATOR LESSER (9TH): I saw something interesting on the news this week. I guess the State of North Dakota, is now exploring creating a public option for a coal mine insurance because coal mines in that state are having trouble purchasing insurance because insurance companies have made the decision not to underwrite coal mines on a voluntary basis is anything about it. And I just thought it might be an interesting thing for those of us on this committee to consider.

DAVID JONES: I saw the same report. And there was apparently, hearing in the North Dakota legislature on the issue of the declining availability of insurance for coal. I think what that represents is an increasing number of insurers, concluding that ensuring coal also helps to continue in industry, that's a major contributor to greenhouse gas emissions, which in turn, is driving catastrophic weather events, and other perils, wildfire, drought, flooding, sea level rise, you name it, which then are showing up on the underwriting side of the insurers balance sheets. And so, a growing number of insurers are concluding that it's really not in the industry's best interest to continue to provide that insurance.

SENATOR LESSER (9TH): Thank you, Mr. Jones, and thank you, Madam Chair. And I understand you may have a tight time constraints, so I appreciate it.

DAVE JONES: I'm happy to stay out on an answer as many questions as the Committee might have.

REP. WOOD (29TH): Thank you. We do have another question from Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madam Chair. And thank you, Miss Jones. I'm a former California resident and Bay Area person. So thank you for your work that you've done to California over the years. I am very intrigued by this Bill as well. And I guess I grew up in the auditing world. And so, in looking at some of the things, they're easy to be able to, you know, assess how we can -- how this bill would work.

But some of the questions I would have, and just wanted your expertise, is some of the more subjective things -- things like you know, it says, the degree in which such insurance investments are exposed to primate -- climate risks. You know, coming out of the audit world, you would probably just give a huge blanket statements saying, you know, "Climate risk is an issue, but how would you suggest for like, in California, for example, how would you suggest that insurers quantify this so that people have a real understanding, because that's one of my concerns about this bill is it's pretty subjective.

DAVE JONES: That's a great question. So there are forward-looking tools that enable insurance companies as investors, as well as banks as lenders and other financial institutions to, essentially, run climate change scenarios, against their investment or lending portfolios, and ascertain based on those climate change scenarios and a number of important models that, basically, translate those climate change scenarios into financial impacts and physical impacts with financial impacts, to see to what extent the lending portfolio of the bank or the investing portfolio of the insurance company is aligned or misaligned with the climate change scenario. And that provides insight then into the degree of risks that particular asset classes might

face, whether it's coal, oil, gas, utilities, or cement, or the automotive industry, for example.

So there are tools available. And one of the things that we did at the California Department of Insurance was we partnered with one of the leading international developers of those tools, which has developed a model called the Pack the Model, and ran it against the investment portfolios as insurance companies and then provided to the insurance companies' CEOs a report that identified the alignment or misalignment of their investment portfolios with different climate change scenarios.

The practice is evolving. It's not perfect, but the tools are getting better. And I think there's a general consensus, certainly, internationally and a growing consensus in the United States amongst the regulatory community that we don't want to let the perfect be the enemy of the good. And we have enough tools available to, at least, begin to assess to some extent what these risks are, and make disclosures about them. So excellent question.

REP. DATHAN (142ND): Great, thank you so much. I wasn't aware of these tools. But I guess, you know, like in other parts of the insurance industry, there's actuarial models that, you know, run scenarios through things, and it was probably just a matter of time. Are you familiar, or any other governments around the world running these sorts of models to help combat climate change in their jurisdictions?

DAVE JONES: Yes, so a number of other insurance regulators globally, have begun to take up climate risk scenario analysis, and disclosure. So the Bank of England and its Prudential regulatory authority, for example, in its 2019, general stress test of insurers included a climate risk stress test. The French Central Bank, which also regulates insurers is implementing, as well as the French government, a broader climate risk disclosure law, which applies

both to corporates and financial institutions. And that law Article 173 stayed in effect for about three or four years now. The European Central Bank, the Dutch Central bank, the European Occupational Insurance Pension Authority, there's a growing list of national or international financial regulators that are requiring disclosure, and are also taking up these tools.

I think, in the U.S. we've -- as Senator mentioned a moment ago, we've been a bit behind in this regard. But you're starting to see considerable increasing interest in statements of moving forward by the Federal Reserve, the SEC, the Office of Comptroller Currency, and others. And so this bill would position Connecticut, I think, where it should be, it's had a leadership role in the past in this issue, but also in alignment with which -- with what is happening both at the national and international level in terms of trying to make sure these risks are better understood and addressed.

REP. DATHAN (142ND): That's great. And I really appreciate you providing testimony today, because this is something that, you know, I think there's so many of us on this Committee want to explore more, and I think this Bill is a -- is a good start in in hearing your testimony is really helpful. So thank you, Mr. Jones, for your testimony today. I hope you have a good rest of your day. Thank you, Madam Chair.

REP. WOOD (29TH): Thank you, Dave Jones, for joining us. We appreciate your testimony. Next up we have Rep. --

DAVE JONES: Thank you, Madam Chair, Members of the Committee.

REP. WOOD (29TH): Thank you. Representative Turco, followed by Robert Schoenberger.

REP. TURCO (27TH): Great. Good to see everybody. Representative Wood and Senator Lesser and Ranking Members Hwang and Pavalock-D'Amato and all the members of the Insurance and Real Estate Committee. I am State Representative Gary Turco. I represent the 27th House District, which comprises most of the town of Newington, where Senator Lesser also represents, and Representative Wood what represents, so it's great to be here with you all. And I'm testifying here today in support of House Bill 6626, AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES, AND COST TRANSPARENCY. And my comments for that Bill, are reserved for Sections 24 to 28, which are the sections that have to do with our early detection test for breast cancer.

And you've heard from the great Jan Kritzman, who is a Newington constituent of mine and champion on this issue. And you've heard from Joe Lunden, both gave incredible testimony. It is a tough act to follow. But I want -- I'll fill in some details of maybe some things that they didn't cover, some other things that I think are interesting for committee members to know about this film, what we're trying to do here.

And my mom is a three-time breast cancer survivor. So, you know, I grew up watching breast cancer and what it can do to families and to a woman and seeing her struggle and surviving through it. And my mom was lucky because my mom was able to catch this breast cancer at a stage, even though she went through chemo and surgeries and a lot of difficult things, but catch at a stage where it wasn't terminal, where she was able to defeat it and be a survivor. But many women do not.

Now here in Connecticut, Connecticut alone in 2021, we will have over 3,000 women that will be diagnosed with breast cancer this year, we'll have a couple of 100 men that will be diagnosed breast cancer this year. And it's estimated going off of past year

data that over 400 women in Connecticut will die from breast cancer this year. So we have more to do. And I know I worked with many of you including the chairs, Minority Leader -- former Minority Leader Themis Klarides, who was a leader in this issue, Representative Dorinda Borer and others. We passed landmark Legislation in 2019. to mandate that there's insurance coverage, with no out of pocket costs for ultrasounds and MRI tests for women. And these tests are used a lot, which you've heard from previous testimony to detect breast cancer when a mammogram is not sufficient enough. And that's usually because a woman has dense breast tissue. And without these additional tests, a woman may not have the breast cancer detected at an early stage. And when it is detected a more serious stage and could result in death, obviously.

So as you learned, you know, from Jan Kritzman, the Bill we passed in 2019 was great. We've saved lives in the State of Connecticut. We've also saved a lot of money and health care costs. Insurance companies save a lot of money. Because as you heard, when you detect cancer in the early stages, the treatment and the surgeries and the hospitalizations and all of the costs that go into it is significantly less than what it will be when you end up detecting cancer at a much later stage. So we're saving money all around and we're saving lives. That's a great thing, right? As legislators I mean, that's -- what else what is more important than saving money and saving lives together. That I feel like if we can continue to do that we're all doing our jobs well.

Well, after passing that legislation, I got a lot of phone calls from women throughout the state, and in my district of Newington, saying, "Hey, I'm still getting a Bill. I'm still getting a Bill, it's still applying to my high deductible of thousands of dollars, or I'm getting a thousands of dollars of a bill for coinsurance or I'm getting my whole high copay. What happened here?"

So what this bill aims to fix, among other things, is making sure that we're mandating not just screening mammograms, MRIs and ultrasounds, but diagnostic MRIs, ultrasounds and mammograms. And the difference I've learned to screening is when you go in and you have no symptoms of breast cancer, and you get a screening and diagnostic is when the doctor already has seen something a little wrong, seen something wrong in the mammogram, something suspicious or maybe there's a lump and says, "You need an ultrasound."

Now does it make any sense to have insurance covered with no out of pocket costs? When it's a screening, when a woman has no suspiciousness, then and not cover it fully via insurance with no out of pocket costs when there is something suspicious? No, they both should be covered with no out of pocket costs. We don't want to give anyone a reason not to go get their ultrasound, MRI, or mammography, when a doctor asked them to, because they can't afford it because it's only going to be more expensive. There's other things in this bill as well, that are very important, such as making sure that those high-risk individuals -- and this could be men and women -- are able to get these important screening and diagnostic tests at an earlier age as well. So that's another important thing looking for these preventative tests at an early age.

So, again, we've done some great work together in 2019. But we have more to go. There are loopholes here where women and men are not getting these tests covered. And, therefore, they're putting them off. And as a result, it could cost them things being more expensive. It could cause of death. And I don't want to see that for anyone else here in the State of Connecticut. So I urge this Committee, to please take a really good look at this Bill, Sections 24 to 28, especially, and pass that -- pass it out so we can save more lives and save more money. It's a win-win for the entire State of Connecticut. Thank you for allowing me to give my

testimony. And if there are any questions, I welcome them.

REP. WOOD (29TH): Thanks, Representative Turco, for your leadership and your work on this, and really bringing this issue to light in 2019. Questions from the Committee? Representative Nuccio.

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

GARY TURCO: Thank you. Good afternoon.

REP. NUCCIO (53RD): So I wanted to kind of talk a little bit about what you said about your residents coming forward with Bills. And just point out, the Legislation that passed the two problem with the Legislation that passed is only applicable to fully insured plans. And that's about 30% of the people who are insured in the entire State of Connecticut. The majority of people are insured under ASO plans and the Legislation did not extend to that.

So even if we want to make these changes here, I still think it's just applicable to fully insured. So that's where I struggle, like how do we expand that out? Because ASO plans are not administered by the Department of Insurance. And you can't dictate that. So the Legislation that we're passing is affecting such a small portion of the people who need the services. So I just wanted to give you that little bit of information because I was really happy when I saw that we had passed something to and the -- and the press was that we passed, you know, the payable for the whole process, but it's not. And that's part of the struggle. So that may be helpful to you with your constituents and as we work to try to figure out how to make this applicable to everybody who needs it and not just a certain selection of insureds.

GARY TURCO: Yes, Representative Nuccio, you are so correct. That is another issue that the -- despite

the landmark Legislation we passed here in Connecticut, those on self-insured plans, instead of fully insured plans will not be able to benefit from this, unless there, and my understanding, is a federal change. And that's what was so important about the Affordable Care Act, Obamacare, was that it mandated the requirement on the federal level for mammograms to be covered by all 50 states in insurance with little or no out-of-pocket costs. For women, it did not go far enough and do some other things that are very important, like ultrasounds and MRIs.

So you're right about that there's still going to be women that are going to -- and then they're going to be left out. But there were women that I spoke to that again in this bill will fix it for at least the fully insured that they got their mammogram MRI and ultrasound, and it was coded as being diagnostic and not as a screening test. And regardless of fully insured, self-insured, that was not covered without any out-of-pocket costs.

REP. NUCCIO (53RD): Yeah, yeah, I agree with you. If we could get something federal that would help with that. Because it's hard to -- it's hard to legislate the ASO plants but I'm fully in agreement with you. So thank you very much for your testimony today.

GARY TURCO: Thank you for your questions.

REP. WOOD (29TH): Thanks, Representative Turco. Have a wonderful day. You too. Thanks, everyone.

SENATOR ANWAR (3RD): Next up is Robert Schoenberger, followed by Christopher Gallagher. Robert Schoenberger coming on. I know he has some technical difficulties. All right, is Christopher Gallagher available? Christopher Gallagher next, followed by Deborah Kritzman.

CHRISTOPHER GALLAGHER: Yes, thank you.

Co-Chairs Lesser and Wood, Vice Chairs Anwar and Comey and the Honorable members of the Insurance and Real Estate Committee. I'm Christopher Gallagher, Federal and State Affairs Consultant for the Obesity Action Coalition with the largest patient organization, representing those affected by obesity. We have 75,000 members, with over 1100, which are Connecticut-based.

Today, I'm going to talk about S.B. 1007, which would require border health insurance coverage for bariatric and that

REP. WOOD (29TH): Are you happy you gonna get on?

ROBERT SCHOENBERGER: Later, but I can't get -- I don't know.

CHRISTOPHER GALLAGHER: And FDA approved anti-obesity medications. The OAC very strongly supports S.B. 1007. Throughout the past decades, the prevalence of obesity has skyrocketed across our country with now nearly 30% of Connecticut citizens affected by obesity. Despite this fact, some policy, policymakers continue to view obesity as a lifestyle choice or personal failing. These perceptions and attitudes have allowed health insurance plans to take vastly different approaches to how they cover obesity treatment, even in the age of COVID-19. I wanted to talk a little bit today about some of the policy statements that have been made by a number of groups, including the AMA, which declared obesity a chronic disease in 2013 and further policy encouraging that patients should have access and coverage for all obesity treatment avenues. This catalytic move helped spur other federal and state policymaking groups to do it, following up for example, in 2014, the Office of Personnel Management, basically prohibited federal employee health plans from denying coverage for obesity treatment avenues on the basis that care, either obesity is a lifestyle or that treatment is cosmetic in nature.

In 2015, the National Council of insurance legislators adopted its first-ever disease-specific policy, urging Medicaid state employees and state health exchange plans to update their benefit structures to improve access to and coverage of treatments for obesity, such as pharmacotherapy and bariatric surgery. 2018, the National Lieutenant Governors Association basically said the same thing. And then late last year, the National Organizations representing the black and Hispanic caucuses of state legislatures adopted policy recognizing the health inequities and communities of color that have led to a disproportionate impact of COVID-19. And that states must address the high rates of obesity to improve the health of racial minorities and prepare for the next public health epidemic. And they encourage legislators to take steps to address obesity in their own states by ensuring that their constituents including those using Medicaid, have access to the full continuum of treatment options for obesity, including your --

PETER MURSZEWKSI: Excuse me, your three minutes has ended, please consolidate your testimony.

CHRISTOPHER GALLAGHER: Thank you very much in front of us. In some way, we support S.B. 1037 and we encourage the committee to support patient access to the full continuum of obesity.

REP. WOOD (29TH): Thank you, Christopher. We have questions from the Committee. Representative Dathan.

REP. DATHAN (142ND): Thank you very much. Mr. Gallagher, I didn't see your written testimony. Did you provide any?

CHRISTOPHER GALLAGHER: I did. I'm sorry.

REP. DATHAN (142ND): Maybe I'm just missing it. I will -- I will have another look. Do you know if there's any studies about the cost of some of these

longer term issues, as a result of obesity, in terms of how much it's cost for -- apart from loss of obvious loss of life for COVID, for example, for diabetes, other heart disease --?

CHRISTOPHER GALLAGHER: Yep.

REP. DATHAN (142ND): And other things? Do you know if there's any studies that show the -- quantify the cost for us?

CHRISTOPHER GALLAGHER: Yeah, I know we looked at some studies. For example in Medicare premier anti-obesity medication is our denied coverage, there is studies showing that if these medicines would it be covered over a 10-year period, the Medicare program could save between $18 billion dollars and $23 billion dollars. And in the sense of bariatric surgery, there are studies that show, basically, you can recoup the cost from a bariatric surgical procedure in, roughly, three years. And I'm happy to provide the Committee Members with the copies of those studies. And I know people going after me are going to talk more in depth about that. So thus I was focusing my remarks on the policy statements of other groups.

REP. DATHAN (142ND): Okay, yeah. I always get very interested on the sort of ROI, if you will, on these surgeries. I mean, obviously, you know you can preserve someone's life and we've seen how people who are obese have been adversely affected by COVID in the last year, but it is also interesting what, you know, these hospital stays and other sort of lifetime of medication and treatments for chronic diseases are costing America. So thank you so much for doing that. If you would forward that to our clerk I'd greatly appreciate it. You can just send it to the same testimony email. Thank you for your testimony and thank you, Madam Chair.

REP. WOOD (29TH): Thanks, Representative. And, Christopher, we appreciate your testimony. Have a great day.

CHRISTOPHER GALLAGHER: Thank you.

REP. WOOD (29TH): Next up Robert Schoenberger. I see that you have joined. It is your turn to speak. Hi Robert. We can see you. Can you just take yourself off mute and we can hear you? Robert, you're still muted. Any of the staff can help him get off mute.

CHRISTINA PEN: I am hitting the Ask to Unmute. It should pop up at the bottom for him.

REP. WOOD (29TH): Robert, look at the bottom of your screen.

ROBERT SCHOENBERGER: Okay, wait a minute.

REP. WOOD (29TH): Yep, there you go.

ROBERT SCHOENBERGER: Okay, you just got to do the right thing. I have a -- this regard to Bill number S.B. 1046, and it's in regards to the long-term care insurance. And my name is Robert Schoenberger. I'm 88 years old. My wife is 87, and we purchased this insurance originally through Travelers, and then it got changed to Metropolitan, and then went to Brighthouse or they separated it. And our premiums were level for -- at $5140 dollars per year until 2017.

After two rate increases of 18% to 37%, our premiums cost rose to $11,556 dollars. This does not include future overlapping rate increases or additional 25% that was approved last month. We live on a fixed income. This has caused financial and emotional hardship and stress. The rate increases are a calculated effort by the long-term care industry to force us to reduce our benefits or relinquish our unprofitable policies. We bought our policies

promoted by the State of Connecticut Partnership Program. We bought the policies in good faith, believing that we were approved by -- and somehow guaranteed by the State of Connecticut that -- Connecticut.

We attended several meetings locally in 2/19, where the insurance company claimed insolvency. They have claims of insolvency then investigated to be true. If they are true, they should be the responsibility of federal government. And a significant number of seniors in my LTC as advocacy group have dropped out because of the -- relinquished their policies for the past year. They gave us hope that the Legislation -- legislative solution would be passed and solve the skyrocketing rate increase.

For every senior that gives us up there LTC policy. The state Medicaid program would be responsible for pay of the costs of the LTC. I had peace of mind. I had -- excuse me, I worry every day if I will be able to keep our policy, I don't feel that this program does enough to provide release for the future rate increases. I would like to add some ideas to the -- include -- to strengthen the Bill for consumers. They should have a cap on -- propose to increase a cap on the great increases of maybe 3%, eliminate some of the overlapping --

PETER MURSZEWSKI: Excuse me. Your time is up, please consolidate your testimony.

ROBERT SCHOENBERGER: Thank you.

REP. WOOD (29TH): They won't listen to you anymore.

ROBERT SCHOENBERGER: Okay.

REP. WOOD (29TH): Robert, thank you very much for coming on and sharing your testimony. I have one question for you. When you say you bought policies that were promoted by the State of Connecticut. Did

that mean that you're a former employee of the state and that you found this policy as an employee?

ROBERT SCHOENBERGER: No, this was -- this we did on our own. It was bought through financial advisor back that --

REP. WOOD (29TH): Okay.

ROBERT SCHOENBERGER: And they said that the state was promote -- well they did some good things in it about not taking all your property if you -- if you didn't have insurance, so always -- there's always -- you would not lose your home instead.

REP. WOOD (29TH): Okay.

ROBERT SCHOENBERGER: But the insurance is getting so high, as you retire, you obviously know that the increases in our -- we don't get that much extra year and from a --

REP. WOOD (29TH): Right.

ROBERT SCHOENBERGER: Those securities. So it could become -- they don't -- these percentages get pretty high when you think of how much to build this, you know. I know it costs a lot for taking care of the people.

REP. WOOD (29TH): Nursing care.

ROBERT SCHOENBERGER: The nursing here, I know that. But that's --

REP. WOOD (29TH): Yeah.

ROBERT SCHOENBERGER: That's why I bought it to save what I had.

REP. WOOD (29TH): Right.

ROBERT SCHOENBERGER: And save the state to take care of us. So --

REP. WOOD (29TH): Yeah.

ROBERT SCHOENBERGER: I -- I'm lost for words, because I think this -- I think the insurance industry or company is not being forthright. They -- I don't think they can say that they are -- they're going to close business because they don't have all good insurance policies. They have some. Like everybody else you got some bad you got some good, and they should cover each other, but these seem like they're just trying to close up business, it seems like. So I don't know. I --

REP. WOOD (29TH): Well, yeah.

ROBERT SCHOENBERGER: Every year I go through the same problem of, "Should I reduce it? If I reduce it, I won't have enough." The problem that comes about as people with Alzheimer's or Dementia. It becomes a longer term situation in the -- in a -- in a home. So that's where it gets important to us because I certainly would have not like to use up all your assets, totally. I know some people do, but we did do the right thing we thought in the beginning. So --

REP. WOOD (29TH): Right.

ROBERT SCHOENBERGER: So we've lost all the premium if we can't -- if we decided to cancel -- you know get out of the --

REP. WOOD (29TH): Right, right.

ROBERT SCHOENBERGER: So --

REP. WOOD (29TH): Well, thank you for sharing that with us. We do have another question from a Committee member. Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madam Chair and thank you, Mr. Schoenberger for your testimony. I know my mother -- my parents invested in this as well. My father ended up dying very early in life so never got to use it, but it was really beneficial for my mom who, as you pointed out, patients with Alzheimer's what she had, it really did help her. And I think you raised some important suggestions and I just wanted to thank you for your suggestions. And I do think this is something that we need to address in our state. And I appreciate you taking the time to highlight these things for us, because we do need to make sure that we protect seniors, who need to use this insurance and other seniors who, you know, are using this as what it's for -- an insurance policy so that you can have your costs covered. So I just wanted to say thank you. So thank you.

ROBERT SCHOENBERGER: Thank you for listening.

REP. DATHAN (142ND): Chair.

ROBERT SCHOENBERGER: Thank you for --

REP. WOOD (29TH): Thanks, Robert.

ROBERT SCHOENBERGER: Okay, bye.

REP. WOOD (29TH): Have a wonderful day.

ROBERT SCHOENBERGER: Bye now.

REP. WOOD (29TH): Our next up, we have Deborah Kritzman, followed by Martin Hoyt. Is Deborah on? I don't see Deborah, so we will move to -- I do see Martin. We'll move to Martin Hoyt, followed by Pavlos Papasavas.

MARTIN HOYT: Good afternoon, Representative Woods, Representative Pavalock-D'Amato, Senator Lesser, Senator Hwang, and all the other hardworking Members of the Committee. My name is Martin Hoyt, and I

represent Christian Healthcare Ministries or CHM. We are the largest and longest-serving minute -- of the healthcare-sharing ministries. We have over 800 members in your state. I want to thank the Committee for raising Senate Bill 1041 and the critical issues that it addresses. Likewise CHM is very actively committed to cleaning up, the healthcare sharing lane, and we are appalled at some of the abuses and outlandish behaviors that are occurring by bad actors across the country in the name of healthcare sharing. And with that, I'm here to support -- strongly support Senate Bill 10 -- 1041 with a proposed clarifying amendment that I think would enhance the Bill.

Specifically, what we'd like to do is add a new paragraph C, the Section 2 that clarifies paragraph E, basically, stipulating, that selling soliciting, negotiating or administrating a health care sharing plan does not apply to a salary person, who's employed by sharing ministry and does not receive any form of commission, compensation or other valuable consideration, based on enrolling new members. And then, secondly, that a new member referral program limited to no more than 12 referrals would also be exempt.

In short, we agree with the Bill, and we see the agent issue and perverse incentives, as contaminating sharing and creating consumer confusion. So our amendment simply clarifies the intention of the Bill to ban practices that incentivize individuals acting in the name of the ministry to sell, negotiate or operate as sharing point. We think it's excellent public policy and, perhaps, the most important component of the bill to promote habit, the use of insurance agents to sell memberships and healthcare sharing ministry.

We also are concerned, or would like to clarify that running -- as it applies to administrating a health care sharing ministry, that there are no -- in that you should be allowed to draw a salary, provided

that there are no incentives to production or to enrollment or to negotiation of prices. I think there's a simple distinction, otherwise ministries would have a problem, ceasing to exist, let's say, we're not able to pay a salary. So our amendments simply clarifies paying a salary is not included in the public policy, prohibiting incentives tied to production of new members or any other aspect of sharing operations. Briefly --

PETER MURSZEWSKI: Excuse me, your three minutes is up. Please summarize your testimony.

MARTIN HOYT: All right. Well, I'd be happy to answer questions. But in close, for the reasons that have been addressed, CHM opposes use of insurance agents by any health care sharing plan. We also oppose plans use of incentive an incentive base of employees and, frankly, anything tied to the membership growth, and we strongly urge the Committee to support 1041 with the amendment. And I'm happy to answer questions in detail.

REP. WOOD (29TH): Thank you, Martin. We have questions from the Committee. Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you, Madam Chair. I know I spoke to you prior, Mr. Hoyt. And maybe I -- this Bill -- the way it's drafted now, I think I'm just a little confused and maybe have to get some clarification from the -- from the Chairs. It's -- people have been -- a little concerned that it prohibits the -- them from existing these plans, all together. And I know that you had referenced in other states laws. And I mean, do you feel that this is prohibiting a healthcare sharing ministries altogether, or is it --

MARTIN HOYT: Thank you. That's an excellent question. First of all, with the clarifying amendment that we're asking for this would not prohibit that at all. The issue is whether you can

operate with an insurance -- with insurance agents or not. And these -- some of these ministries are claiming that, "Oh we're out of business, if we don't use an insurance agent." And that's not correct. You have neighboring states that have similar requirements. And these ministries are -- some of these ministries are continuing to operate in those states. It's an -- it's a question of revenue flow and whether it's worth their while to be in the state if they're -- if they're not using agents.

REP. PAVALOCK-D'AMATO (77TH): Okay, well, I know, also, you know, it's not insurance so it's not necessarily falling under the insurance statutes, so maybe it's -- the language we have is covering what we possibly can in the insurance committee, as opposed to a consumer protection. But -- and I see your point with the agents. But do you think that the language as written as far as a plus your amendment doesn't confuse people. They are using an insurance agent. I mean to me that's --

MARTIN HOYT: Well, if you're using an insurance agent, it's already confusing. Because, first of all, as Senator Lesser pointed out how many of you have a divinity degree? And, secondly, how many of these insurance agents really know whether the prospective client is going to be compatible with the ministry and what their spiritual outlook is, which is diverse. And then you have the monetary incentive, which I don't know if you've reviewed these across the country but they're perverts. Some of these commission's go as high as 70%. And most of them are well-above what an agent will receive for selling and qualified ACA plan.

So there is a lot of incentive to direct them to a sharing ministry, regardless of whether they fit. And the training is not up to par to help the agents do that the folks that are best trained to help someone join a ministry, and the answer questions

whether people employed by the ministry. They can operate without agents.

REP. PAVALOCK-D'AMATO (77TH): Okay, I know I have -- I think I have your contact information, so I'll probably be reaching out --

MARTIN HOYT: Yep.

REP. PAVALOCK-D'AMATO (77TH): For a little more clarification, but, hopefully, I don't know if anybody else has any questions that maybe you can help me and some others with some of this language. That would be appreciated. Thank you for your testimony.

MARTIN HOYT: Thank you.

REP. WOOD (29TH): Martin, thanks for joining us today. Have a good day.

MARTIN HOYT: Thank you.

REP. WOOD (29TH): Pavlos Papasavas, followed by Meagan Moskowitz.

PAVLOS PAPASAVAS: Good afternoon, Members of the Committee. Thank you for the opportunity to provide a testimony in support of Bill 1007. My name is Pavlos Papasavas. And I'm the President of the Connecticut Chapter of the American Society for Metabolic and Bariatric Surgery. I've been a very bariatric surgeon since 2001. And in my 20-year career, I have seen, talked to, examined and provided treatment for thousands of patients with obesity. And I came to understand how complicated this disease is. This is a recalcitrant, chronic, understudied disease that affects millions. And, unfortunately, some members of our society have a simplistic and naive approach to obesity and its treatment.

There is no cure for obesity but there are effective treatments and some of our services do not have access to these treatments. I was talking to a Medical Director of an insurance company a few months ago, who was denying care for one of my patients. And he said to me, "Tell your patient to go out and exercise and follow a diet. If I can do it, she can do it." And that is naive, that is ignorant. It ignores the underlying mechanisms of this disease and we have to do a lot of work to change this kind of attitude. Bariatric surgery is extremely safe. It is a safe as gallbladder surgery and it's very effective. It is the most effective treatment for obesity and it's comorbid diseases, like diabetes, hyperlipidemia, sleep apnea, fatty liver disease.

We asked to provide access to this effective treatment for obesity that affects our minorities disproportionately. It affects people of color; it affects people in low income. And these are the people who are affected the most from the COVID-19 pandemic. We know that this minority -- this vulnerable populations of our state suffered the most from COVID-19. These are the people have a higher rate of hospitalization and more severe disease. And COVID-19 is very strongly linked with obesity, so this pandemic that we're dealing with now brought in the forefront the other pandemic -- the pandemic of obesity of the last 40 years. I feel confident that we'll have your support in this very important bill and provide the gift of life, because this surgeries in this dream is provide more years of good quality life to our most vulnerable citizens of our state, thank you for your time.

REP. WOOD (29TH): Pavlos, thank you for that testimony. Do we have questions from the Committee? Great. Thanks for joining us, Pavlos. Next up, we have Meagan Moskowitz, followed by Peter Kochenburger.

MEAGAN MOSKOWITZ: Hi, good afternoon everyone. my name is Meagan Moskowitz. I am -- I'm addressing the Members of the Insurance and Real Estate Committee today in support of Senate Bill 1007, AN ACT REQUIRING HEALTH INSURANCE AND MEDICAID COVERAGE FOR THE TREATMENT OF SEVERE OBESITY.

I work in the field of bariatric surgery. My background is that I am a registered nurse. I currently work for a bariatric surgery program for Hartford Healthcare. And prior to that, I worked as a floor nurse on a medical and surgical floor, taking care of both medically sick patients, many of who suffered from the disease of obesity and those corresponding comorbidities, as well as taking care of post-op bariatric surgery patients.

My previous experience working on the floor in the hospital, needed sensitivity, training, education on caring for the patients with the disease of obesity, education on weight bias, all to prepare us for working with that patient population. As a nurse, I did my best to practice with empathy, care, compassion. But looking back at what I know now, I realized that I did not have a complete understanding on what weight bias and stigma really mean. Now that I've worked more indeptly in the field of bariatric surgery, and I've had more interaction with patients with the disease of obesity, and have heard so many stories, struggles and journeys, I now have a better understanding of the daily struggles and what weight bias really does mean.

Prior to COVID, I ran a monthly support group for patients both before and after bariatric surgery. In these support groups, we would have a post-op patient come and speak about their journey through weight loss and the surgery. Listening to those countless inspiring stories really showed me the amazing opportunities that very attic surgery can provide for patients. In addition to all of these medical comorbidities that are improved or resolved

as a result of weight loss surgery, what really inspired me with stories with patients and what we call non-scale victories, from being able to garden again, to playing with grandchildren, to being able to comfortably sit on an airline seat. Many everyday activities that we take for granted, are real struggles for people with the disease of obesity, and hearing how much their quality of life improved as a result of geriatric surgery is truly inspiring, and really highlights the importance of providing the opportunity for all patients who suffer from the disease of obesity to undergo bariatric surgery. Thank you for your time and consideration for this Bill today.

REP. WOOD (29TH): Thanks, Meagan. Any questions? Great. Thanks for coming and testifying.

MEAGAN MOSKOWITZ: Thank you.

REP. WOOD (29TH): Next up we have looks like Sabrina here we -- oh, Peter is there. Peter Kochenburger, followed by Sabrina Marino.

PETER KOCHENBURGER: Thank you. Good afternoon, Madam Chair. And thank you and the Committee for this opportunity to testify, in support of Senate Bill 1047 on service and climate change. I'm an associate professor at UConn Law School, where I teach insurance law and I help direct the Insurance Law Center. I am also a consumer representative at the National Association of Insurance Commissioners and have been in that capacity for 10 years. I am speaking today, however, in my personal capacity, based on the work I've done in this area, and not on behalf of these organizations or any other association.

I support this Bill for three primary reasons, based on the vital role that insurance and insurers play in addressing climate change. First -- and this is insurers role as investors. As we know, insurers collect billions -- many billions of dollars of

premiums each year. And they are required to set aside a significant amount of this money to pay for claims that may occur months, years and sometimes many decades later. These investments are closely monitored by state insurance departments. And they have been for many years and like other financial institutions and service therefore major investors in our nation's economy, as well as State of Connecticut, certainly, in addition to the employment.

These -- since these reserves are closely reviewed, these new reporting requirements that are in S.B. 1047 so will provide essential information that, otherwise, is not available, and determine how insurers are managing the risks. And the social well in line, as I mentioned with regulatory practices. While these particular requirements may be new, the ability of states or the need for states to understand how insurers are investing their money is not.

The second reason is in their role -- insurers' role as the world's risk manager -- managers. I wish I'd had coined that term, but I didn't. But I think it's very well -- I think it's nicely characterizes the role insurers play in this area, but for many years, but also characterizes -- it -- the insurance is different. It's unique in this area, unlike other financial institutions.

Insurers, as we know, are the experts in evaluating pricing and underwriting risks, and conditions with increasingly greater precision, whether through their own model and we're working with companies that can model bound to the individual homes or businesses at times for risks of flood or other natural catastrophes. How they underwrite, however, is both the public powerful tool for addressing climate change, the -- where you can -- for example, where we will insure our home and at what cost we'll insure our home. So a powerful tool for addressing

climate change, but it is also essential for post-disaster recovery.

The third is Former Commissioner Gary Jones addressed this much better than I can. And that is the insurer's role in addressing climate change is been well recognized throughout the world, as increasingly United States, including by the Federal Reserve Board and the NEIC.

PETER MURSZEWSKI: Excuse me. Your three minutes are up. Please summarize your testimony.

PETER KOCHENBURGER: Thank you. My only two suggestions are as much as possible is to align the reporting days with NEIC's climate risk disclosure survey, or to reduce the burden on insurers. And secondly, Connecticut Insurance Department I think will need additional funding or the ability to retain consultants to make their reporting possible and fulfills the purposes of this Legislation. Thank you.

REP. WOOD (29TH): Thank you, Peter. Did you submit your testimony?

PETER KOCHENBURGER: Not yet. I will.

REP. WOOD (29TH): Yeah, if you could submit your testimony, that'd be really helpful to us.

PETER KOCHENBURGER: Thank you. I will.

REP. WOOD (29TH): Any questions from the Committee? Seeing none, thanks for joining us, Peter.

PETER KOCHENBURGER: Thank you.

REP. WOOD (29TH): Next up Sabrina Marino, followed by Craig Floch.

SABRINA MARINO: Good afternoon. Thank you so much for having me. And I just want to pull something

up. Excuse me, I'm going to have to read from a prompt, just because I do have a bit of an emotional story to share. My name is Sabrina Marino. I'm a mom, stay-at-home mom to two little boys, and my husband is an emergency department R.N. at the Hospital of Central Connecticut. I'm here today on behalf of our family, and many like our own, to urge you to consider this bill before us, particularly the sections including insurance company coverage for cochlear implant surgery for individuals, including children struggling with appropriate unilateral and bilateral hearing loss.

I am very confident that this will positively impact the lives of so many families, and especially children in Connecticut. My own son was implanted just before Thanksgiving. And we've already seen tremendous, tremendous improvement and growth in his communication and motor skills. It is a little known fact that children with hearing loss also have balance and walking gross motor problems attributed to the vestibular aspect connected to their hearing loss. So he's made tremendous growth since then in all aspects.

In addition to our own personal experience, I just ask you to consider that cochlear implant surgery is a necessary component of treatment to prevent further communications ways for individuals who have chosen listening and spoken language as their preferred communication. And I hope that you'll take the following into account with open minds and open hearts. I did submit in my written testimony a very detailed version of our story. But in short, my son was born hearing, he was born with congenital CMV. And due to that, he does suffer from profound hearing loss, which is progressive and lifelong issue that we have to worry about, 20% to 30% of children born with CMV will demonstrate mild to moderate loss and 70% to 80% will demonstrate profound hearing loss. So this is something that many families struggle with.

By the time my son was one year old, his hearing loss had progressed to the point, where he was no longer receiving sufficient sound from a hearing aid. I think it is very important to note here that hearing aids are not equivalent to cochlear implants, which is something that insurance companies can't seem to understand. They believe that they are equivalent devices. And that was one of the reasons that some of the families that I've talked to have been denied, along with the fact that their children are under five, which is why my son was also denied. And only that's bilaterally, excuse me, unilaterally. So because he was not bilaterally deaf, they felt he had sufficient hearing.

It's crucial to note that it is acceptable and practice for children as young as 12 months of age, who are not receiving benefits with hearing aids to be considered for cochlear implantation, and it actually is recommended for them to be implanted as early as possible because their brain is --

PETER MURSZEWSKI: Please summarize your testimony.

SABRINA MARINO: Okay, in short, I just like to point out that other states are already putting these practices into place. In fact, there's also a federal act being considered Ally's Act, with similar goals, mandating this coverage would change the lives of so many families, and children in Connecticut. And I am very grateful to be here today, and thank you for the opportunity to share our experience and hopefully answer any questions you may have.

REP. WOOD (29TH): Thank you, Sabrina. It's nice to meet you after emailing back and forth. I was wondering if you could share your insurance coverage stories with us? You know, did you have to meet a deductible? You know, tell us about the cost to your -- to your family for this.

SABRINA MARINO: So, at the time, the deductible actually is something that we -- it wasn't an issue -- our deductible have been met, actually, ended up paying a little more because it reset by the time that he got his approval, that -- the issue was solely that he qualified for a hearing aid. They thought that he had enough struggle to give them a hearing aid, but he wasn't struggling enough to get an implant, I guess, because one year was sufficient. And he wasn't considerable for eligibility for an appeal or anything because he's under the year -- five years of age, which confused our doctors because all of the surgeons and therapists and everyone we work with suggested that between 12 and 24 months was the ideal time to implant him to allow his brain the time to adapt and learn around hearing the way that he would be, as hearing with the cochlear implant is not -- oh, an amplified sound like you would get with a hearing aid how we hear. It bypasses that part of the ear -- the damaged part entirely, and stimulates your nerves in your brain. So it's more of a mechanical way of hearing and your brain needs to learn how to do that. It doesn't just -- you put on your cochlear implant and you're off with your life. It's a very intense process and needs to be started as soon as possible.

REP. WOOD (29TH): Great, and other families that are going through this, are they having to cover a lot of this costs themselves? Have you shared this with other families? Or you know, do you know any other stories that you can share with the Committee.

SABRINA MARINO: So the -- there are a number of families who, unfortunately, would have liked to be here today, just couldn't make it work. But -- we did have a lot of testimonies sent in. The biggest issue is getting it covered to begin with. I -- there were so many families that are just straight up denied. It's not in -- for us, it wasn't a matter of what was left over to pay, it was not

covered at all. And no surgeon is going to go ahead with a surgery that big and not get paid. And for other families, that there is a struggle of maintenance and therapy after the initial implantation, because like I said, it's not a one and done deal. You don't get surgery. And then you're hearing from then on now. The individual needs to go through extensive therapy to learn how to hear, to learn -- in my son's case, because he's so young how to speak. These are not things that happen overnight. And, unfortunately, a lot of them are not covered, even if the initial surgery is.

REP. WOOD (29TH): Well, I'm glad to hear that your son is doing better with this implant. And I really appreciate you coming and sharing. Do we have any questions? Great. Thank you. Thank you for being here this afternoon. Next up, we have Craig Floch, followed by Diana Goode.

JULIE SJOBLOM: Hi, this is Julie Sjoblom at Dr. Craig Floch's office. Unfortunately, he cannot be on this afternoon due to him being pulled into the O.R.

REP. WOOD (29TH): Okay, did he submit testimony that we could read?

JULIE SJOBLOM: Written? Yes, he did. And so --

REP. WOOD (29TH): Okay.

JULIE SJOBLOM: Did his entire staff.

REP. WOOD (29TH): Alright, so we will do that. Thank you for sharing that and we're sorry that we missed them.

JULIE SJOBLOM: Okay, thank you.

REP. WOOD (29TH): Diana Goode, followed by Tom Swan.

DIANA GOODE: Hi, everyone. Senator Lesser, Representative Wood and Members of the Committee, thank you for letting me testify today. We are offering our support for House Bills 6626. Session 13 of the Bill creates a requirement for insurance companies to provide treatment for gambling disorders, which addresses what we think is a huge loophole in the problem gambling safety net. My name is Diana Goode, I'm the executive director of the Connecticut Council On Problem Gambling.

So I want to start by saying that Connecticut Counsel doesn't advocate for or against gambling, we are not the fun police. We are not here to tell people how to spend their disposable income. We just want to make sure gambling becomes easier and more accessible, that there are safeguards in place. And one of those safeguards is definitely access to treatment. There are plenty of people who gamble and don't have a problem. We are not concerned about them. We are concerned about the people who gamble and develop a problem.

Where the statistic that we use is if you live within 40 miles of a casino, the odds double that you will have a problem with gambling. Once the proposed gambling expansion becomes a reality and you can get them on your phone, everyone will have a casino in their house. We, currently, estimate there are about 100,000 people in Connecticut who have a problem with gambling. And if you include the impact to their families, that number increases to about 275,000 people. The way we break that down is, approximately, 735 individuals in 1,900 family members in each House District, over 3,000 individuals and almost 8,000 family members in each Senate districts. With the proposed expansion, we think those numbers will just keep growing.

So the issue for us is that although gambling addiction is recognized in the DSM-5, insurance companies can still choose to not cover that treatment. So a lot of times when a problem gambler

finally raises their hand and says they have a problem. They are emotionally at rock bottom, they are financially at rock bottom, and then to have the insurance company deny their treatment and deny their claim is just another really devastating blow to them. We are hoping that this address -- this issue will be addressed before gambling expansion instead of after. So thank you for letting me talk today. If you have any questions, I'm here to answer.

REP. WOOD (29TH): Diana, thank you. Senator Lesser.

SENATOR LESSER (9TH): Yes. Thank you, Madam Chair. Thank you, Diana, for your testimony. I guess I'm a little confused about your testimony. Certainly, I understand that problems are probably gambling, enurable constituents that their lives destroyed by it. But we have a number of laws around Mental Health Parity we passed on in 2019. We're actually getting -- you've heard of data from insurance companies starting March 1st of this year, and probably be overhearings on compliance. I guess I'm not sure based on what you just added to that this is covered by the DSM-5, why coverages are isn't already required by our parity law or even expansion.

DIANE GOOD: We don't know either. All we know is that when our therapists are trying to get coverage -- get -- trying to get their claims covered for people who are problem gamblers that the insurance company can deny it, if it's used as a primary diagnosis. So we don't know the answer why insurance companies can arbitrarily decide to not cover problem gambling.

SENATOR LESSER (9TH): Okay, and have you had any conversations with the Connecticut Insurance Department, we'll try to get them to sign up.

DIANE GOOD: No.

SENATOR LESSER (9TH): Maybe we could sort of stand up those conversations just to get a good answer.

DIANE GOOD: Thank you.

REP. WOOD (29TH): Thank you, Diana. Have a great day.

DIANE GOOD: Thank you.

REP. WOOD (29TH): Next up we have Tom Swan, followed by Dana Cantiello.

TOM SWAN: Good afternoon, Senator Lesser Representative Wood and other Members of the Insurance Real Estate Committee. My name is Tom Swan and the Executive Director of the Connecticut Citizen Action Group. And on behalf of our 1000s of members, I want to voice our support for Senate Bill 1047, AN ACT CONCERNING INSURANCE AND CLIMATE CHANGE and Senate Bill 1043, AN ACT CONCERNING THE HARTFORD COURANT. We believe Senate Bill 1047 is an important bill that will protect shareholders, policyholders and the general public, we're not the only ones to think this.

Last week, Moody's released the report it -- then a link in my testimony I'm submitting. It says, "Closer regulatory scrutiny of climate risk is positive for health insurers because it will push the industry to better evaluate and monitor climate-related risks. It will also support insurers in making difficult choices in response to climate risks, such as reducing exposure to certain profitable but carbon-intensive sectors."

Our insurance department is already part of a compact with several states that insurers report their potential risk for climate change to the NAIC. We believe on this legislation will have that information more readily available to Connecticut residents and stakeholders here, and hopefully in a

more user friendly manner. We also know that the California Insurance Department has successfully required, as you heard from Dave Jones to the disclosure of investments in fossil fuel companies. Their most recent data, though, is from 2017. And we know that the industry's approach to fossil fuels has changed on a daily basis.

Last year, we did a state-based report that I'm linking in my study on the 2017 data. Our discussions with insurers leave us hopeful that they're beginning to see the need for change themselves. Just today, Bloomberg reported on a study from the International Energy Agency and found global portfolio renewable powers -- power. Post companies posted an annual average return of 18% in the decade to 2020, compared with 4.7% for fossil fuel stocks. The total return for renewables during the period was 426%, more than seven times the figure for fossil fuels. This is a fiduciary issue that stakeholders have a right to know.

We applaud what is a groundbreaking clause in this Legislation, where property casualty insurers will be required to report the fossil fuel projects they are underwriting. We believe this is a crucial step forward that can help guide future policy initiatives in both the private and government sector. We were happy to see a Representative from the Harper play an active role in the recent G.C. train process including advancing ideas for how we --

CHRISTINA PEN: Mr. Swan, your time is up, please summarize.

TOM SWAN: Okay, I'm just let that -- how we finance efforts related to climate change. The irony was at lost on us so whether we're looking at items financed by means other than insurance, while at the same time underwriting some of most disruptive projects and companies, in regard to climate change.

It -- this is similar with -- it said, in closing, I want to voice your support for Senate Bill 1043 related to Hartford Courant. What Alden Global Capital done and will do if left to their own devices unconscionable in a threat to the public's right, they need to know. We believe the effective corporate charter is including state Legislation. You have additional leverage than over most companies. And we urge you to use that in every way possible to protect the public's right to know in a free medium. Thank you.

REP. WOOD (29TH): Thank you, Tom. I was wondering if you can elaborate a little on the Hartford Courant piece. Do you know -- you know, can you elaborate on any sort of layoffs or moving services out of Connecticut that isn't fair?

TOM SWAN: I mean I do -- if we were in session and going on to -- you know to testify in person, like most years, we could be seeing the big for sale of the Hartford Courant. They've cut down on staff, I believe, since Alden Capital, by about 20%. There are others that can speak about that. They're not covering local communities; they're not offering the same level of coverage of the Legislature. I remember when I started, I think there were four or five reporters dedicated full time to -- here. And what they're doing in terms of just ripping it apart and selling, it represents the worst practices that that hedge funds are feared for doing. And it's doing it in real public -- in a real public cost. And I want to really commend this Committee for elevating this issue and giving people a chance to talk about it's really important. So thank you.

REP. WOOD (29TH): Thanks for that. Any questions from the Committee? Thanks, Tom. Have a great afternoon.

TOM SWAN: Thank you. Cute baby, man.

REP. WOOD (29TH): Next up is Dana Cantiello, followed by Penelope Abernathy.

DANA CANTIELLO: Hello. Hi, everybody. Thank you, Madam Chairwoman, and the rest of the Insurance and Real Estate Committee. Appreciate this time to come forward to you guys. I was part of this last year and, you know, obviously, we had to kind of put things on hold because of COVID. So I appreciate this coming forward once again. My name is Dana Cantiello. I'm a nurse -- excuse me, I'm the nurse practitioner in Middlesex Health -- Medical Weight loss and Geriatric Surgery Program.

As a medical professional, I've met many Patients affected by obesity. In the state of Connecticut, 29.1% of our residents are affected by the diagnosis and complications associated with it. That's up from 26.9% just last year. According to the Obesity Action Coalition, $1.7 trillion dollars is being spent each year to provide care in this country towards obesity-related healthcare. healthcare costs for individuals affected by obesity are 34% higher than the rest of the individuals. The obesity epidemic will continue to get worse as our children and adolescents are affected by this disease. Children in Connecticut, two to four -- two to four-year-old, 14.5% and 11.5% for ages 10 to 17 are affected by obesity. The Center for Disease Control provides funding to 15 states for training to help early childhood education settings with obesity prevention. Connecticut is not one of those 15 states, so we can't prevent it. How can we treat it? So here are the facts I want to bring to your attention.

There are several insurance companies in Connecticut choosing not to cover its insured population with an obesity diagnosis, and they will not approve life-saving procedures and medications. Again, let me repeat that again. Several insurance companies in the State of Connecticut are choosing not to cover

its population with an obesity diagnosis, and will not approve life-saving procedures and medications.

So being a nurse on the frontlines of obesity medicine, my professional opinion, this shouldn't be tolerated. This is not inclusive coverage for all diagnosis. This is the president -- prejudice of diagnosis. This is discrimination and exclusion because of the patient's weight and appearance. The State of Connecticut become -- can become a proactive problem solver for its residents by mandating these insurance companies to suspend any practices of discrimination or exclusion based on size, weight or appearance relating to obesity. There's a three-fold increase in mortality for these patients. People living with obesity, 28.2% of their annual healthcare costs are treated -- or expect treating obesity-related conditions. So why are insurance companies still denying access to treatment or surgery?

I mainly work with medications and I see a lot of post-op patients to my patients to meant -- approved for obesity treatment to reduce weight led to a greater weight loss and increased likelihood of meaningful weight loss outcomes, not from the Journal of American Medical Association. So often medical treatment for obesity makes economic sense, as these individuals are at risk for developing additional, costlier chronic diseases. Insurance coverage for medical weight loss management is not sufficient. This places an economic burden on the healthcare system as costs increase with these progression. Some medications are completely excluded from insurance plans --

CHRISTINA PEN: All right. That's three minutes. Your time's up, please summarize.

DANA CANTIELLO: Despite showing effective results. These medications can give you a 5% to 10% weight loss, along with other lifestyle modifications. And this year, we, as a state and country, will do --

heart conditions associated with COVID. We know COVID and obesity are highly linked. So it's so important for us to treat the disease of obesity as a chronic condition and it will help with those other comorbidities that these patients are dealing with.

You're going to hear from a lot of our patients from our program today. They're going to tell you their stories. But truly utilization of obesity treatment will generate Medicare budget savings and I believe someone else had said this -- $18 billion dollars to $23 billion dollars, we're going to get that money there in a 10-year period. So we need to act now.

So again, this population is being readily stigmatized, and now they're being denied lifesaving care. So I urge you to support S.B. 1007, enabling the segment of our population to be fully covered by their insurance, in order to obtain treatment for obesity, reduce or eliminate comorbidities and to have a better quality of life. So thank you for letting me talk. I appreciate it so much.

REP. WOOD (29TH): Thank you so much. Your testimony covered a lot of great points and we appreciate it.

DANA CANTIELLO: Thank you.

REP. WOOD (29TH): Any questions? Seeing none, Dana, thank you. Have a great afternoon.

DANA CANTIELLO: Thank you so much.

REP. WOOD (29TH): Next up we have Penelope Abernathy, followed by Ellen Andrews.

PENELOPE ABERNATHY: Thank you for the opportunity to provide testimony regarding Bill number 1043 that seeks to prohibit the Hartford Courant from incurring debt or issuing debt dividends that are not in the public interest. By way of introduction,

I'm Penelope Abernathy, the author of four recent widely referenced reports on the state of local news in the U.S. and the author of two books on digital business strategies for news organizations. Prior to becoming the night chair in journalism and digital media economics at the University of North Carolina in Chapel Hill, in 2008 I was a senior Business Executive at the Wall Street Journal, The New York Times and the Harvard Business Review. I'm currently a visiting professor at the Northwestern University's School of Journalism.

Extensive research has shown that from a very early stage, strong newspapers have played a vital role in nurturing our democracy, binding us together as a nation, while also building a strong sense of community and regional edition -- indemnity. However, successive technological and economic assault have destroyed the business model that sustained our newspapers for two centuries. Local newspapers today are in a perilous financial state. In response, hedge funds and private equity owners have swooped in to purchase newspapers at bargain basement prices. They then employ a standard management formula, focused on aggressive cost cutting and financial restructuring, including bankruptcy. Most of these acquisitions have been financed with significant debt, usually underwritten by other investment firms. Profits from cost-cutting are not reinvested in the newspapers they own, but instead used to pay loans, management fees to principals in the firm and shareholders.

Newspapers in the country have historically been equal parts -- business enterprises and civic institutions with special constitutional protections. Newspapers need to be profitable in order to stay in business. However, unlike the newspaper barons of the 20th century, many of whom were journalists, the hedge funds and private equity owners lack an appreciation for journalism's traditional civic commission. They're so focuses on the finances. They view their newspapers as

investments to be bought, so traded harvested or shuttered in order to maximize financial returns. Over the past 15 years, we've lost the fourth of our newspapers 2,100 and at the same time, we've lost half of our newspaper journalists with what -- with round after round of layoffs rightly diminishing the newsrooms of the country's largest regional newspapers, including the Hartford Courant. Investment firms like to say that through aggressive cost cutting, they have saved local newspapers. While that may be true in some cases, many of the survivors are ghost newspapers mere shells of informer sales.

There is another way to save newspapers. My research tracks a growing number of independently-owned newspapers, regional media companies and digital sites that are investing in their communities, as well as their newspapers by developing sustainable for profit, nonprofit or hybrid business models that embrace journalism, civic mission. Massive consolidation in the industry and the dominance of hedge funds and private equity owners have shifted local --

CHRISTINA PEN: Hi. That's three minutes. If you could please summarize? Thank you.

PENELOPE ABERNATHY: Yeah, I will -- have shifted local editorial and business decisions to owners without a strong stake in the communities where their businesses are located. Newspapers such as the Hartford Courant have historically provided the information that builds trust in our democracy and in our institutions. Reviving local newspapers in whatever form and medium they are distributed in the 21st century, requires investment and long term-term commitment to the communities where they are located by placing limits on the use of data, Bill 1043 attempts to reassert a balance between the Hartford Courant's profitability and its journalistic mission between its business interest and its public interest. Thank you.

REP. WOOD (29TH): Thank you very much for your testimony. Questions, Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair. And thank you, Professor Abernathy, for your testimony. You know, I'm looking -- and, obviously, this is a tricky issue, because we are, obviously, dealing with an institution that in the case Hartford Courant in the United States been around for over 200 years. And there is this question about the First Amendment. So I think the First Amendment that it really important. That -- there -- well, I see the U.S. Constitution, but the protection of newspapers of the press at the very top of the list of rights we ask. And looking at the legislative history of the Hartford Courant in particular in 1887, we as a legislature,
at the Courant's request, gave the Courant a charter -- again because we saw, as a Legislature, public value, overwhelming public, having the residents of our area when we get access to timely and accurate news about events of the day.

I mean, it seems like we have -- throughout our country seen the news, it's something we need more for form -- and citizens to be able to vote in elections, to know what's going on in their state they need access to -- so I get the concerns that something's have about us, saying, you know, reopening a charter that's been in effect for work 150 years and encourage public focus. But I'm also concerned that the problem with Alden Capital Management isn't that they're running their newspaper badly or they're not -- some of the news -- that they're not interested in being in the news business. That what they're really seeking to do is to sell off all of the assets of the newspapers that they're buying off. Is that really the concern that this Bill helps to address or whether or not a newspaper wants to sell newspapers or if they see themselves, in the case of this company, is being in real estate for happen to own the land that

[inaudible] and having some presses that might have side -- having other assets that they can sell off. These are things that our business is in telling a newspaper how to operate. But it isn't telling folks that, "We really want news of some kind," that people live in Greater Hartford should be able to know what's happening in the world.

PENELOPE ABERNATHY: Well, I think you raise a good point. And I think part of it depends on where Alden Capital is in its cycle. I mean, historically, they have used the massive number of newspapers they acquired in the early teens, to, basically, offset losses they had on everything from investing in great debt to pharmacy chains and in Canada. They have been one of the few investment firms that's been willing to sell off our properties as long as you meet their price, unlike many of the private equity firms that want to just sell them all in mass.

So I think there is an -- there is a considerable notion within various communities that are currently owned by Tribune, that they want to try to buy back the papers and put them back in local ownership. And as I stated, there are some -- an increasing number of successful examples we can point to where that has happened. I think that it is a -- I think it's also interesting that you're attacking it from the debt function, because leveraged debt has been -- leveraging a company has been a tactic for both hedge funds and private equity companies since the 1980s. And that -- with the leverage -- with a leveraged company that increases the risk, that you're paying off interest, you're paying off the debt and you're paying the management fees, what the way this is structured, so that there's nothing really going back into investing in the newspapers.

So I mean, to me, I love the way that you appraised it public interest. There is extensive research out there now that shows that when you have strong local newspapers or lose a newspaper, because it's very

diminished, you have a decrease in voter participation because people just can't find the information they need, you have the cost of business going up for the government's both locally and in the state level, because there's a lack of transparency and people questioning what you're paying for bonds and the like. And you have a spread of misinformation that -- and no because there's a vacuum on social media and into that goes misinformation. And then there's also a notion that when you lose a paper like the Hartford Courant, that you actually lose the connection in the state, that people depend on their Hartford Courant, as a regional newspaper, to kind of bond together not just Connecticut, but the region, in order to come up with policies that at the state and national level, that save lives and avert disaster.

SENATOR LESSER (9TH): Thank you. And I do note that in addition to the accumulation of debt, there's another provision in it that allows the issuance of dividends, if they're acting in the public interest. My understanding is that --

PENELOPE ABERNATHY: Right.

SENATOR LESSER (9TH): It could be a corporate parent authority has a large amount of cash saved up, which you know --

PENELOPE ABERNATHY: Right.

SENATOR LESSER (9TH): Should be going to like in the business. But the theory that here -- that Alden may lose in the formula [inaudible] ensure that the actual viability of various attributes [inaudible].

PENELOPE ABERNATHY: Yeah, yeah, you're correct. Thanks for pointing out the large accumulation of cash. Right.

SENATOR LESSER (9TH): All right. Well, thank you very much. And I'm sure -- I know we have a lot of folks who are interested in this Bill and there may be other [inaudible] I think that Chair will do.

REP. WOOD (29TH): Thank you. I'm not sure who raised their hand first. Senator Anwar, are you available to speak? It look like you might be testifying in another committee.

SENATOR ANWAR (3RD): I can speak to a manager. Thank you so much. Actually -- we'll quickly share with you. First, thank you so much, Professor Abernathy, for your testimony. I truly appreciate you sharing your experience. This is a phenomenon that is at a risk of happening across the board. And because the news industry has become somewhat challenging in the print form, even the digital form has its challenges. So what would be the impact on a community when that happens when we lose out on local and statewide news?

PENELOPE ABERNATHY: As I just mentioned, there's been tons of research over the last five years by many scholars in the university, as well as industries researchers that have shown that voter participation has gone down steadily when you lose the newspaper -- when you lose a newspaper or when a state newspaper is significantly diminished. We have depended on our state newspapers for instance, to bet the candidates for state office. And I mean, I don't know
about you. I feel pretty comfortable as evaluating the person running for governor, based on where they stand, even the Attorney General. I'm less comfortable in North Carolina, assessing who makes a good agricultural secretary, who makes a good auditor? So that has been a traditional function that we have relied on papers like the Hartford Courant to do.

The second thing is that whole notion of just oversight, transparency, providing shining a light

on it so that we know when there's an issue that we need to be concerned about. And then finally, there's the whole issue that newspapers have, historically, encouraged not only, you know, political growth and political resonance is also helped regions grow economically by identifying the issues that are important for long-term sustainability. So there are a whole raft of -- there's a whole raft of research that says while every one of us should be concerned about the loss of a newspaper, or the diminishment of a -- of a long-standing newspaper, like the Hartford Courant.

SENATOR ANWAR (3RD): Thank you. Thank you so much for that. And right now, the challenge we are also having is that because of as I touched on the fact that this news business has become financially less sustainable, what are the models that are out there? Because the private equity model is not a sustainable model?

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): So what are the other models that we --

PENELOPE ABERNATHY: Well, my research has shown that there are three things that you need in order to construct or increase your chances of a -- of a -- putting together a sustainable business model, whether that's for profit, nonprofit, or hybrid. The first thing you need to do is in a community that has above-average economic growth or population growth prospects or is relatively you can piece together a number of affluent, you know, businesses individuals in the -- in that area.

The second thing you need is you really need an owner or a publisher who has a mandate to identify and address the needs and expectations of both residents in that area and the businesses in that area. That's really important because you've been -- what we don't want is to get into a situation,

where you have to be wealthy, to pay for access to the news. We want everyone in the community to be well informed and businesses play a key role through their sponsorships, through their marketing in the like, have historically done that in providing the news and information.

And then thirdly, one of the mistakes I see are groups that -- local groups that come together to buy a newspaper is that they tend to focus on the cost of acquiring the newspaper and not realizing need, at least, five years' worth of capital to invest in transforming the business model so that it is delivered to meet the changing needs and expectations of the residents and businesses in that area.

SENATOR HWANG (28TH): Thank you so much. And my final question, Professor Abernathy, is now in the current era where Social media has taken a twist in a direction, which is pretty concerning about the external influences and outside of the country, people are trying to influence opinion right here through various groups and the town groups literally have influence from out of country. And in that situation, we need a trusted source. So -- and then -- and, historically, just trusted source have been very few and Hartford Courant has been one. So can you speak to that, and then the value for that -- for the communities?

PENELOPE ABERNATHY: Well, there's also abundant research over the last two or three years that points out how much of the information that flows on the Facebook, on social media, even on Google is aimed at the national level. So it contributes to, in many ways, the polarization that we have in this country, it's very easy to find more than 90%, by some estimates of what circulates on the internet is of national consequence. We need -- we need to understand how a Bill in Congress has local relevance to us. And that's the key role that a Hartford Courant would have play. I have done

analysis of local news that, theoretically, ran on a Facebook feedback in 2019 and 2020. And we found that it was preponderantly crime news, that was kind of one-off interesting, crazy crime, or it was kind of feature stories, of which none of that helped us make wise decisions about the quality of our lives that day, whether it was safe to go to the grocery store or not.

And one of the very important functions of a trusted source like the Hartford is you have professionally trained journalists to adhere to professional standards, and provide context around the news. So it's not just a rumor that appears as facts. It comes from a trusted source. So, you know, some people have said, "Why do you want to support a dying industry?" And I said, "I'm not supporting print newspapers, I'm supporting the important function that newspapers have played in our democracy in whatever form they're delivered."

SENATOR HWANG (28TH): Thank you so much, Professor. Thank you, Madam Chair, for allowing me to ask the question. Thank you.

REP. WOOD (29TH): Senator Hwang.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Miss Abernathy, thank you so much. I was reading through your resume. And it's doggone impressive. And I guess you would retire. So congratulations on retirement.

PENELOPE ABERNATHY: Thank you.

SENATOR HWANG (28TH): Can you talk a little bit about the crisis on local news? I think you've pinned the phrase local news deserts.

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): What do you mean by that? I mean, I think we all see it as legislative leaders

and running for elections and multiple towns, we see it. But can you kind --

PENELOPE ABERNATHY: Yes.

SENATOR HWANG (28TH): Of articulate it for our audience to really put it into kind of a clarity for us?

PENELOPE ABERNATHY: Well, my own definition has changed. And what is a news desert. And let me just say, I'm not wedded to news deserts, it seems to have taken off. Some people call it news poverty. I initially defined it news dessert, as a place that like the local newspaper. And as I said, we've lost the fourth or 2,100 of our newspapers in just 15 years. That's how dramatic the decline has been. And the reason I did is because newspapers have, historically, been the prime if not sole source for most people of local news and information. Newspapers have, historically, had many more people employed as journalists than any other medium. So we depended on them to cover the local school board, to cover the County Commissioner meeting that that region televisions didn't hear, or that the radio stations didn't have someone to do.

If my -- definition evolved considerably is I've mapped out where reach digital sites are located, what kind of coverage comes out of public broadcasting, and also where ethnic media are. And what I've come to determine is that as news desert is a place where residents have limited access to the kind of credible news and information that feeds our democracy. Does that help a little? I mean, so limited access can be in terms of lacking digital infrastructure to receive it. It can be limited access in terms of the information that comes across, and it can also be limited access in terms of not being able to afford it. I mean, the cable bills can be $200 dollars a month. And for many people, that's just not an essential part of what they are. So that forces them to their cell phones,

whereas it forces them into looking for news on the Internet.

SENATOR HWANG (28TH): The reason I asked that question is the Alden Global Capital business model is to leverage.

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): And with the changing revenue dynamics that papers and news media outlets are experiencing, the first thing to go is local news.

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): The local reporter that's reporting on Joe and Jill's school dance and things like that, they're the first ones --

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): To go. And we've been seeing that, when -- and going back to the purpose. The --, obviously, germaine issue to this bill is the fact that these big hedge funds with a different business model really have created an exasperated this, this local news desert that people have all of a sudden realize overnight, "Boy, I missed that newspaper report."

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): Or coming down to the to the Girl Scouts cookie sale and the Boy Scout luncheons, you know? So that's why it's important for us to address this bill from that context. The other part that I wanted to ask of you is, well, I'm going to make a pitch for you. People should take a gander at your major report, news, deserts and ghost newspapers. Will local news survive? I think you did an incredible job in scaring people, in understanding what they realized they had, they will never know it when it's gone. And then that's

important. Your paper talks about not only from a local paper perspective, but also feeding the next generation of journalists, and people who will read the news and understand that there's a much higher standard in regards to journalistic integrity, journalistic validation, than what gets thrown on to a Wikipedia or a social media post. So we -- losing that. And you put that beautifully in your report. So I'm pitching that because people should read it. Because it's a loss of journalists. It's also a loss of people's expectation of reading the news.

The other big piece that you -- I was really impressed I'm going to read that later, I didn't get to read a little bit about it is your work on strategic digital media --

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): Which kind of segues away it's an interesting point, you said. You're not, per se, talking about printed newspaper. But in regards to how you get news that's validated --

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): That its objective, that has professional and high integral journalist, being able to translate that. I mean, one of the examples I've seen is the New York Times, how they made that transition --

PENELOPE ABERNATHY: Yes.

SENATOR HWANG (28TH): Into the digital medium, paywalls is a consideration, but then that annoys people. So talk to me about how we can look at the digital media has a business model that complements the tradition, as well as the objective integrity, and the incredible journalists that we have developed. Not right, not only up and coming, but the ones that we value and take for granted that write such great, great, great news content with

such history. How do they -- how do you suggest meshing that without the interruption of a -- of an Alden that keeps on trying to squeeze revenue without understanding the important role that news has in our society and in our democracy?

PENELOPE ABERNATHY: Well, first of all, thank you, Senator. That was a wonderful endorsement. And if I need a P.R. person, I know exactly who I'm going to -- coming back. I want to address a couple of things. One, when I first went to North Carolina, after being at the Wall Street Journal, people said, "When are you going to come up with a new business model?" And I think that what we have to acknowledge is there was one dominant business model, or newspapers of the last 200 years, what it's 80% to 90% of the revenue that sustained our newsrooms came from advertisers, and it came in, in form of grant.

You know, there are a number of challenges to morphing into what you are. But I mean, what I say is there's not going to be one business model, there's going to be many, and it's going to be dependent upon the needs and expectations of the residents and businesses in that community. So I can point to several. As I mentioned, independent newspapers, reached a small smaller regional chains or even digital sites that have done a really good job of understanding where they are located, understanding their community, understanding how people want to receive news, and what sort of news they're missing. What -- I mean, it was very encouraging to me that in 2019, when the Pew Research Center asked people what they thought of what news was missing, more than half of the people said they noticed that there was much less local news that occurred in the last five years that was relevant to them, and that syncs with what we've seen from scholars who've looked at 100 different communities and found that on a typical week, at least 20 of the 100 had no local news whatsoever.

So for me, as the researcher who's been banging this drum for the last five years, it's very encouraging to me that we finally got public awareness that something is slipping away. It's also very encouraging to see historians, like Timothy Snyder, talk about how our democracy depends on local news. The FCC when it did a report back in 2011, estimated as much as 85% of the news that makes it into national headlines originates with local newspapers. And having worked at the New York Times, that makes perfect sense. So the news, the newspapers that I have seen, that have evolved into a different model, they're not just going for a digital model. They often have print products, they often have an E-newsletters, they often have in house digital ad services, that help with the local businesses, get on the internet and do a whole range of things.

One of them he actually owns an independent bookstore that has done quite well; it was losing money. And it -- from there that has encouraged him to think about e-commerce, it's encouraged him to think about being a community gathering place, again, being kind of the town square, where you bring people together to discuss and debate important issues that are going to affect the quality of our lives and as well as future generations. So it is -- it is you really taking a holistic approach of what your community needs, and what your civic responsibility, is that's what distresses me so much about the shift in what we've seen in the last 10 or 15 years, in terms of newspaper ownership.

SENATOR HWANG (28TH): And your conversation is not just simply about the Hartford Courant, which this Bill is --

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): Germane to but any of the --

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): Numerous local papers that have -- that have all dried up. And --

PENELOPE ABERNATHY: Yes.

SENATOR HWANG (28TH): And it's such a painful loss. You lost a very good friend in some ways.

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): And I will share with you, your national reputation notwithstanding for you to take the time to do this, it's important for us to ask the question of why this Bill is in the Connecticut Legislative Committee on insurance, right?

PENELOPE ABERNATHY: Right.

SENATOR HWANG (28TH): And I got to share with you it's a really good question as I was debating it myself. And it is important to recognize the unique history that the Hartford Courant has in this country's founding --

PENELOPE ABERNATHY: Yeah.

SENATOR HWANG (28TH): And the ethos of journalism in this country. And if I -- if you will indulge me the fact that to understand a brief history lesson, you know, the Connecticut Courant was this country's -- this country's oldest newspapers, right? It was actually founded before this country's origin. And in fact, the date was 1764.

And the other interesting part is, it had one of the first female publishers in the business.

PENELOPE ABERNATHY: It did.

SENATOR HWANG (28TH): And it has such an important role in the Revolutionary War. You know, and if you

studied history, as I love history, you realize what a -- what a special Connecticut gem we have and a great source of pride in the Courant. When you think about the important role they have in informing the public, going all the way back to 1764, talking about public get -- you know they published the Stamp Tax Act, which got people kind of getting started about our revolt against England, taxation without representation. Then we had the Tea Tax, which led to the Boston Tea Party, which is in our annals of history. That was reported by the Courant. And the fact as I was reading through and do my homework that the Courant actually published the entirety of the Declaration of Independence after its release.

Now, considering the act of -- the act of uprising, if we had lost the war, they would have been considered treasonous for publishing such a document. That was, to me, even back then, the independence of the press to get the news out. So when we think about that power, the founding of this country and the important integrity that we have for journalistic objectivity and transparency, it begins right with the Courant. And it's funny because we talked -- well, with the legislative issue, we shouldn't get into it, right. It's a private enterprise, etc. But would you believe in the -- in the same 1700s, the Connecticut General Assembly actually enacted a lottery to pay for the burnt down paper mill so that they can continue to publish and inform the people during the revolutionary war. Can you tell I love history?

PENELOPE ABERNATHY: You've actually -- you've actually informed me. I thought I knew a lot about the Hartford Courant. But I've actually learned a few things here.

SENATOR HWANG (28TH): And we're so lucky that when we're in the General Assembly, it's right across the street, and the reporters are living legends in the regards to -- so to me, this discussion, and, you

know, is so important, beyond the third rail or a free market enterprise. I think we have an important responsibility to use the symbol of what the Courant stands -- to preserve democracy, transparency, and the news that dates all the way back to our founding of this country.

And you would ask why, you know, perhaps maybe as a Republican, why I wouldn't want to cater to the market forces. I will share with you. I look at the press has a treasure third rail. For me growing up in a country where, as opposed to democracy was under martial law, we didn't have freedom of the press, freedom of the election, freedom of really understanding what opposition viewpoints are. We, as an individual, did not know any better, Ms. Abernathy. And, perhaps, we've been spoiled in this country, because we've had the media to keep some degree of objectivity, whether you like it or not, right? The fact that there is an opposition viewpoint is something that we in democracy have the responsibility to protect and to maintain.

So that's maybe for me, when I look at this as an issue, it's not just simply a business decision. It's protecting the integrity and the objectivity, and the transparency of what goes on in our government. Because without sunlight, you know what? You know, power corrupts all. And we have a bad habit of trying to do it my way or no way. And the newspaper is our only tool, in some cases, when there's an overwhelming majority, to be able to let people know that there are other choices out there. So I -- I'm a big fan of the media, from the standpoint of transparency, but I'm an even bigger fan with the Courant means to the State of Connecticut. And I really appreciate your time spent this afternoon sharing your perspective, but I would encourage other people go read your report. It's really a compelling read. So thank you, Ms. Abernathy.

PENELOPE ABERNATHY: Well, thank you for the opportunity to talk with you guys there.

SENATOR HWANG (28TH): Thank you, Madam Chair. I see you smiling there.

REP. WOOD (29TH): Yeah. No, it's a great discussion. Representative Nuccio.

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

PENELOPE ABERNATHY: I'm doing fine. Thank you.

REP. NUCCIO (53RD): I think I'm gonna be the semi opposition to my good friend, Senator Hwang here, and ask for some clarification. It sounded like you were talking about -- you -- to me -- I think you actually haven't mentioned the business model, you know, the matter of whether or not the industry has come up with a good business model. And I understand that local newspapers have struggled to switch to the online media format, which is just so sensationalized, and as you said, you know, it's so divisive. You know I struggle a lot with where media lives and breathes right now.

But -- so my question here is I'm struggling with trying to understand what this piece of Legislation is doing. So if the Hartford Courant is a business in and of itself, and it has been purchased by another business, that's a business transaction. And I guess I'm trying to figure out how legislators can get in here and then tell that business owner what they can and cannot do with the business that they purchased. So I'm truly honestly reading the Legislation, it's one page and even reading it, I -- I'm still not sure what it's trying to do, in essence of trying to protect the Hartford Courant from something. So I was wondering if maybe you could give me some insight in your mind how this works.

PENELOPE ABERNATHY: Yeah, thank you for asking that. And the devil is always in the details. And I'm -- my testimony is in -- is around the notion of what you're trying to do. So let me back up philosophic philosophically and make an argument philosophically. Because I leave it to you, very wise legislators, to figure out that the unintended consequences of things like this, because I think you always have to -- I think that one of the things that has separated the press in this country has been that it is what I mentioned. It has been both a business enterprise and a civic institution, with constitutional protections. So those constitutional protections have been used over time to support the press through subsidies that are enacted in the U.S. mail system, through supporting NPR in for what it does and us gathering. And so, what I like about the way it is worded -- and I leave it to you with the details -- is that what you're really saying is, I want you to honor the tradition that oppressive -- presses had in this country. It has had the ability to be both a business enterprise and make money. And it's also -- but it's also had a civic mission.

So one of the ways to think about this is when the Hartford Courant was owned by the Times Mirror Company. They were a publicly owned and traded on the Stock Exchange. So many people worried, "Okay, there goes the business, right? All they're going to do is they're going to press, all they're going to do is satisfy their shareholders." But as a shareholder, I had the option of knowing exactly how the trip -- because it was publicly available information, thanks to the SEC, of knowing how the money was spent and invested, because they had to file quarterly reports, they had to file annual reports. So if I really cared about good journalism and cared about the newspapers, that the change zone, I would invest in Times Mirror versus some other options that I had. I would invest in the New York Times versus some other options.

So what -- I what this is doing is simply asking that the hoard of cash, that the Tribune Company currently has, because it sold off its TV stations, right. So it's debt-free there, that with all the buying the stock, that it not undervalue the price they're actually paying for the Tribune Company, and then start selling off all the assets, but that any debt that is incurred or build up should be going back to the public interest. It's not saying that you can't do it for profit, because hey, as long as it's a for profit model, it needs to go for profit. But there needs to be some justification that it's honoring public interest. And if you look at the history of what Alden has done with large newspapers that its own, such as the Denver Post, there is a history of it going from a staff of 300 in a newsroom to down two years ago, it was about 60 in the newsroom. So -- and that's a larger metropolitan area than even Hartford, I think, if I'm remembering correctly.

And there are a lot of issues there. I mean, we have historically relied on state newspapers, to not only deal with the local issues, but to kind of bond as a state together by covering those big major issues around education policy, around environment, a whole things that kind of trickle across arbitrary political lines, and kind of help feed that back up into the national system. So I understand what you're saying. But I'd also say there's a 200-year history in this country of treating newspapers very differently or treating the press very differently. The calls -- it is both a business enterprise and a civic mission.

REP. NUCCIO (53RD): So, I guess, then our -- do you feel like this piece of legislation then is asking us to take additional steps beyond what we have constitutionally for free press to protect the -- not only the industry, but like if you look at the Hartford Courant and the fact that they may have been flagging in the past and not doing as well, and maybe they don't have a good business model or

whatever, but for the state to step in, and then protect that entity, even though it's a private-owned entity because of its civic obligation?

PENELOPE ABERNATHY: Let me answer that as I would when I was a Senior Business Executive of the New York Times. When I had to make presentations to the Board of Directors at the New York Times, I've made arguments not only based on why it was good for the business side and what it was good long term, but for how that also was good for the mission of the New York Times, the journalistic mission and the civic mission that the New York Times failed to inform the country or inform the people around the world. So I mean, I don't -- I don't see what the way it's currently written, that it's asking a newspaper to do anything that whatever newspapers have historically taken on it is their dual mission, that of making enough money to support journalists at the same time or having enough money to support journalists, at the same time doing it in the public interest because it's a civic institution protected by the Constitution.

REP. NUCCIO (53RD): Okay, so then I guess the last thing I have done because I really -- I'm not trying to be obstinate.

PENELOPE ABERNATHY: Yeah, I thank you for the questions.

REP. NUCCIO (53RD): I'm just really trying to understand it.

PENELOPE ABERNATHY: Yeah.

REP. NUCCIO (53RD): So are we then just looking to tie the hands of Alden to not pillage the company? Is that -- is that what you've kind of maybe see this as?

PENELOPE ABERNATHY: I think if Alden can make an a -- Alden has his own record. And I'd wish I could

remember the exact quote, that they cared about the quality of the journalism that was produced in their papers or something, or they were the bastion of producing that. I think you're just simply asking them to live up to the statement that they made, and I'll be glad to send that to whomever the statement that has come straight from Alden about why they wanted to buy the Tribune Papers and some about how they cared so much about journalism in this country. And, yeah, I will even -- I will even attach the editorial that came from the publisher and owner of The Little Rock Arkansas Gazette, doing the same thing that I think your Legislation is doing is asking them not to strip mine is newspaper or newspapers, but instead invest in the newspapers and care about the quality of the journalism.

REP. NUCCIO (53RD): Did they do that fair? Did they respond well to that? Or did just -- no.

PENELOPE ABERNATHY: Oh, where that -- where that -- Little Rock, Arkansas, this ad is owned -- is independently owned and operated, but has had the -- has had the ability to go in and buy some of these newspapers and revive them that have been owned by private equity and hedge funds. And it looks -- that person is I think he's a third generation newspaper owner in Arkansas and has watched with some dismay, you know the management of newspapers, especially by the chains owned by the private equity and hedge funds, which, by the way, dominate four out of the five top largest chains in this country.

REP. NUCCIO (53RD): Yeah, I definitely think that there's a lot of oddity in media and news media across the whole spectrum with certain only so many companies owning pretty much every news outlet out there.

PENELOPE ABERNATHY: Yep.

REP. NUCCIO (53RD): So diversity is definitely the better way to go. So you can actually get the news

in an unbiased way, in my opinion. So is that -- what specific part of this Legislation do you think is going to enable us to be able to hold Alden to that?

PENELOPE ABERNATHY: Well, I think it's simply asking them if they want to take on debt or like the Board of Directors simply to ask them if they want to take on debt or pay dividends, that they show how it's in the public interest to do that.

REP. NUCCIO (53RD): If they're going to take on debt or pay dividends?

PENELOPE ABERNATHY: Yep.

REP. NUCCIO (53RD): And that --

PENELOPE ABERNATHY: And I think -- I think -- I think the -- there is a danger of giving that cash hoard that, you know, Tribune has been very attractive because it is -- does have a substantial cash from having sold off the television stations that have not been invested in the newspapers either.

REP. NUCCIO (53RD): Okay, thank you. Thank you very much for helping me try to understand this. I appreciate it.

PENELOPE ABERNATHY: Great.

REP. WOOD (29TH): Penelope, thank you for your testimony and spending so much time with us today. We appreciate it.

PENELOPE ABERNATHY: My pleasure.

REP. MESKERS (150TH): Next up, we have Ellen Andrews, followed by Jennifer You.

ELLEN ANDREWS: Thank you. Thank you very much for this opportunity to share the Connecticut Health

Policy Project support of SB 1004 and 10 -- 1051, ACTS ESTABLISHING TASK FORCES TO STUDY INSURANCE and HEALTHCARE IN THE STATE AND TO STUDY MEDICAL PRACTICE OWNERSHIP MODELS. These Bills are -- address important issues with profound implications for healthcare in Connecticut. They deep focus study to measure the impact of changing market forces and make recommendations to protect consumers and taxpayers.

One of the main drivers of rising healthcare costs in Connecticut is consolidation in the healthcare market. consolidation is complex, and it's getting worse. Connecticut's hospital markets are among the most consolidated in the U.S., and we have growing concentration in our physician market in Connecticut. The trend toward consolidation is accelerating because of the pressures of pandemic but it started long before COVID.

There's considerable evidence that provider consolidation drives up prices for healthcare without improving quality. I won't go through that in my three minutes. While Connecticut has adopted some measures to promote competition in the marketplace, that isn't enough. And there are several legislative options available to improve the competitiveness of Connecticut healthcare markets. Other states have adopted many of these options and it makes sense to
convene a task force to consider them.

Contracts are governed by state law and can have anti-competitive provider payer contract clauses and also provider health system contract clauses. Things like all or nothing contracts, exclusive contracting, anti-tearing or anti-steering clauses, gag clauses, I love that term, non-compete clauses and in network referral requirements all restricts competition. My -- I didn't send in my testimony that describes these in more depth. It didn't get up on the website, but I'm sure it'll be there soon.

There are regulatory options to promote competition. The state could require notification and approval for all proposed mergers and acquisitions regardless of size, multi-agency approval could be required for more complex approvals. And the review should include the impact on prices, volume of care, impact on market competitiveness, self-dealing and conflicts of interest, access to care, quality implications, referral patterns, consumer choice, community benefits, impact on underserved communities, health disparities, and the impact on state and local budgets and local economies.

Too often, mergers are approved with promises of improved better outcomes, but there's no follow up to ensure that those things happen or to monitor for unintended consequences. Even a farm is found, it's too late to do anything about it. Merger approval should include enforceable conditions on the mergers as necessary to address potential harms identified in the review. Other policies that new payment model payment reforms can carry incentives for provider consolidation. In fact, the Accountable Care Organization model promoted by Medicare and others relies on consolidating providers into large health systems to save money.

PETER MURSZEWSKI: Excuse me. Your time is up, please summarize your testimony.

ELLEN ANDREWS: Sure. private equity is also concerned not just for newspapers, and price transparency can help. And some Connecticut's healthcare markets are increasingly consolidated and less competitive, both the causes and policy remedies are complex and risk, unintended consequences. The problem needs thoughtful public study and discussion in a taskforce of independent minds with diverse perspectives to find the best policy options to make healthcare more affordable. Thank you.

REP. WOOD (29TH): Thanks, Ellen. You know, I'm always happy to support a task force that is functional. And that actually comes back with suggestions for us to do the good work the following year. But I'm concerned that this -- some of these may be redundant to work that has already being done out there. And I was wondering, if you can't answer it now, maybe you can provide us with some other working groups that are, you know, working on these things that we could look to for this, you know, research. Or maybe, you know, you think, "No, let's, you know, bring that working group into this task force." Just want to make sure we are doing the right thing with the resources that we have going forward.

ELLEN ANDREWS: Right, there -- the healthcare cabinet did just have a presentation by Katie Gudiksen -- I'm probably messing it up -- from the University of California Hastings School of Law, she was excellent. And she helped me with a lot -- with the testimony that I provided. But that's all that's happened. And there's been nothing -- no, it was just last week, I think. And nothing's come of it.

This isn't really something that unfortunately, it isn't really being talked about in -- we have a lot of task forces and a lot of committees and I get that. And I'm not a big fan of task forces or committees. And it has to be done right. Like you said, it has to be functional and thoughtful. And it has to have good people around the table with lots of input from the public. Or it's -- and I've been a member of these many times and talking to friends. It's like, "Can we cut and paste from the last one we just did on this?" That I don't think that's really the case here. I think this is a new problem, and I don't recommend a task force easily or quickly, or, or happily, frankly. But I do think that there is a need for it in this case.

REP. WOOD (29TH): Okay, and these are two very separate issues. So consolidating this wouldn't make any sense, correct?

ELLEN ANDREWS: With the healthcare cabinet, because the cabinet looks at so many other things. They might convene a workgroup --

REP. WOOD (29TH): Okay.

ELLEN ANDREWS: On drugs at one point, but nothing hit of it.

REP. WOOD (29TH): Great. Thank you.

ELLEN ANDREWS: That is --

REP. WOOD (29TH): All right. Senator Hwang, you're up.

SENATOR HWANG (28TH): Thank you, Madam Chair. And, Ellen, great to see you again.

ELLEN ANDREWS: Good to see you.

SENATOR HWANG (28TH): You're -- you said it very quickly. So you -- you're testifying and not having your testimony, just want to double check. Your comments were related to Senate Bill 1044, correct?

ELLEN ANDREWS: 10 -- is it 1044? Did I mess that up? I think it was a one -- 10 -- 1004 and 1051.

SENATOR HWANG (28TH): Okay, I -- it's not on the agenda. So I'm -- so -- but let me -- let me make it easier. So you're talking about the task force to study insurance and healthcare in the state.

ELLEN ANDREWS: Yes.

SENATOR HWANG (28TH): So that's 1044.

ELLEN ANDREWS: Okay.

SENATOR HWANG (28TH): Okay? So -- and just your thought in reading the other testimonies, would you be opposed to having a Connecticut Hospital Association representative, as well as other shareholders on this task force?

ELLEN ANDREWS: No, I think it's actually really important to have them engaged.

SENATOR HWANG (28TH): Great. Thank you for that input. And because that was one part of the testimony. Then, I believe, your other bill was 1051, AN ACT STATUTORY TASKFORCE TO STUDY MEDICAL PRACTICE OWNERSHIP MODELS.

ELLEN ANDREWS: Right.

SENATOR HWANG (28TH): Right. So obviously, there was a testimony and feedback in regards to health insurance companies, who also purchased medical groups. And what are your thoughts on that as a -- as a prohibition? Or do you think allowing it is a good idea?

ELLEN ANDREWS: Yeah, it's definitely consolidating in -- you know, we have horizontal consolidation between hospital systems, and then vertical consolidation, you know, with the practices and nursing homes and such with hospital groups. I don't know. I guess we're gonna need a third dimension to talk about this kind of consolidation. So it troubles me, I'll be honest. And it also -- you know, you'd probably need a spreadsheet, at least, to figure out the incentives when you have -- and I mean, part of the way the health system is supposed to work is that insurers represent payers and the people paying for it, and providers, you know, want to provide care and the natural tension there, when insurers start buying practices that that does get an -- it's another form of market -- I don't want to call it a failure. It's a market distortion. And so, I'm not going to say that it

automatically is a problem, but I'd be watching it really quickly.

SENATOR HWANG (28TH): Well, I think as we've had many debates in this Committee talking about how we contain health costs, I think you've been consistent as a -- as an advocate in saying that consolidation has not always been in the best interest of the consumer. And unlike business models, healthcare is a uniquely different model. You would think that with the vertigration of consolidation across the board, you would get efficiencies. But, nonetheless, we see costs continually increase. And that's why I all want to plug again, and thank you for your advocacy in some of the suggestions for cost containment. And I know you've come in from a consumer side, and an objectivity side. And so, your comments and thoughts are always valued.

But I do want to point out that the two comments -- of the two Bills you're commenting on that there are opportunities and make it better so we can get some better data points to address the issue at hand. So I want to take a moment also, thank you for your always, always committed work on behalf of healthcare consumers. So I'm a big fan. So thank you very much, ma'am.

ELLEN ANDREWS: And I apologize if I got the wrong agenda, I apologize.

SENATOR HWANG (28TH): That would be a rare time where I get you for me to be right, then you wrong. So I'll take that. But, nonetheless, I think that's the challenge, right? There's so many Bills with numbers. I always say to people, jokingly, when you start referring Bills by numbers first, then you got me because you're way over me, in regards to that being delved into these issues. So -- but, again, I want to take a moment to thank you for your tireless work. And it is remarkably consistent, that we may not always agree, but I know you always have the interest of consumer mind. So as we move forward on

future issues in this Committee, your thoughts and insights are always valued. So thank you, Madam Chair.

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

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

ELLEN ANDREWS: I'm good. How are you?

REP. NUCCIO (53RD): Oh, I'm thriving. So I have a -- I have a couple of questions for you. Was looking at the two Bills that you talked about, and there are kind of different Bills. And I was wondering if you could weigh in a little bit. The first one, I understand everything about the task force, the task force, the task force, but I think if there's one area that we truly need to kind of focus in on is actually how to control the costs of healthcare. It's funny because we're the Insurance Committee and we tend to talk an awful lot about insurance, but the actual driver behind insurance is healthcare costs. So the first 1044 is, basically, studying healthcare in the state. And I was wondering if you have an opinion on if you -- how you think benchmarking would help with that? And if you think that would be something that would really kind of help us hone in the costs and how to improve those?

ELLEN ANDREWS: Yeah. Two thoughts. I mean, I've raised concerns with the benchmarking. I love benchmarking, and I've always been on getting new reports and data. However, I've had real -- and so I was sort of -- I didn't have a position on benchmarking before it started. I've been very concerned with how it's been implemented how if -- it it's started with the end in mind. And then it's trying to back into getting to a particular goal that was pre-determined. And I still don't have -- and I talked to the people who were drafting it.

And I still don't have a good sense of how they picked those numbers, how they picked those specific pieces.

For one -- for instance, in one piece of it, it includes improve -- controlling costs, but then expanding -- doubling primary care spending. They chose to exclude primary care that is provided by OBGYNs -- women who choose to go to an OBGYN for their checkups, their primary care. I think women should have that choice. The O.B.s are trained and licensed to provide that care, and its care that's being provided, so it ought to be counted. They chose not to count it. And the reason given was that if we counted that we'd already be over the 10%, that the Governor said in his executive order. That's just -- that's a stupid -- I'm sorry not that word. That's not a --

REP. NUCCIO (53RD): I gotcha. If we have a problem with primary care, we should look at what those problems are. And then --

ELLEN ANDREWS: Exactly; get back to it, just because places that do other job in primary care spend more than 10%, doesn't mean that throwing money at the problem is necessarily going to get us to a better primary care system. So I -- benchmarking, I don't have a problem with I have a problem with this particular process that's happened. The second part of it is they are not looking at consolidation at all. Trust me, if they were looking at that I'd be good. I would not be up for another task force to -- you know, I've got enough meetings that I already monitor. It's -- that they're really not looking at that as a cost driver. And when you look at the literature, it's really hard to miss.

The other piece of is that people get drug costs, they get that, everybody gets that, they're out of control, and they need to come down. That's easy, general public incident, policymakers get it. The

implications of consolidation are more hidden. And hospitals are just different than drug companies. You know, we all, you know, go there, they save our lives, you -- with birth there, you know, friends who work there. They're huge employers in the state. It's different in terms of how people feel about at hospitals that shouldn't blind us to the fact that their consolidation is having impacts on the premiums. We see premiums going up, but we don't necessarily connect it.

And that taskforce can not only do a lot of drill down into these issues, because I've only spent the last like week or two working around them. And, and I've learned that these are very complicated, and you couldn't make big mistakes, if you don't think it through well with really smart people. But it's also -- I also think task forces can raise awareness about issues.

REP. NUCCIO (53RD): So I find what you said very interesting, because I think I am the least science person in my family. I'm a math girl. But even I know that when you're conducting research, you don't go in with a pre-determined, you have a hypotheses, and that's it. So, you know, for us should be hypotheses should be what is driving healthcare cost, and then gather the information and then be able to delineate in that data, what it is. So I'm a little concerned that you say that you feel like that's not happening, because I don't think we should be trying to drive an ending here, I think we should be striving to understand all of the levers, and then how we can move them to make things better. So that's a little concerning for me now that you said that.

And I wholeheartedly agree with you, a lot of these consolidations I hate to use a word that people don't like, but they create monopolies. They create entities that dictate what their reimbursement is going to be. And if you do not comply, they pull their network and leave you without providers --

significant amount of providers in major metropolitan areas and outskirt areas. So -- and they are a main driver in healthcare costs. I don't think we can look at just insurance on this or just the providers or just drugs, we need to kind of look at a holistic plan on what we can do to bring the care of -- the cost of healthcare down. So if this study -- if this task force could get us that -- I don't know how you change what's already happening if there's already a task force. So that -- you've given me a lot to think about with that one.

ELLEN ANDREWS: Well, actually I think this is parallel to the cost cap. The cost counting is completely silent on consolidation. And what I'm talking about is actually focusing on just that part of the market. So it should be complimentary to what's already going on. It doesn't have to be ripping -- again, duplicative.

REP. NUCCIO (53RD): Yeah, I do think there's a lot to look at there with the consolidation. You know, we've got ample data to show what happens when you start having these consolidations across the country, not even just in Connecticut, but literally major areas -- Florida, California, everywhere. So the information is there if we want it. And then on 1051, you -- this one here, if I'm reading this correctly, or is this the implication that like if you have a clinic that is run by a -- an insurance company or something like that, that is that what this is kind of going after?

ELLEN ANDREWS: I don't know what the intention of the task force was. What I -- the reason that it called out to me was medical practice. And, you know, these clauses that are not only driving up costs, but also within like the AMA and the American College of Physicians are creating concern about the practice of medicine, and how, you know, keeping referrals and within a network. Suppose you need a particular kind of pediatric cardiologist, and that person isn't in the network, this -- they have

really strong clauses in your contract that you have to refer within the network, that might not be the right thing for the patient. It's also very obviously not competitive, but it's also harmful to patients' needs and choices.

So I think that it's a bigger issue and I think it is part of medical practice and ownership models. I understand now talking about it like ownership by an insurance company, but I think that the contracts and the private equity firms, as well some of those stories that I've read about that are really disturbing about how they are, you know, really decreasing and starving practices for resources for -- to make profits. And then they end up, you know, being gobbled up by somebody else. They make them much more susceptible to consolidation. And I think that's another problem. But maybe it belongs somewhere else. I -- you know, I just saw these two Bills. And this is something that's been bothering me and it sort of seems like it fit there. But --

REP. NUCCIO (53RD): Well, actually, what you just said, makes a really good connection point. You know, if you look at these models, and you're talking about like the medical practice, ownership model, and being able to only refer to -- and network, etc., it's exactly what these major hospital -- consolidations are.

ELLEN ANDREWS: Right.

REP. NUCCIO (53RD): You know when they can say, "You know, we're gonna pull us and every single one of our providers are providers, including radiologists, and labs, and primary care physician", it's a medical practice ownership model also. So you just made a good connection that I don't necessarily think the Legislation was intending to make, or maybe it was, and I'm just reading it wrong. But I think that's a really good point to bring up, Ellen, I appreciate that.

ELLEN ANDREWS: Well, that's my job.

REP. NUCCIO (53RD): You do it very well.

ELLEN ANDREWS: Thank you.

REP. NUCCIO (53RD): That's it for me. Thank you very much.

ELLEN ANDREWS: Thanks.

SENATOR LESSER (9TH): Thank you. Representative Comey-Reva to Chair.

REP. COMEY (102ND): Yes, hello. Thank you. Okay, so we are on number 25 out of 80 something. And been at it, I find it hard. So I'll come down for a long night. Next on the list, we have Jennifer You, followed by Robin Roark.

JENNIFER YOU: Hi, good afternoon, Members of the Insurance and real Estate Committee, Representative Comey, thank you for this opportunity. My name is Jennifer You, and I'm testifying in support of H.B 6589. I am a general dentist and have been practicing dentistry in Connecticut for over 15 years. And at the end of 2013 actually became a practice owner and a small business owner in Connecticut.

Being a small business owner in and of itself is a challenging proposition and the learning curve is steep. And during the first couple of years of owning my practice, I gain knowledge about dental insurance companies and the various strategies they're able to implement that can make it nearly impossible to provide great dental care for my patients in a timely manner. One of these strategies is called network leasing. Network leasing refers to a mechanism by which a Preferred Provider Organization or a PPO can sell or lease access to their contracted provider networks, and their discounting fees.

So, ultimately, what happens is that a dentist who has signed with one PPO can find his or her name is part of an entirely different PPO. So they inadvertently agree to participate with potentially hundreds of PPO plans from across the nation. And, generally, we are only made aware of this network lease after the patient has already visited the office received treatment. And we, therefore, then received their explanation of benefits.

Currently in the State of Connecticut, network leasing happens without our knowledge or our consent. So not only is this unfair to practice owners, but more importantly, it can put our patients at risk. So when my office is unfamiliar with a new dental insurance that we've never encountered before, we are almost paralyzed because we have a lot of difficulty in giving our patients accurate estimates of their out-of-pocket portions for their dental care. Sometimes, hastily, it can result in the office providing incorrect out-of-pocket expenses for the patient, leaving them with the surprise bill later. Or we can be completely transparent and we can tell the patients we don't know they're out-of-pocket for a given procedure.

And when this happens -- when either of those two scenarios happens, patients are reluctant to move forward with their prescribed dental care. I have personal experiences of both situations, in which we have told patients incorrect out-of-pocket expenses, or where urgent care was delayed because we could not accurately tell the patient or find out -- financial obligations. So either situation, in my opinion, does not serve the patient's best interest and can be damaging to the trust and the patient-doctor relationship. And I can share more about these particular situations if you'd like to hear more.

So I am -- I am proud of the care that I give to my patients and great care includes education in

transparency in all aspects of their care, including the patient's financial obligation. If we could provide our patients with accurate information, we would have the confidence to tell patients what their out-of-pocket expenses are make arrangements.

DAWN MARZIK: Excuse me, can you please summarize?

JENNIFER YOU: Sure, and provide the care they need. So I'm speaking in support of the proposed Bill, H.B. 6589. It will give us a chance to have transparency and it will give us an opportunity for us to approve or reject proposed insurance network leasing contracts. Thank you for the opportunity again, and I'm happy to entertain questions.

REP. COMEY (102ND): Thank you, Jennifer, it's good to see you as always for intervening --

JENNIFER YOU: Good to see you.

REP. COMEY (102ND): Great input from -- I love that those that come before our next committee or public health assessment. I've been on that. So thank you very much. Have a question -- well, other than that, you did mention that you're concerned about the patient care aspect of that, can you give me -- besides transparency and billing, which, of course, is the dental care, I think is probably your number one -- number one issue with this patient care or, you know, choosing to get -- to get procedures done, what else -- what kind of other situations have you --

JENNIFER YOU: Well, you know, like I say, I like to be very transparent with my patients, because it establishes trust. And that's what all of our relationships are based on. So, in many instances, when we meet a new patient on an emergency basis, we're squeezing them in to our already full schedule. And when we're unfamiliar with them in their general insurance, we always have some

homework to do on our end, so that we can accurately tell them what their out-of-pocket is.

So imagine being a patient, you're in pain, you have a tooth that either needs to potentially be extracted, or potentially root canal treated, and you're having to wait to find out what your out-of-pocket is. Because, you know, you're on a budget. When we call these dental insurance companies that we are unfamiliar with, that we may have been network leased out to, a lot of times there's -- well, first of all, you have to try to reach a live person to speak to. So there's a lot of waiting on hold, to speak to someone live, just to get information about a patient's insurance benefits and what kind of coverage they may have towards certain procedures.

So there's a lot of waiting time, as far as finding out -- finding that out. And, you know, it's not always easy to treat these emergency patients and alleviate their pain same day, if we cannot get this information to them. So that is something that we do encounter pretty frequently. And it's unfortunate that we're beholden sometimes to a patient's dental insurance, when all I want to do is to help the patient. So I hope that answers that question.

REP. COMEY (102ND): Absolutely. And I know that when I get a procedure done, it -- I certainly don't know what will be covered and what won't be covered. And I rely heavily on the office of professional staff to let me know what my options are sorry for the word. You had an impressive number or there was a pretty impressive number of pieces of testimony -- written testimony, I should say, on the website, and I was proud of them.

JENNIFER YOU: Oh, that's great to hear.

REP. COMEY (102ND): Yeah.

JENNIFER YOU: Yeah, it affects pretty much, you know, every dentist in the -- in the state that because we -- there are very few offices that are fee for service, meaning we can bill what our office fees are. We have to accept plans in order to be viable. And, you know, when we -- when we sign on with one PPO, the last thing that we're even aware of, you know, in our day to day of running a business is that we could, potentially, be opening ourselves up to a whole host of other PPOs that we're unaware of. And I get that a lot of times we aren't -- this information is not disclosed to us. And we don't discover it until after the procedures have been done. And then an explanation of benefits comes to our office. So it's at --

REP. COMEY (102ND): PPO, would a typical office be accepting?

JENNIFER YOU: That's a good question. And I think that ranges depending on the type of practice they're -- the type of practice and what the provider chooses to participate in. But, you know, I am a part of a couple of PPOs, and in even just being a part of that, again, it opens me up to many more that I'm not always aware of. So it makes -- giving our patients care in a timely manner really challenging, so.

REP. COMEY (102ND): When you go to sign a contract with a -- with a PPO, I imagine the selling point is the amount of people that are on your plan and you locate your price as an individual business owner, or you've heard about it from a larger group?

JENNIFER YOU: That is a good question. And I actually don't know a complete answer to that. But what I do know is that there are particular dental insurance plans in the State of Connecticut that have a set fee schedule for the whole state. So you don't get a say or you can't -- you don't have any negotiating rights or power. So what they offer as their fee schedule is what you accept. And, again,

I fully understand that when I sign on to a PPO plan with one dental insurance company, but my -- I feel, if I should, at least, have the opportunity to know what they're going to lease out our networks. And have the right to say yes or no to, to increasing my PPO patient base, so.

REP. COMEY (102ND): Thank you. I don't see any other hands. I'm just gonna go back to my questions. The -- one of the insurance -- one of the testimonies that I saw was a society or something of life insurance, canceled life insurers, and they had some suggestions on. I think they understood the transparency issue, and they certainly see this happening across the country is what the person said. They had a couple of suggestions, the notification requirements. And I'm just wondering, like that saying something about, you know, you get notified every year when it gets renewed. And that should be enough. Is that --

JENNIFER YOU: I know, I apologize. I don't have that --

REP. COMEY (102ND): Okay.

JENNIFER YOU: Testimony in front of me. But I think that is true that we renew every year, we renew annually. And we are able to review our contract. But we still -- it is still not disclosed to us as the health care provider, whether or not we -- our network has been leased. Does that make sense?

REP. COMEY (102ND): That's -- yeah, that I mean, that's I think it's --

JENNIFER YOU: Yeah. So that's --

REP. COMEY (102ND): I don't mean to say it's a bait and switch. But it is sort of a transfer services, so.

JENNIFER YOU: Right. So, again, we just -- we are asking for transparency, so we can be transparent with our patients. So I'm not -- yeah, I just want -- I just want the opportunity to at least know if something like that could happen and also the potential to say, yay or nay.

REP. COMEY (102ND): Okay. So I'm gonna -- so if you could just, you know, when you get a chance to take a look at that piece, the first piece of testimony on the [inaudible].

JENNIFER YOU: Okay. Yeah, I'll be -- I'll be more than happy to take a look and I'll submit my my comments.

REP. COMEY (102ND): Oh, thank you.

JENNIFER: Yes. Thank you so much. I appreciate it. Have a good day.

REP. COMEY (102ND): Okay, next we have Robin Roark. Is Robin Roark here?

ROBIN ROARK: Yes, I'm here. Thank you. Hello.

REP. COMEY (102ND): Hi, Robin. Can you turn your camera on or?

ROBIN ROARK: It keeps telling me you can't start your camera 'cause the co-host had stopped it.

REP. COMEY (102ND): Let's see what we can do. All right. Go ahead.

ROBIN ROARK: Okay. Oh, start my video. Okay, here we go. I'm okay now.

REP. COMEY (102ND): Oh, nice to see you. Thank you, Robin.

ROBIN ROARK: Hi, thank you. Good afternoon, Senator, Lesser, Representative Wood, and all

Members of the Insurance and Real Estate Commission. My name is Robin Roark. I'm from Ellington, Connecticut, and I'm testifying in support of the Senate Bill 1007. I'm nervous. I'm sorry.

I had bariatric surgery for the first time in September of 2008. I was slowly killing myself with food. I probably had about 200 extra pounds on my body. I tried every diet and every plan sold to the masses. I had failed at everything I had tried. Then I met Dr. Darren Tishler and my life that changed that tissue to perform my lap band surgery in 2008. Prior to surgery, I had D.C. with type II diabetes, sleep apnea, high cholesterol, you name it, I had it. Within six months of my surgery, almost all my comorbidities has declined or disappeared altogether.

Over the last 13 years, I've had to had to resist -- revisions due to medical complications, including reflux. Everyday is a decision for me. Every day I must decide to eat correctly. Every day I must decide to exercise. Every day I must decide to put myself first. Obesity is a disease that is slowly killing people daily. Because of Dr. Tichler and because the bariatric surgery, I am healthy, I am focused and I'm fit. I have gotten my life back and I've gotten my health back. Sometimes the status part is I am the same person 13 years ago, but being 150 pounds smaller now, I am treated so much better by strangers, by co-workers, by medical professionals and the world on a whole. Obese people are made fun of disrespectful, labeled lazy and lacking of self-control. I am the same person I was 13 years ago, still driven, still is focused. Dr. Tishler knew he could help me. I decided with his help to save my life.

REP. WOOD (29TH): Thank you, Robin. Thank you for sharing your personal experience. Those things that sticks with us. And this is one of those pieces of legislation that we hope can change lives for so many people. And thank you for taking the time to

come and share your story with us. Do we have any questions?

ROBIN ROARK: For --

REP. COMEY (102ND): Seeing none, thank you very much. And we'll see you on the other side.

ROBIN ROARK: Thank you.

REP. COMEY (102ND): Okay, next on the list, we have Rossana Ruiz, and after that we'll have Dr. Floch.

LOGAN COTTER: The next person we have is number 29.

REP. COMEY (102ND): 29, okay. Susan Regan -- Patricelli-Regan, Regan, you're on. I see her down there in the corner. I'm gonna call again. Susan Patricelli-Regan, you can unmute. And then your camera on.

SUSAN PATRICELLI-REGAN: Well, I'm here.

REP. COMEY (102ND): Hi, welcome.

SUSAN PATRICELLI-REGAN: I'm here.

REP. COMEY (102ND): We hear you. Go ahead.

SUSAN PATRICELLI-REGAN: Thank you. Okay, all right. Thank you very much, Madam Chair and the Real Estate and Insurance Committee for the time afforded me today to testify on House Bill 6626, specifically line 74 through A1.

The testimony today is for an app requiring insurance coverage for equine therapy for veterans suffering from PTSD. As President and Founder of Foxfield Farm Corporation, a 501(c)(3) three nonprofit established in April 2016, I wish to testify to the value of equine therapy to be of substantial benefit to veterans with PTSD as a supplement to traditional clinical approaches. The

website is www.foxfieldrecoverymission.org. The cathartic advantages of working with horses has long been established to successful results as experienced by those who have special needs and physical disabilities.

I referred to the documents that I sent to the Real Estate Insurance Committee on February 2nd 2021, for which I provided in my written submitted testimony, which outlines the objectives of our trademark equine groundwork program that offers a healthy alternative to treat PTSD and a prospectus relative to your Committee's consideration. The benefits to the participants and Connecticut families are providing optimum options for our brave servicemen and women who suffer from PTSD and related mental issues -- is physically oriented -- fiscally oriented and prudent and our budget challenge state by capping the outside costs, lower cost approach that can supplement or even replace more costly clinical therapies and prescription methods. There's less risk, there's less stress, educationally trade oriented functionally more enjoyable for the participants.

So your current 2021 legislative session, we have provided a constructive financial solution to PTSD. And I did provide a proposal in my written testimony that outlines that exactly. In summary, our veterans deserve better than only one recourse because it's easier to keep medicating the patient, which only masks the issue, but does not solve it. An alternate truth equine approach may make all the difference between life and death. Thank you. And I welcome any questions.

REP. COMEY (102ND): Thanks, Susan. I know that you have some fans up here in the Legislature for the work that you're doing with the Redskins. And I know how important. I've done a little bit of work with and heard stories from CAD, which is, I think, service dog and how many have been lifesavers for that trend. So it's great to hear that your farm is

set up to do the same with horses. And I know it's really effective for kids as well because --

SUSAN PATRICELLI-REGAN: Yes, it is. Yes, it is. It's been a well-proven fact that we know that animals help everyone, particularly dogs, of course, but the horses are special. There are special nurses that reach people. We've had people come here. We've had veterans come here and literally within three weeks, their lives have been turned around and change. They have been had the ability; they've gained confidence. And I want to emphasize the fact that is a groundwork program. People ask us to, "How about riding?" I've taught hundreds of people to ride over the years. But you need to understand how to work around horses, how to work with them personally from understanding them, then comes the confidence because when you have the confidence, the horses relax, you relax. The therapy works, it's not something that's easily -- easy to explain, but it is easy to experience.

REP. WOOD (29TH): I love that. You know, we're talking about alternative routes to better health. And I think that is definitely something that we should be continuing to explore as a health care insurance system as a -- as a committee so I believe --

SUSAN PATRICELLI-REGAN: I will share with -- yes, I thank you for that. I will share with you that they have said that being with people with white coats on makes them nervous. And they have shared stories with us about their personal lives that they said they have never shared with any of their therapists or their doctors.

REP. COMEY (102ND): Wonderful. Thank you so much. Is there any questions on that? Okay, well, thank you so much, and we appreciate the time you took.

SUSAN PATRICELLI-REGAN: Thank you.

REP. COMEY (102ND): Okay. Next on the list, we have Mr. Nelson -- Fraser Nelson. I think I saw him here, and followed by Darren Tishler.

FRASER NELSON: Yes, it's Fraser Nelson. Female. That's okay.

REP. COMEY (102ND): Sorry.

FRASER NELSON: Oh, no worries. No worries at all. I'm here on behalf of Senate Bill 1043. So my name is Fraser Nelson, and I'm reaching you all the way from Salt Lake City, Utah, where I led the transformation of our newspaper, the Salt Lake Tribune, to a nonprofit organization, the first such conversion in the United States. I'm now helping to build a new nonprofit called the National Trust for local news, which is doing some of the work that Dr. Abernathy explained to you earlier today.

Like the Hartford Courant, the Salt Lake Tribune has a story and history. And in Utah, as in Connecticut, local facts and stories and voices can and do change the way we live and work, from schools to elections, from the face we follow, to the businesses we grow, from the laws have passed and the voices that are overlooked in the process, no community can know itself and no democracy can function without a shared understanding of what is true and what isn't true. And like the Courant, the future of our trusted and local independent newspapers in our civic life was uncertain when Alden Capital purchased and immediately began dismantling the Salt Lake Tribune.

Fortunately, we were purchased by a local philanthropic family, the Huntsman's, and Paul Huntsman several years ago, made the decision to transfer the ownership of the Tribune to the community, and its survival is now the responsibility of all those in our state who value accurate information and the accountability journalism crucial to Utah's success. Paul's gift

to our state is tremendous with the future of the paper is in our hands, and I can assure you that the tribune is thriving and the community has taken its ownership to heart and to its wallets.

We may have been the first to make this move to become a nonprofit. But we're far from the last. Just recently we saw Stuart Bainun, Jr. lead the nonprofit acquisition of the Baltimore Sun from the trivium chain, which is itself being overtaken by Alden. Other very successful models of community ownership exists as well. From the benefit corporation model of the Philadelphia Inquirer to as Dr. Abernathy explained many small nonprofit digital first -- digital first newspapers that are starting up around the country.

The legal status, the revenue model and the size of these examples vary, while we all share a common commitment, just like the Hartford Courant to serve our communities. This is fundamentally the difference between community ownership and ownership by out-of-state fiscal interest. For too long, we have led the fate of established local journalism to financial firms, focused on optimizing profitability, not serving communities, urgent action is needed and solutions are emerging. Connecticut no doubt has plenty of residents able to financially support a nonprofit newspaper, and maybe a few of them are listening now. And as the Legislature has the ability through this law, to start that deeper community ownership by allowing any subscriber to sue the Courant, if the company takes on debt, or pays out dividends in a fashion that harms news coverage. I encourage passion to passage, and I appreciate the time today.

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

SENATOR LESSER (9TH): Yeah, thank you, Madam Chair. And thank you for your testimony. It's -- one of the nice things about Zoom is that you get to hear

people from Salt Lake City. Can you talk a little bit about how the Hunstman family founded takeover with engineering? How does someone go around looking [inaudible] local newspaper?

FRASER NELSON: Sure. So what happened was that the Hunstman entered into a lengthy negotiation with the owners and bought the paper outright. So they owned it for a number of years. And Paul looked very carefully at the business models. And you could imagine this the same thing that Dr. Abernathy explained so brilliantly to you earlier today. And he realized there really wasn't a financial future going forward.

Now the Hunstman's have a long history of philanthropy in Utah, and understand well the nonprofit model. And Paul asked me if I would come on board and help figure it out. And what we did was we created a new nonprofit organization called Salt Lake Tribune Inc. and the assets from Tribune LLC., which was the corporation that Paul created when he purchased the paper, moved into that new nonprofit. None of the liabilities were transferred, including pension, just the -- just the assets.

At that point, we began business -- and as a new nonprofit organization, but we kept subscribers. We kept advertising. We were the first paper that the IRS approved as a nonprofit. And it proved it within -- with both of those things in place. On the advertising side, we play unrelated business income tax, but any paper will tell you they'd rather have 60 cents to none. And on the subscriber side, that is a program-related income. Just like when you sell tickets to the opera, or the symphony or a ballet, you sit in the seat and you realize, "Hey, it's not just my ticket that's underwriting this, there's a lot of other money that's coming into it." So we also raised a real substantial amount of philanthropic dollars from leaders, as well as private foundations that help support the

transformation of the paper to the nonprofit and gave us that important piece of runway that Dr. Abernathy spoke about as well.

SENATOR LESSER (9TH): You have any -- you mentioned, Mr. Biden's proposed purchase of Baltimore Sun. I guess there's been a little bit of uncertainty about that and got the whole -- hold the deal. Obviously, we're focused on the Hartford Courant, which is a Tribune property. Do you have any information about how that -- how that came to pass? Or how that specific deal, you know, became part of the conversation? because I assume Members of this Committee would be much more comfortable to get the word local ownership about the Courant that spoke to all of this?

FRASER NELSON: Yeah, I mean, I think it's probably not a journey, unlike the Hunstman's family. We're a very critical piece of not just the way that we function as a society in terms of the way we vote and understanding elections, school boards and the rest, but the economic health of the community. you know, needless to say, I've received dozens and dozens of calls from newspapers around the country. And one thing people say loud and clear is, "If we lose our newspaper, we can become a second rate city. We -- who are we if we don't -- you know, we won't be able to attract new industry, et cetera."

And I think that the -- Mr. data, and then we might be looking at some of those same economic outcomes, as well as, of course, all the civic concerns that he's mentioned. But he was -- it's something that he's been thinking about, from what I understand for quite a long time. And he's recognizing both the economic impact as well as and civic. And mind, you know, these hedge funds are scooping up these papers, because there's still value in them. They're not buying them, because they don't make any sense economically. But I think with the right mix of, of philanthropy, or local ownership, or a change in digital strategy, they can become profitable or

at least profitable enough to keep to be sustainable. Certainly not the kind of money that they used to make, but specific value remains. I think you're on mute, sorry.

REP. WOOD (29TH): Yeah. So I was good. So thank you. That's great. And thank you so much. And thank you for sharing, you know, a way forward from Salt Lake experience and maybe will help you instruct in a way.

FRASER NELSON: Well, I went to high school in Simsbury to it's fun to face school in seventh grade. So it's fun to be virtually back in Connecticut.

SENATOR LESSER (9TH): Well you're both -- virtually Welcome. Anytime, good to see you. Thank you, Madam Chair.

REP. COMEY (102ND): Thank you very much. Thank you for interest and coming. Oh, wait, we've got another question for you.

FRASER NELSON: Oh, another question? Sure.

REP. COMEY (102ND): Yeah, Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much. I totally appreciate, Senator Lesser's questions as well. I just wanted to thank you, Miss Nelson, for your testimony. And I think you're giving us a lot of material to think about and strategize as a community. And I think in the last many years, Hartford has given us so much. Now it's -- we have to figure out as a community, what can we give back. And I think this is what we have to think about a model. So this is going to make us all think and I hope people who are listening with the nonprofit industry can learn from your example and experience. Thank you so much.

FRASER NELSON: Oh, we'd be happy to -- the National Press for local news is created really to help or, you know, communities like yours move forward, and we've been in touch with the folks at the Courant and look forward to being of assistance if we can do

SENATOR ANWAR (3RD): Thank you. And thank for your time. Thank you, Madam Chair.

REP. COMEY (102ND): Okay, now we say goodbye. Thank you.

FRASER NELSON: Bye bye.

REP. COMEY (102ND): Okay, next we have the Darren Tishler. And after that, we we'll have Tam Le.

DARREN TISHLER: Madam Chair, Senator Lesser, Representative Wood, Ranking Members and Members of the insurance real Estate Committee. I'm Dr. Darren Tichler, a Connecticut native in support of Senate Bill 1007, AN ACT REQUIRING HEALTH INSURANCE and MEDICAID COVERAGE FOR THE TREATMENT OF SEVERE OBESITY. This is my personal testimony. It is a pleasure to sit before you again today as I did last year. Unfortunately, the pandemic cut short of the goal of passing a similar bill.

I am the Chief of Metabolic and Bariatric Surgery at Hartford Healthcare and Hartford Hospital, and a Bariatric Surgeon, who's had the privilege of treating thousands of patients with obesity in my 17-year career. I treat and often cure extremely costly health problems like type II diabetes, high blood pressure, arthritis, chronic pain, and many other serious health conditions related to morbid obesity.

I also helped to prevent many obesity-related cancers. This year, I have personally witnessed many patients in my hospital's intensive care on ventilators due to the COVID-19 pandemic. Too many of these patients have died and the majority

overweight or obese. The next time you see a picture of an ICU taking care of COVID patients, notice that the patients you see are likely suffering from obesity.

Earlier this month, according to the CDC, almost 80% of patients hospitalized with COVID-19 infection are overweight or obese. Additionally, high blood pressure and type II diabetes are major risk factors for severity of COVID-19 infection. It has not been a surprise to me and my colleagues that COVID-19 has had a significantly greater negative impact on lower socioeconomic classes in persons of color, as they are the same groups disproportionately affected by obesity.

According to the CDC, non-Hispanic black adults have the highest prevalence of obesity followed by Hispanic adults. All too often, I have to inform a patient of mine that they do not have insurance coverage for bariatric surgery. Unfortunately, I have to have this conversation every week in my practice. Most states have Affordable CARE Act required benchmark plans that include coverage for bariatric surgery. Connecticut is the only state in the northeast that does not have such coverage. Obesity causes more than 200 serious inexpensive health conditions, including cancer, diabetes, and high blood pressure and leads to early death and of stroke, heart attack and blood clots. Nearly 30% of Connecticut residents are affected by obesity and nearly 10% have type II diabetes.

The costs of obesity are staggering. Health care costs for those with obesity are 42% higher when compared to those without obesity. My written testimony contains information from the Office of Legislative Research on the cost effectiveness of bariatric and cost savings to employers because of improvements in worker productivity after bariatric surgery. There's a threefold increase in mortality and those without ask the bariatric surgery over nearly 10-year period.

As a physician, I've responsibility to act in a fiscally responsible manner, but at the same time do what is right for my patients and offer them the most effective treatments. I urge you to support Senate Bill 1007. And I sincerely hope that this is the year that we've joined our neighboring northeast states in and improving the access to bariatric surgery and the treatment of morbid obesity. Thank you.

REP. COMEY (102ND): Thank you here so much, doctor. Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much, Madam Chair, and good to see you, Dr. Tishler. Thank you for your testimony.

DARREN TISHLER: Thank you.

SENATOR ANWAR (3RD): Thank you for waiting. And thank you for the work that you do. And, obviously, I have to share with everybody that I share many patients with you and blessed -- that our state is blessed with the person of your skills to be able to help our patients and our community.

DARREN TISHLER: Thank you.

SENATOR ANWAR (3RD): I just wanted to know last time, last year, you were able to give us some verses of -- about the savings per patient, if I may remember or if you remember offhand. In other words that earned by the state, the amount that you recover back is exponentially much more.

DARREN TISHLER: Absolutely. In my testimony, I have those numbers. I don't have it right in front of me here. But it's in my written testimony that I submitted. But the biggest impact is on productivity. And, unfortunately, the return on investment here is not in six months or a year, it's in a period of a couple of years. And I think we

have a lot more patients are gonna be testifying today that will tell you about how their lives have been changed, and how they've been able to become more productive. And I think allowing someone to be -- to reach their full potential in their -- in their work career is probably one of the greatest gifts we can give someone with surgery.

SENATOR ANWAR (3RD): And so, if you don't mind my asking this question for the benefit of individuals who may not look at obesity as a disease, they would look at it as a life choice that people have made. And you know that we have stereotypes. And I think that's important to try and avoid those stereotypes and if you can allude to that.

DARREN TISHLER: Sure. One of the biggest things that we fight in my career is the stigma of obesity. And in fact, there's been quite a bit of research done right here in Connecticut, on the negative impacts of obesity stigma. There is a cycle of patients who are obese that have -- that have negative feelings against them that become internalized -- these negative internalized biases that we see then lead to patients having a lack of desire to seek health care. And, of course, when someone doesn't seek health care, the health problems get worse. So the strong bias against obesity is wrong. It is been said that obesity is the last area where it's okay to discriminate. And we're working to make sure that this is, you know, far from the truth.

SENATOR ANWAR (3RD): Thank you so much. And I think many of the times I see is that different people have respiratory illnesses, so they are unable to exercise. And they obviously would gain weight and we give them steroids and make their lives even more difficult because they would have other challenges, but I truly appreciate your testimony. I am also hopeful this is going to be the year. Thank you so much.

DARREN TISHLER: Thank you.

SENATOR ANWAR (3RD): Thank you, Madam Chair.

REP. COMEY (102ND): Thank you, Senator, and thank you, Dr. Fisher -- Tishler for coming. No other questions. Have a good day. Okay, next Dr. Tam Le.

TAM LE: Thank you, Madam Chair, Representative Wood, Senator Lesser, and Members of the Insurance and Real Estate Committee. My name is Tam Le. I've been practicing dentistry in Connecticut for over 25 years in the Cheshire and Hamden area. I've served on the Connecticut State Dental Association Board for a number of years and currently, am -- is the President. I'm here to ask for your support of the proposed H.B. 6589, AN ACT CONCERNING THIRD PARTY ACCESS TO PARTICIPATING DENTAL PROVIDER CONTRACTS. It's also known as the network leasing Bill.

While the network leasing concept does have its place in serving the patients, their employer and some dental providers, it's lack of transparency, however, has caused confusions and difficulties between patients and dentists. Without network leasing loss, health care transparency suffers. Patients and providers should be fully informed about the cost of care as early as possible in any healthcare transaction. Lease network often have the opposite side effect. Because lease networks operate in obscurity, the provider and the patients unable to determine the actual coverages. This erodes the patient and dentist's trust, which can lead to assumptions and treatment plans and costs based on false understanding of patient coverage. As my colleague Dr. Jennifer You stated earlier, when there is a lack of understanding between the patient and their providers with regards to the financial obligation for care, the disruption of care occurs.

The Connecticut State Dental Association is advocating for network leasing law that would expand

transparency and provide an opportunity for dentists to consider their options. Currently, almost half of the states in the U.S. have employed such a Legislation. I'm here to speak on behalf of the Members of the Connecticut State Dental Association and our patients, because the CSDA is the trusted leader and voice for oral health in Connecticut, dedicated to the profession and the public. I'm looking forward to collaborating with you on policy solution to help patients better understand insurance and the use of their coverage more effectively. I urge you to join the 20 states that currently have network leasing laws in place by supporting H.B. 6589. Thank you.

REP. COMEY (102ND): Thank you, Doctor. And thanks for all your work you do advocating for dental health in the state and with your colleagues, we had a lot of them if you've heard them earlier, but we have a lot of testimony on this Bill. So thank you. You're doing a good work. Senator Lesser, you have a question?

SENATOR LESSER (9TH): No, I just wanted to say thank you, Dr. Le, for your testimony. I know we've talked about this before, and look forward to working with Association and sort of putting our heads together on this [inaudible].

TAM LE: Thank you for the opportunity.

REP. WOOD (29TH): Thank you. Okay. So I'd like to go back and see if Dr. Neil Floch is here. I see that he's in the attendees or now he's in a -- participant. So if he is here, he can turn on his camera and his microphone and go ahead and testify.

NEIL FLOCH: Here.

REP. COMEY (102ND): Great.

NEIL FLOCH: Hi. Thank you so much for going back to me. I'm not sure what happened. I want to thank

the Co-Chairs and the Members of the Insurance Real Estate Committee. My name is Dr. Neil Floch, and I'm a resident of old Greenwich, Connecticut. I work in Norwalk, Connecticut. I'm a bariatric surgeon for 20 years. I'm the Director of Bariatric Surgery in New Vance Health System here in Norwalk, and the immediate past president of the ASMBS in Connecticut. I performed well over 2,500 weight loss with what we call metabolic surgeries, because they change people's metabolism and alters the weight that the body wants to be. That's a -- that's a concept that most people don't understand.

I've struggled to help people who need bariatric surgery, and weight loss medications obtain their insurance approval for treatments, and this has been a difficult problem my entire career. This year, countless amounts of our patients contract the COVID-19 and several died while waiting for their bariatric surgery. It has been the most tragic social experience of my lifetime, as I'm sure it has been for all of yours.

When the COVID-19 epidemic began, we believe that age was the biggest and worst risk factor for the coronavirus as it struck China. But we later found out that younger patients were dying. Patients with a BMI of greater than 35 actually had nearly a four times greater risk of being admitted to the ICU and patients with a BMI of 45 and above had a two times higher risk of dying from this disease. This year the public became aware that obesity is a deadly disease and immediate death from obesity from this horrible COVID 19.

The CDC report from just last week, March 8, 2021 showed that 78% of the people hospitalized, put on a ventilator died, were either overweight or had obesity. 50% of these people had obesity. Many people have normal weight, as we're all seeing, are gaining weight during this horrible pandemic and our problem is getting much worse. A study out of France and another study from the Cleveland Clinic

by Dr. Aminian, my friend, showed that actually bariatric surgery will help you with COVID-19. The study showed that of the 4 million people they watch 541 had bariatric surgery, and they looked at those people that people didn't have surgery, 15% of them were put on ventilators, 14% of them died of their obesity. Whereas if you had bariatric surgery, only 7% of people went on a ventilator, and a quarter of those people in comparison 3.5% died.

All patients with obesity have long been the targets of bias and discrimination of their disease. That's why you don't see more patients coming on and testify. They're scared, they're afraid they're ashamed. And they have to tremendous courage to speak up.

DAWN MARZIK: Can you please summarize, sir.

NEIL FLOCH: Obesity is also an issue of race and color, as it is most prevalent in non-Hispanic black adults and then Hispanics. Structural racism is a root cause for both obesity and COVID-19 among communities of color. It is a discrimination problem and people with COVID-19 get sick because of their obesity. Black people die seven point times higher because of this disease than Caucasians. I would be happy to answer any questions. It is a horrendous problem. And I seek your support for S.B. 1007 to pass this year. Thank you very much.

REP. COMEY (102ND): An incredible testimony. Thank you so much and for all those data points, I -- your testimony -- your written testimony is in the -- in the -- we have that?

NEIL FLOCH: It was submitted last night before eight o'clock. I hope that it's in there. If not, I will submit it later. And I'm happy to answer any questions now.

REP. COMEY (102ND): Okay.

NEIL FLOCH: I'm very passionate about this.

REP. COMEY (102ND): Yeah. Great, Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair. And thank you, Dr. Floch. It's good to see you. And --

NEIL FLOCH: Good to see you.

SENATOR LESSER (9TH): You are passionate about this issue. And you're absolutely right. This is something that we were hoping to address, at least last year before the pandemic hits. But, you know, I really appreciate your thoughtful comments and how this really connects to the pandemic.

You know, one of the things that I have been -- one of my pet peeves has been all the folks out there who say when someone dies, especially a younger person dies of COVID, "Well, they must have had comorbidity," as if it doesn't count a death doesn't matter if it's somebody who has some sort of other underlying health condition, obesity is certainly is going in them. And I don't know whether it's just the lack of compassion that folks have or lack of awareness that, you know, we all have one predistinct condition or another -- a risk factors. But the evidence that you've laid out that, you know, obesity is an incredibly significant risk factor for COVID is -- I find very compelling.

I also remember as well that we spent a lot of time last year focused on the issue of hygiene. But wonder as well, if they bariatric surgery would be helpful in helping ahead of type II diabetes. Is that something that has been proven and that to quickly cross over their research on them?

NEIL FLOCH: Yes. I can't -- the volume is not so great. But the best treatment or the most successful treatment for diabetes is actually metabolic surgery. What we like to call metabolic

surgery, people don't understand it. If it changes your metabolism. People call weight loss surgery. So we go along with that. But it is the best treatment. It simulates a hormone called GLP-1 of other things which is a drug coming out that is extremely successful. You may have heard of Metformin. There's another drug coming out called Ozempic that these treat diabetes. They're produced naturally after you perform a gastric bypass or sleeve or a duodenal switch surgery. So this is the best treatment we have. And people keep calling it a last resort.

Study just came out from Lancet, my friend in London are writing a tremendous paper showing the fantastic results of 10 years -- very long years for these things to work, get rid of diabetes. So when we look at diabetes treatment, we have to look at weight -- what people call weight loss surgery, what we in the medical profession, call metabolic surgery, because that's what it is. It changes your metabolism. endocrinology -- endocrinologically, it improves you and improves the response to the pancreas, as well to sugar and keeping insulin levels normal.

SENATOR LESSER (9TH): Thank you. And I will point out to the Committee, because I've been -- since I've come to know you I've been really impressed by how you are involved it seems like in everything. So folks have Twitter accounts, you have one of the more active at Twitter accounts, I think, in medical Twitter, so certainly appreciate all that you do. And I'll just note that I think you were the first doctor I remember seeing advising the general public to wear masks during the pandemic or long before mainstream -- yep. Long before mainstream public health experts in this [inaudible]. I noticed that and I'll remember that. So thank you, doctor, and I'm sure there are other members with question.

NEIL FLOCH: Thank you for your support. Thank you. Thank you, Senator Anwar, you've been wonderful, as

well as Senator Bertel. I really appreciate your efforts and passion. Thank you so much.

REP. COMEY (102ND): Senator Anwar, you want to say a few words?

SENATOR ANWAR (3RD): Yes. Thank you, Madam Chair. Thank you, Dr. Floch, good to see you, hope your surgeon did well. And the question I wanted to ask you was Would you be able to speak to us a little bit about the safety of the surgery over the last 10 years? And how 10, 15 years ago, it was a different surgery compared to where we are right now?

NEIL FLOCH: Yeah, so probably the biggest safety issue that has been corrected isn't the education of surgeons and their techniques, and their ability to perform this operation really close to as perfect as you can. We can never do anything perfectly. But the techniques have improved tremendously. The stapling, devices have improved tremendously. And the work up and evaluation of patients has been tremendous. All these patients see a cardiologist, they see a psychiatrist, they see nutritionist, they're mandated to see nutritionist for six months, and many of the insurance policies.

So we're doing our best to technically improve safety, we've done our best to make sure that we have the healthy patient as healthy as possible going into surgery. And many of us put patients on a diet to not lose weight before surgery, but to decrease the inflammation caused by the liver. Because as you know, you absorb food and the first hit is through the liver, which causes and leads to the diabetes et cetera, the high cholesterol et cetera. So doing that is another safety measure.

When you look at the data -- and we're talking about hundreds of thousands of patients -- the ASMBS has collected. And you compare this surgery to gall bladder surgery which we all think is safe. Studies have shown that this surgery is either much safer

than gallbladder surgery or equal safety. So we have reached the level of safety that wasn't -- didn't exist when I first started, 20 years ago, it wasn't as safe. But now it is very safe. It is safer for these people to have surgery than not have surgery. And it is no comparison.

SENATOR ANWAR (3RD): Thank you so much. I just had not alluded to that though, with some of the other speakers because I wanted to make sure we rest on that part too. Thank you so much for your testimony and thank you for the work that you do. Thank you, Madam Chair.

NEIL FLOCH: Thank you. Thank you.

REP. COMEY (102ND): Okay, we've got a couple more questions. Let's stick around. We have Rep. Delnicki.

REP. DELNICKI (14TH): Thank you, Madam Chair. And thank you for your testimony, Doctor. You know, it's interesting, a friend of mine had that surgery about 10 years ago. And I hadn't seen hadn't seen the person probably for about two or three months prior, or after the surgery and the amazing difference in how they carried themselves, how they interacted, and how they had a big smile on their face, and they were so happy. And, quite honestly, they were more enthusiastic and able to do their jobs better, and enjoy life more, and avoid some of the pitfalls that I know they probably would have come down with. So even having been done 10 years ago, the difference has remained constant. And it has stood the test of time; because I know a number of folks that asked me about it. You know, I'm not a doctor, I don't even claim to be one. And I didn't sleep at a Holiday Inn.

But to see that, that change, and how the change has been sustained over the years, in my eyes is proof positive. Thank you, Doctor. Thank you, Madam Chair.

REP. COMEY (102ND): Thank you. Representative Meskers, you're up.

REP. MESKERS (150TH): I want to thank you for your testimony. I came in a little late to that testimony. I've been in multiple meetings. So I apologize. I guess the only question I have is, when we talk about efficacy and we talked about builds that help promote this as the appropriate procedure, and I'm not questioning that. I guess what, where you want to go next is to make sure that we have in place or do you feel we have the appropriate standards, right? Because if you think about this type of surgery, you -- you're really looking also that is not that the benefit and the cost so that you're ending up with what's the general benchmark of success? Because is first is the surgery, obviously, in the survival. As you said, surgery is going down. The next question is how -- like, the recidivism I guess is the question like -- I mean like how long what's the success rate look like over time over four to five years?

NEIL FLOCH: I don't know if you can see this graph. But this demonstrates -- so you look, this is the greatest study we have. You'll have to look at it more carefully.

REP. MESKERS (150TH): Right.

REP. DELNICKI (14TH): And this is the Swedish Obesity Study. These patients are out now about 25 years. Sweden does a great job because they can track everybody.

REP. MESKERS (150TH): Okay.

REP. DELNICKI (14TH): And what they show is the greatest operation, because it's been around for that long is, is the gastric bypass.

REP. MESKERS (150TH): Okay.

REP. DELNICKI (14TH): We haven't been able to study other things. And patients will lose a significant amount of weight, whether it's about, you know, 60% to 70% of their excess body weight. If you look at 20, 25 years and take the average patient, you're about a 50% the -- 50% of the weight will be regained over that time. But that's the reality of it.

You know, some of those patients will keep everything off. Some of them will regain everything. But that is the best data that we have. It's tremendous. There is nothing that compares to surgery. You can't have a medication that compares to it. We're getting some medicines that are excellent and there's one coming out that's outstanding. And we need these medications as well. They're very important because what we've learned to do is medical doctors and the surgeons we work together. We work as one and actually I prescribe medication as well.

So what we do is we do the surgery, and then some people may become hungry afterwards, and we'll put them on medication. And that keeps them from regaining weight. It's wonderful. You know, in the past, surgeons and medical doctors didn't know this work so well together. But now we are really partners. And, in fact, I do the weight loss medication, it helps.

But the surgery alone is incompatible. You can't compare a -- you're having a relevant discussion if you're saying that exercise or a diet is going to cause long-term weight loss because it doesn't. We see people on the cover of People Magazine going on keto diets, and they do lose the weight. But if you look at those people long-term, they regain. Some of you have also seen a TV show called The Biggest Loser. Dr. Kevin Hall is from the National Institutes of Health. And Dr. Hall did a study on all the winners of The Biggest Loser television

show. And what happened is all of these people regained weight. Some of them lost weight if they had bariatric surgery again. And what happened is their metabolism changed. And they needed to eat 400 calories less a day to maintain their same body weight.

So dieting -- going on these diets where you diet, you lose weight, and then you regain more, it actually alters your metabolism in the wrong way. So what we found is that the efficacy in order is really surgery, then medication, along with these are in addition to staying on a diet, because as doctors, we put everybody on an appropriate diet. We have to push them to see their nutritionist, see their therapist, exercise. And exercise, by the way, it's a fallacy to think if you're going to lose weight on an exercise, because the best studies show that if you exercise five times a week for one hour a day, you will lose about 11 pounds that year if you don't change your diet, okay? So it's changing your diet that helps. So from an efficacy level, you have to do all those things. And then you need to add medication and/or surgery if those things don't work.

REP. MESKERS (150TH): So just to be clear, what you said was basically that -- yeah, I heard the efficacy that was very good. So it's about a 50% the -- one second. So about a 50% -- it's a phone ring, sorry about that. So, 50% weight loss on average, over the life of it.

NEIL FLOCH: Now, we call -- we say excess body weight loss initially. Initially, the weight loss is significantly higher. It's about 70% of your excess body weight. But if you go to 20 years, what you'll find from the graph that I put in my testimony is that patients 20 years later will get -- regain about 50% of that weight. So you're averaging --

REP. MESKERS (150TH): Is that half of the excess, basically?

NEIL FLOCH: Yeah, of the excess.

REP. MESKERS (150TH): Okay. Perfect, that was the question.

NEIL FLOCH: That's reality. I think we've gotten better over time. But that's -- the people that were studying 20 years ago, and following up 20 years later.

REP. MESKERS (150TH): Thank you. Very helpful.

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

REP. NUCCIO (53RD): All right. Thank you, Madam Chair. Good afternoon, sir. How are you?

NEIL FLOCH: Great.

REP. NUCCIO (53RD): Okay. Good. Actually, Representative Meskers just asked the question that I was going to hit that -- that piece of information caught my ear, too. So if what you're saying is the -- I just want to make sure that that I have this right. That after surgery, people can expect to lose 60%, 70% of their body weight. But after 20 years over again, about 50% of what they lost. Has all of that then calculated into the expense ratios that you guys are looking at from the savings perspective? Because I would assume that losing 60% to 70%, putting 50% back on still -- could have you add an excess weight, which would still cause medical issues. So are we calculating in the resurgence of any of those medical issues and the savings?

NEIL FLOCH: So Dr. John Aranow is our expert, who has calculated all this, and I hope he can put in his testimony. And, you know, you've got to look at

the value of five years, 10 years, 20 years, you know, some people may die after 20 years. So, all this is -- it has been looked at, at shorter intervals. But you've got to then compare that to those people being alive, who have severe obesity, who've developed many other medical problems 20 years later, and have not -- have not lost any of that weight. So it can swing both ways. I understand your argument. Many of those studies have been done. And I don't know exactly how to answer your question directly in the state because that study has not been done.

REP. NUCCIO (53RD): Okay. All right. Thank you very much.

REP. COMEY (102ND): Thank you very much. Okay, I think that's it. All right. Now you've got a bunch of new followers. Thank you on, Doctor, on Twitter.

NEIL FLOCH: Thank you very much, very passionate about this, and it will save us money, and it will help our people and it's the responsible thing to do. So thank you.

REP. COMEY (102ND): Yes. So next, we have Linda Halpin. And after that we have Rick Hart. Linda, you're up. Thank you for being so patient, number 33. I think --

LINDA HALPIN: Can you hear me?

REP. COMEY (102ND): Yes, go ahead.

LINDA HALPIN: Okay. Thank you. Thank you for letting me speak. Thank you from -- for the -- thank you, insurance members. My name is Linda Halpin. I live in Bloomfield, Connecticut. I have the sleeve in 2016. In 2008, I began my journey. I originally had the lap band in 2008. That's when I was at my heaviest weight and I choose 217.8 pounds. I couldn't walk up the stairs good or tie my shoes, or even put a towel around me. I have the sleeve to

improve my health. Now, I would say I'm at my weight. I've maintained my weight for three years now at 116. I recently lost two people due to obesity complications in COVID. This is why I feel Bill number 1007 needs to be passed. And I want to say thank you for letting me speak.
Any questions?

REP. COMEY (102ND): Thank you, Linda. Thank you for sharing your story. And how are you feeling?

LINDA HALPIN: I feel wonderful. I exercise seven days a week, and I eat healthy and just feel really great.

REP. COMEY (102ND): Good. Well, hopefully, we can get this bill passed and help a lot of other people as well. Might have any questions on the Committee? No, thank you so much for your heart-felt testimony.

LINDA HALPIN: Thank you.

REP. COMEY (102ND): Have a good day.

LINDA HALPIN: Yep.

REP. COMEY (102ND): Okay. Rick Hart, nice to see you.

RICK HART: Nice to see you too, Representative. Vice Chair Comey, Chairs Wood and Senator Lesser, and Members of the Insurance and Real Estate Committee. My name is Rick Hart. I represent the uniform Professional Fire Fighters Association Connecticut, which memberships include 4,000 career firefighters across the State of Connecticut and I'm here today to testify in support of Senate Bill 1004, AN ACT Concerning Firefighter Training and Crumbling Concrete Foundations.

Well, the entire bill has merit, I'm just here to address specifically our support for Sections 1 and -- excuse me, 2 and 3, inclusive. For years, dating

back to 2010, the fire school operating budgets -- the nine regional fire schools in the State of Connecticut have been flat funded. That's 11 years of the same funding, which in today's post-9/11 world and now in our COVID-19 world is woefully underfunded. Having a well-trained fire service, and EMS service in the State of Connecticut will provide a more efficient and safer delivery of services to the citizens of Connecticut. The fire service has gone from a quote "fire service" to an all-hazard service, which means we respond to medical emergencies, chemical spills, hazardous materials, incidents, major traffic, transportation incidences, along with fires, as well as the fires, as I said.

The Bill before you will provide a -- the Connecticut will establish the Connecticut fire safety fund. And I have to give a credit to the person that is behind this. And that is our dear friend, Linda Orange. Back in 2016, she came to me and said -- has Linda can go, "Rick, find me information, draw a proposal. And let's get this done." A huge proponent of it -- of the fire service, so I want to task.

In creating a surcharge on the insurance policies within the State of Connecticut, it will create a fund that, based upon the $7 dollars surcharge, would have been just residential based upon the information in my research will create a fund of $6.391 million dollars, which would be a fund that $2.1 million dollars -- $2.5 million dollars of that monies would fully fund all nine regional fire schools, which means it wouldn't rely on the state to have a line item in the budget to fund the schools, it would become totally independent of the state budget process, as you put in your in the bill, that desk, and the Commissioner would be the guardian of this. In my testimony I have --

DAWN MARZIK: Excuse me, sir. If you could please summarize.

RICK HART: Yes, ma'am. I did put in substitute language that would allow for the creation of an equipment fund because as you all know; I am huge on cancer prevention in the fire service. This would provide on a grant application basis, providing every firefighter in the State of Connecticut a second set of turnout gear, which is the gear that we were going into fires in the prevention and reduction of cancer exposures for firefighters in the State of Connecticut. So I'd be happy to answer any questions. Please support S.B. 1042. And so, we can move to Connecticut fire service forward. Thank you.

REP. WOOD (29TH): Thank you. Questions from the panel. Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair. And thank you, Rick, it's good to see you. And, you know, you're -- as you -- as you were testifying, I could sort of hear our friend with the oranges -- voice in my head telling me how important the regional fire schools are. And I could never say no, never, at any point. So it's --

RICK HART: Not many people could.

SENATOR LESSER (9TH): You could try, but I would never -- never your best interest.

RICK HART: It's different.

SENATOR LESSER (9TH): So just wanted -- you know I decided -- I have a -- I have a bunch of questions about the proposal. Obviously, we are -- we've been looking for a sustainable funding source for the operations of both the operations and I guess also the capital side of the -- of the fire school. But you mentioned nine years ago fire school, is that -- is that assuming that all are built out? Because I know that there's been sort of a separate question about the construction of the fire schools as well.

Is that -- is that right? Is it -- is it that there should be nine or that there are nine?

RICK HART: Presently there are, in name, nine regional fire schools, excuse me. The Valley Fire School has not been built yet. They are -- unfortunately, they have to travel around. They're like nomads going to fire houses and different fire departments, in order to do their training. That is the next fire school to be -- to be built. I know Middlesex Fire School, excuse me, is tentatively on the list to be built after the Cheshire, which is currently the Wolcott Fire School that is -- there is a physical plant there but it is -- it is in dire need of replacement due to the years of usage and the potential for the actual -- the burn building to collapse.

So, there are eight physical schools with the Valley School being a charted -- chartered regional school without a burn building our classrooms, which needs to be built that is a priority for the fire service that we received bonding for that, for it to be built and then Middlesex -- then it would be Cheshire and then Middlesex.

SENATOR LESSER (9TH): And so where -- like -- what's the status of that? Where there is a -- I know that there's been a bond authorization passed by the Legislature? Is that right? And so it's waiting for the Governor's Office to -- or the OPM to place on the agenda. Is that -- is that the status or where are things in terms of when that build out, will occur? And that also depends on the operating funds being available. Are those two things connected?

RICK HART: The capital expenditure and the operating funds are two different issues. We get operating funds presently in the budget. We're just waiting for the Governor to release the funds. They've been authorized years ago. And we're just waiting for him to put it on the bonding agenda to

authorize the building. The bids are in. Representative Rochelle could probably address it better than I could being that's her district. And then they -- they're shovel-ready.

SENATOR LESSER (9TH): Well, she's a member of the committee saw I'll defer to her on her fire school. Just in terms of the theory here though, obviously, nobody likes seeing a surcharge on their -- on their homeowners' insurance. I can't imagine this would be something that people would love to see. But, obviously, everybody also benefits from, from having reliable fire service and making sure that we're supporting our fire departments, both career and volunteer. And so, just wanted to get your sense on what's the -- what's the theory is that these in the idea that, that having -- that funding the regional fire schools will result in lower insurance profits or fewer buyers? Is that -- is that sort of the connection here? I'm just I'm trying to understand that. Is it -- that I think I can sort of see where a connection might be.

But I'm just trying to make sure that I understand, you know, if we got questions from the constituents about it.

RICK HART: Fire service is rated based on a one to 10 rating, one being the best, obviously, and 10 being the worst, and the insert -- ISO rating. And a lot has to do with training. We're mandated by the NFPA to do 288 hours of training per year, not to and that does not include EMF trading, if we do provide EMS training, that could be up to an additional 40 hours per year. And so, there would be an absolute benefit to the municipality. If your ISO rating goes from a four to a two, based upon the training, that means your insurance rates will go down their fire insurance rates.

It's -- also it's an ounce of prevention for a pound of cure. We could -- there's there's a serious issue in the fire service today in Connecticut,

especially in the volunteers of the career firefighters, we you know, we have to be firefighter one firefighter II certified, along with all the HAZMAT tech -- the HAZMAT training. But with the volunteers, they have to pay for it themselves. And it's, approximately, $1,200 dollars per student and go through the training. This fund would provide training for 4,000 -- upwards of 4,800 individuals in the State of Connecticut, free of charge.

So you go to the class, you're paid -- you're paid for. That burden comes off the municipalities. It comes off the individual if they so chose to go on their own. any training. And that's the beauty of this because we can get more training based upon the fire school is being funded or through operating budgets which they have to rob Peter to pay Paul, basically and you see a corresponding increase in the tuitions for firefighter training. And that's not just firefighter I and firefighter II. You have hazardous materials; you have the EMS. You have pump operator, aerial operator, there's a myriad of training programs that are run out of the fire schools, that cost money, plus time. And this would alleviate that completely.

SENATOR LESSER (9TH): I may have other questions in a minute, but I want to turn it back to the Chair. And really we should work on this one because I -- it's a problem we got to solve. And I know it's been something that's been troubling their Legislature for a while that's all. Happy to work with you and that you be effective.

RICK HART: Thank you, Senator.

REP. WOOD (29TH): Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Madam Chair. And thank you, Rick, I'm glad you're here testifying on this. Having joined the fire EMS caucus when it first reappeared, that was always a question that came up on how in the world are we going to ensure

that these training schools are properly funded? Now, refresh my memory? Was any money ever swept out of the funding for the training at these schools?

RICK HART: Yes, Governor Malloy, unfortunately, when we we're going through the budget issues a few years ago, two years in a row swept the funds, which left them with zero balances. If you look at the desk budget, you'll see in there, some of the schools receive upwards of $100,000 dollars to operate because it looks like -- the Eastern Fire School, I believe, receives about $100,000 dollars because it serves all the communities basically east of the Connecticut River. So they have a large pool of students that they have to teach.

So that was crippling, to the fire schools. You know, they had to -- you know, they operated at a loss they. Scott Bisson, who is the Chair of the Connecticut State Firefighters Association Education Committee, is scheduled to testify later, and he will have the exact figures to give you as far as the budget fluctuated since 2010. But on average, they've been flat funded since then, with some years, the accounts being swept.

REP. DELNICKI (14TH): Thank you for that answer. I believe earlier, you mentioned it would benefit both the career fire service departments and the volunteer departments. Is that correct?

RICK HART: Yes, sir. It -- this is -- this isn't a career versus volunteer issue, it is a fire service issue. Everyone will benefit from this both career and -- it actually will benefit the volunteers more, because a lot of them shell out the $1200 dollars on the front end. And once they pass the program, then they get reimbursed by their department or their municipality. So this would alleviate all of that. So if you have South Windsor, you have 10 people that want to go to fire school, but only the department can only afford to send three, this

alleviates that. This allows all tend to go to class get certified, boost your roles in the fire department, free of charge.

REP. DELNICKI (14TH): Well, that's a real benefit from my perspective. As a former municipal leader, it was always critical key and critical that we funded our volunteer fire department. And we have over 100 members of that volunteer fire department, and we have a very, very robust explorer post that matter of fact, our Chief who serves actually as a uniformed professional firefighter in Manchester, and the Chief in the South Windsor Fire Department, volunteer department, he went through that explorer post. And then as a community, their budgets would see -- could see a reduction by not having to fund those positions to pay for those folks to go to the -- to the school. That sound right?

RICK HART: Yes. And the other benefit is, like I said, I offered up substitute language to use the excess monies to create a -- an equipment cash, which would go first to purchase turnout gear, which is approximately $1,500 dollars to $2,000 dollars per set per person. We can come up with a cache of a number, you know, 1,000 sets a year that would be handed out to the -- and I look I envision is a smaller departments that cannot afford to purchase this or they have to bond it or they have to, you know, somehow scrape together the money just to have adequate protection for their firefighters. And next weekend, the self-contained breathing apparatus that we wear run around $15,000 dollars per unit, the National Fire Protection Association puts out standards on every year. And the SCBA standard changes, and departments if they want to be NFA compliant have to purchase these on air packs.

So we could purchase this -- these a number of these air packs and again, provide a -- on a grant application process, the smaller municipalities the ability to get these for free. I like it to be on the federal side. It's the assistance to fire

fighters grant, the AFGE, the turn of -- by FEMA. This will be a lot faster and more streamlined than going through the federal government if we can have this administered, through desk -- through the Connecticut fire administrator, where they know the people they know the departments and we could outfit our outfit and train our firefighters to the best that we can.

REP. DELNICKI (14TH): And that is an obligation, we have to ensure that our firefighters whether they be career or whether they be volunteer, have the tools to do their job to be there to be able to respond and to do it in a safe fashion because quite honestly, nobody wants to have one of those days when somebody doesn't come back. Now, it sounds to me like this would have a significant benefit for many of the smaller municipalities in Eastern part of the state, in my neck of the woods.

RICK HART: Yeah, I mean, it would benefit everyone. It's gonna benefit everyone. It's going to make training much more available. It's going to make -- it's going to make a fire service second to none. I mean, other states, Washington, Massachusetts, West Virginia, among others, off the top of my head, they have a fee schedule that they -- that they use to provide training for their firefighters. So this is not a new concept. It's -- I don't look at as having a downside, the end users of the fire service are the homeowners and they are still building owners in the State of Connecticut. And I think it's a small price to pay for having the benefits such as they are going to receive as a result of this.

REP. DELNICKI (14TH): And it sounded like from your earlier testimony to one of the ISO ratings come out in communities if they have a standard set training paradigm that will in and of itself, help a department and a rating.

RICK HART: Yes, as a matter of fact, some of you know I'm a Deputy Chief in the City of Waterbury Fire Department, and we're going through -- we're going to be going through an ISO evaluation within the next couple of months. That is the first thing that they look at is training. And it's a huge portion of their evaluation. So it's important, it will help the communities across the state.

REP. DELNICKI (14TH): So I thank you for coming forward today. I suspect there's a number of folks out there that have questions that they want to follow up on. Again, thank you, and I appreciate your input. Sounds like we've got something that makes some kind of sense here.

RICK HART: Thank you.

REP. WOOD (29TH): Thanks, representative. Next step is Representative Poletta.

REP. POLLETTA (68TH): Thank you. Good afternoon, and good afternoon, Mr. Hart. Hope you're well. I do have more of a comment than a question. But, you know, I appreciate your testimony and the good work that you have done and that your counterpart, Mr. Kuroda have done all Over the last several years for the firefighters in the state of Connecticut. As someone who represents a town that has a volunteer fire department with about 105 officers, they are a very valuable part of our community. And there was a time when, you know, they needed new tanks, and we couldn't find money in our budget to buy, but we had to ultimately, it was a public safety issue. But I kind of correlate that to these fire schools, and how important they are to the success in and overall safety of our state and our -- of our firefighters across the state from East to West. So my question and you kind of answered it before was what happened to the money? And the answer was that it was swept, unfortunately. So now we're stuck with this multi-million dollar question of how do we replenish it? And I know you, you know, I run out of time there.

I don't know if you have any other ideas or suggestions for our Committee to consider for the Bills ultimately voted on but I'm all yours. And I want a steady streamline of fund, so we can make sure. And selfishly the Naugatuck Valley Fire school is right around the corner from me and we want to get that funded. But any suggestions you have that you want to add would be great, but thank you for all the work you're doing.

RICK HART: Thank you, Representative. The one ask I would have of the Committee is either through the Insurance Commissioner or OLR, find out exactly how many -- I mean I use the 2010 census on owner-occupied houses, and I came up -- it came up with 913,000. I don't know what that is accurate, and I could not find any information on how many commercial buildings there are in the State of Connecticut, because once we -- once we get that -- those numbers, I think if we use $12 million dollars as a ceiling that this fund would collect, we can work backwards. And based upon the number of insurance policies we can find out; we may only need $2 dollars per policy so we may be able to drive that down from seven on that would be my only ask.

REP. POLLETTA (68TH): Thank you.

RICK HART: Thank you.

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

REP. ROCHELLE (104TH): Thank you, I've been jumping back and forth between this public hearing and commerce so I did first half of it. But I wanted to thank Rick Hart for coming today and testifying in this Bill. As he's aware, I'm -- he's a supporter of the fire service. And I think that we as a state have a lot of work to do around the issue of ensuring that our career and professional volunteer departments are funded in a fashion, both for their training for their gear. We have 22,000 persons

strong, workforce in the State of Connecticut, and I think it's something that we often don't think about when people have a fire or car accident, they dial 911. They don't think about who the person is, if they're, you know, what level they're training, how old their gear is, all of these things that we as legislators have a responsibility to think about, to make sure that those who are protesting us, are protected as well and well trained and provide the resources that they need to do the job. So, I want to encourage all of my colleagues to fiercely support this initiative, and the good it will do for everybody across the state. Thank you.

REP. WOOD (29TH): Thank you. Any other questions from the Committee. Thanks for joining us, Rick. Appreciate the testimony.

RICK HART: Thank you, Representative. Thank you, everyone.

REP. WOOD (29TH): Next up we have Chris VanDeHoef, followed by Rodrigue Planck.

CHRIS VANDEHOEF: Good afternoon. Good to see everybody. Thank you, Chairwoman Wood, Senator Lesser, Members of the Insurance and Real Estate Committee. My name is Chris VanDeHoef. I am the Executive Director of the Connecticut Daily Newspaper Association, and I'm testifying in opposition to Senate Bill 1043, AN ACT CONCERNING THE HARTFORD COURANT. As most of you are aware, CDNA is comprised of the 17 daily newspapers in Connecticut, which includes Courant and every member paper of CDNA is strongly opposed to Senate Bill 1043.

Protections provided the media through the First Amendment of the Bill of Rights in the U.S. Constitution are clear. We believe the proposal before you is government intrusion into the operation of what is otherwise free press. The Connecticut State Legislature cannot engage in

oversight of the operations of any newspaper in Connecticut. Moreover, it is reasonable to assume that the definition of public interests contained in the Bill varies from person to person, allowing the Attorney General or any subscriber of the Courant to determine what that public interest is, as it relates to the operation of a newspaper, we believe runs afoul of what has been taught about the protection provided under the First Amendment.

You will find no group more agreeable to the underlying premise that the Hartford Courant should remain in Hartford, with a robust newsroom, providing up to date reporting on the happenings of the city, state and region, as it has for more than 250 years than the Members of the Newspaper Association. However, the Connecticut General Assembly does not have the authority or ability to engage in determining the operations of the Courant or any other newspaper media or press operation. The Bill references a special act from March of 1887 as approving the Hartford Courant. While acts like this were needed at the time to establish the ability to trade as an entity, it did not provide oversight authority to the legislature. Simply put, there was no Stock Exchange or Securities and Exchange Commission to provide oversight or regulation or rules around the operation of business entities that we have today.

By 1887, the Hartford Courant was already 124 years old, having been founded as Connecticut Courant 1764. The great history that the Courant enjoys as the nation's oldest continuously published newspaper is to be cherished by Connecticut, as it was in 1778, when the legislature issued a temporary lottery to raise money to help pay for the rebuilding of the Courant's paper mill after it's burned to the ground by British soldiers. Trying to legislate that the Courant mainly operated its finances towards the "public interest", the suggestion that we believe several centuries of

journalism, the Courant has provided Hartford, our great state, and even the United States.

Nobody enjoys the consolidation of media, the laying off of staff, the selling of chairs newsrooms and buildings. Unfortunately, in today's digital climate, the ever-changing landscape of the media has resulted in some of these unfortunate circumstances. However, the Hartford Courant and all member papers of CDNA continue to provide integral oversight, recognition of our government, our community and our fellow citizens. The Hartford Courant is now, and continues to be dedicated to the City of Hartford in the State of Connecticut. Please reject Senate bill 1043. We believe that it's an unconstitutional attempt to exert government influence over free press. Thank you for allowing me to testify today, and I'm happy to answer any questions.

REP. WOOD (29TH): Thank you. Questions from the Committee, Senator Lesser.

SENATOR LESSER (9TH): Yes. Thank you, Madam Chairman, and thank you and I stand and hope for your testimony. I think all of us on this Committee cherish the First Amendment. And I think the reason why the newspaper industry was singled out by the framers of the Constitution is precisely because we have such a strong and compelling public interest in seeing that it thrives, it flourishes and performs its duty to educate the public about what's happening in our country. That's something that the framers recognized as vital to a functioning democracy. That's why they put it first in the Bill of Rights. They don't -- they didn't put in the other industries they listed your industry because it was so critical to the functioning of a vibrant, I'd say, democracy.

Now, you've mentioned your understanding the Legislative history of the Special Act of the Legislature. My understanding is that they first

Connecticut Corporations Act was passed in the 1830s. It probably didn't have to come in front of the Legislature or get validation after that point. But the Legislature did, right? The legislature passed a Special Act of 1887, recognized the client at a special role of our state. And then again the Courant came before the legislature in 1909, in 1917, in 1925, in 1947, in 1951. And I think again in 1951 on two separate occasions, seeking amendments to its charter, having before Legislature, asking for new roles and new ability to issue stock and organize itself.

I don't see anything in this Bill that talks about how the -- you know what, editorial line, the Courant should adopt or any attempt to influence the coverage decisions. That isn't in our role. I don't think anybody would pretend that is the role of the General Assembly, right? As a subscriber to the Courant myself, and I know many of my constituents or subscribers, we're all anxious because we read in the paper about all this, about whether or not he's committed at all to the business of journalism, and you tell me -- and you tell us that the Newspaper Association wants to Courant to continue to operate in Connecticut, and I would maintain that -- that's all that this committee wants as well.

So if we can get an assurance that regardless of the ownership of this paper, the Courant is gonna continue to be delivered to our constituents. I think that we addressed the concerns. I have a lot of -- I'll be honest, I have a lot of skepticism about that given orientation. So maybe you could speak to that a little.

CHRIS VANDEHEOF: Sure I appreciate your point, Senator. You know I certainly can't speak on behalf of Alden or the Courant as it relates to whatever deal is going to be finalized and they're working through with Tribune Publishing, other than to point out that Alden isn't buying the Courant per se,

they're buying the properties for Tribune Publishing, so I can't promise you that the Hartford Courant would remain in Hartford. I will tell you that the Newspaper Association and all of its members, shares the same concerns, and hopes that the Hartford Courant stays here.

I will tell you now, The Hartford Courant is dedicated to the city of Hartford in the State of Connecticut and the people who are at the Hartford Courant are doing their best to continue doing the great work they've done for 250 years. Unfortunately I'm not a physician I think as you are aware, to promise you that the Hartford Courant will remain in Hartford forever, as I simply am not aware of what Alden Capital should that deal be finalized, as in stored or has planned, but I do appreciate the concern that you and I think that many citizens in Connecticut check.

SENATOR LESSER (9TH): Is there anything that we can do to your mind to help ensure our constituents have access to the news?

CHRIS VANDEHEOF: You know that's a -- that's a good question. It -- I don't think the legislature wants to buy the Hartford Courant from Alden. I think earlier today.

SENATOR LESSER (9TH): Let's take a fact.

CHRIS VANDEHEOF: You know, earlier -- earlier today; Ms. Abernathy, I thought it was very interesting in her testimony. And I think that -- what we're trying -- overseeing what they're trying to do with the gentleman in Maryland as it relates to the Baltimore Sun and potential nonprofit ownership of some of the properties would be something worth, evaluating the woman from Utah whose name I forget and I apologize, you know, suggesting that what they did in Utah was interesting as well and I would like to follow up with her and hear more about that idea, as well.

You know, short of a white knight who is based in Connecticut, with the type of funding and nonprofit status that I think would make us comfortable, I'm not sure that the Legislature unfortunately has a lot of ability to guarantee that newspapers do what the Legislature wanted to do.

SENATOR LESSER (9TH): And to be clear, I don't think we want -- you know, no one here is saying, what your coverage should be or what the Courant's coverage should be what -- I don't see -- I don't like that framing that we want is newspaper to do is certain things. That to me is, is anathema to what the First Amendment's about and what our role is, but ensuring that our constituents get access to timely news that they want to, they can access news about what we're doing, what was happening in the world, I think, it's just critical to having an educated, informed populace so they can make the decision about whether we're doing a good job or we're doing a terrible job, because there's no one to cover us who's to hold our feet to the fire? Who's to shine a light on what's happening? So that's enough for me for right now and I yield back to the Chair.

REP. WOOD (29TH): Thank you. Questions from Senator Anwar.

SENATOR ANWAR (3RD): Thank you Madam Chair. Mr. Vandeheof, I've missed a little bit. You're representing a newspaper or you're a lobbyist?

CHRIS VANDEHEOF: I represent the Newspaper Association. I'm their Executive Director, I'm also the lobbyist for the association.

SENATOR ANWAR (3RD): Oh, so you are the lobbyist. Okay, I just wanted to clarify for since -- for a second I thought you were a journalist, who actually wanted -- so I understand where you're coming from then. So you're lobbying on behalf of Alden or, Who are you lobbying for? I just want to clarify.

CHRIS VANDEHEOF: No sir, I -- no, Sir, I -- representing the Connecticut Daily Newspaper Association, which is all 17 daily newspapers in the State of Connecticut, including the Courant.

SENATOR ANWAR (3RD): And that is, on behalf of the ownership or is this behalf of the journalists?

CHRIS VANDEHEOF: It's behalf of the publishers of those papers.

SENATOR ANWAR (3RD): Okay, so owners, basically. Okay, I just wanted frame and understanding where you're coming. So based on your perspective, that when you have one single private key that owns and dismantles a newspaper that is okay as long as it's a newspaper.

CHRIS VANDEHEOF: I -- that's not my perspective. My perspective is that this legislation that is before you is not -- runs afoul of what the First Amendment protects newspapers to be. I'm not suggesting that I that I think Alden Capital or anybody else should buy any paper and dismantle it and do what I think folks are concerned that they may or may not happen. But what I am suggesting and the reason I'm here representing the newspapers that this Bill before you, is a serious concern about the intrusion of the legislature in the state of Connecticut in the otherwise operation of free press.

SENATOR ANWAR (3RD): So -- because, in other words that the -- who do you think should be able to help? I hope your position would be that newspapers are important for a community. Is that fair?

CHRIS VANDEHEOF: Of course, of course.

SENATOR ANWAR (3RD): Okay. And if the newspaper are controlled by a private equity and they start to dismantle it, then we should just let them dismantle

it and all look the other way because legislators should not be involved or nobody should be involved in trying to save a newspaper, which has been truly identified as a part of our state and as a part of in the entire country?

CHRIS VANDEHEOF: I'm not suggesting that. And I appreciate that concern. However, suggesting that newspaper or the owner of the newspaper can't incur debt or issue dividend that isn't "in the public's best interest" -- "public interest" I guess is the quote. It changes the operations of that newspaper, potentially changes the operations of the newspaper from a covering of the news, or covering of the Legislature, the community, whatever it might be. And so, from that standpoint. I don't think the Legislature has the ability to do that. To your overall question, you know, do we look the other way? You know, I would hope not, but I don't sit here today with an answer on how to solve that, given I think the protection under the First Amendment.

SENATOR ANWAR (3RD): Yeah. No, again, of course, you are representing who you are representing. And I think you're doing a reasonable job there. But I am representing the community and then making sure that we have a voice that is independent and that's a sustainable voice and we have heard from some of the people that that voice is no longer sustainable because it's being dismantled in an organized fashion by a for-profit entity whose primary interest is to provide dividends, and we want our newspaper that has been part of our state for as long as anybody's memory can, at least, around this Senate -- Legislature and beyond, we want to make sure it's protected and it's not dismantled for four or five -- for-profit entities,

So, again, I want to thank you for your testimony. I may not necessarily agree with everything that you're saying but -- and -- but I respect and understand the fact that you're representing the

publisher and the owners. Even if they are for-profit, and even if they are a private equity, I mean, that's your job to protect them. I feel my job is to make sure that we protect the newspapers and independent journalists and also their ability to write without having the fear of losing the jobs. Thank you so much. Thank you, Madam Chair.

CHRIS VANDEHEOF: Thank you. Thank you, Senator.

REP. WOOD (29TH): Thanks for coming today, Chris, and sharing your testimony.

CHRIS VANDEHEOF: Thank you. Have a good day.

REP. WOOD (29TH): You too. Next up, we have Rodrigue Planck, followed by Sherilyn Samson. Is Rodrigue available? Okay. It's Sherilyn Samson. How about Richard Zablocki.

RICHARD ZABLOCKI: I'm here. Richard Zablocki here.

REP. WOOD (29TH): Okay, Richard. You are up.

RICHARD ZABLOCKI: I'm responding to the S.B. 1041, which is the healthcare sharing ministry Bill that's been proposed. I've been a -- so here's my test. I've been a member of one of the major ones for over nine years. I'm a family man. I have three children still on the plan. And I just want to report that I had a good experience. I've been waiting for nine years.

They were all ready upfront that is not insurance. I tell everybody if I have to go to a doctor or my kids have to and my wife, and it's not insurance. But I have this, basically a -- it's not a reimbursable plan exactly but it's similar to one. So I get the Bill, I tell him safe -- self-pay, the ministry tells me, "Ask for this self-pay price," it's not as good as the insurance company pays low, but it's usually pretty good because they don't have to wait long for the money.

And I had two major claims in the -- in those nine years. I think one was in '13 and one was in '18, both in excess of $25,000 dollars. I've got a $300 dollars deductible, and the money came in once I got the dose from the people and they sent the to me now. I mean to me and then I look them over, Okay. And then I send them on to the ministry. And I got the money from 40 different people all across the country that covered everything but $300 dollars. It was wonderful. And that's my main point.

The next point is that, for me, as a small business owner, I think I'm classified in the middle class. I couldn't afford -- I realistically couldn't afford it to everything that goes with like -- a $1,500 dollars to $2,000 dollars, a month premium, I probably winded otherwise. And so this thing really came in the clutch to -- it -- my cost now is $542 dollars a month. Now it was a little lower -- it goes up year to year, and we started at around 425 months, and $300 dollars deductible dollars. I tell people they can't believe it. And it's true, they don't cover pre-existing conditions but that's not a problem for me because I've been here for over 10 years.

And the other thing is the Section 2 language. I think somebody earlier today said they're not really -- might even Senator Lesser, I'm not sure. He said that it's not going to close them down. But from what I can understand the reimbursement to anybody who does administrative work will close them down. So I think somebody else brought up that guy quite from Christian Healthcare or something, that it will -- it -- that he wants an exemption for administrative staff. All right. Agree with that.

And the last thing is these, there are screwballs bad apples, I think, in every industry, including this one, I'm sure. And if they are, it should be weeded out. You shouldn't condemn everybody, rather than, you know, you get the bad actors, get them

out. And, clearly, the same with deception is a -- is a problem, if it's -- if it's -- whoever gets that. My company doesn't do brokerage. They just -- they won't do brokerage. And they're pretty big. They do about $30 million dollars a month. And the second one is, they made --

DAWN MARZIK: Excuse me, sir. Your three minute is up. If you could please summarize.

RICHARD ZABLOCKI: The bad actors should be addressed with language that says, "It's just not insurance." It's basically a best effort thing and it works. Do you -- things work. Okay, that's it. I'm done. I'll take any questions.

REP. WOOD (29TH): Thank you, Richard. We have questions from the Committee, Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair. And thank you, Mr. Zablocki for your testimony. You mentioned that you've twice you've had since you engaged with one of these firms, you've had medical procedures that had those money $5,000 dollars. Is that it?

RICHARD ZABLOCKI: Right, it's true, and some smaller ones too but those are the big guys, right.

SENATOR LESSER (9TH): The big nos.

RICHARD ZABLOCKI: Yep.

SENATOR LESSER (9TH): So did it -- and my understanding is that none of these companies require as a contract between you and the company. Is that -- is that a correct assessment? Do you even --

RICHARD ZABLOCKI: Well, I'm not a lawyer.

SENATOR LESSER (9TH): Yes.

RICHARD ZABLOCKI: You have to apply here. It's about a four page application, maybe some subsidiary schedules. So I don't know if that qualifies as a contract, but it might. It -- but they -- they're clear that it's not a guaranteed pay. But on the other hand, I actually emailed him this morning. I said, "That's a good point because I was watching this all along." And they said, last year the fella who contact me back -- I just sent an email -- the email back. Last year -- I had it here. Because I asked that question. That's a good question.

He said, "The Guardian last year, $759 million dollars in build charges." That's like people submitting a medical bill from across -- I don't do any of these state, but doing a lot of seats. He said their staff was able to negotiate $403 million dollars in provider reductions. They're pretty good in debt. They have all the ins and outs of that. I don't know how they do it.

SENATOR LESSER (9TH): Yeah.

RICHARD ZABLOCKI: They -- but they -- associate it and they said they sent out, just underscore $360 million in shares, and we ignored reimbursements of the court.

SENATOR LESSER (9TH): But, I guess == I guess my concern is, you go into a doctor's office, you say, "I'm okay get a $25,000 dollars medical procedure, but you don't know going into it." If this shipping -- because there's no contracts, there's no requirement to pay. These guys aren't regulated by any of us. You -- you're going in on a wing and a prayer, because you don't actually know whether or not there's going to be that $25,000 dollars to be waiting for you at the end of it or not. You -- and you had -- you go have these. And I don't need to know your financial situation, but I know that a lot of my constituents, they get stuck with a $25,000 dollars bill. That's a -- that's a big hairy deal.

RICHARD ZABLOCKI: Yes. You have a good point that is not guaranteed to be paid. On the other hand, the company that I'm with is getting in build three -- over three quarters of $1 billion dollars. And they have -- I don't know if the around 20 years but I know they're around more than 10, maybe 15 years. And my take my take on this is that they're trying hard for any eligible charge which, basically, takes away dental. They don't cover dental, and they don't cover pre-existing. So you're going into it with your eyes open.

SENATOR LESSER (9TH): But they're not covering anything else either, right? They say we won't cover pre-existing conditions, but they may not cover new conditions either, right? There's no -- there's no promise to pay that it's --

RICHARD ZABLOCKI: The one that I have, they covered every -- according to them, they covered every single eligible charge. Period. So when you say you're not guaranteed, they don't cover everything. I mean they're saying they got $756 million dollars of supply Bills. They negotiated discounts, I think they go over your head, they go right to the provider. You got to give them really detailed bills and you can say check for lawyers and stuff like that. And then they negotiated discounts. I don't know how they did it but they did it.

SENATOR LESSER (9TH): Yes.

RICHARD ZABLOCKI: And then they -- they then they got their members, I think is around 150,000. They got -- they got their members to write checks to me -- I mean, 40, 50 of them, and I got these checks over the course of several weeks. One of them was in December. And so, what happens is, I got the money to pay the bills and everybody's happy. So you're right, it's not -- I can't take them to court. If they say, "Sorry, sucker, you're not -- you've got a dollars $25,000 bill, and your -- it's your responsibility, we're going to Florida in

order." So that never happened, and I -- and I have a $300 dollars deductible, which is the envy. I'm actually a tax accountant, so I'm -- I see all these things. And, I mean I talk to my clients, they're pretty friendly, and that's about the lowest deductible of anybody of 400 people, and I'm not -- I'm not complaining.

I mean, then your drawbacks, nothing to pure good but these drawback, but I mean the $25,000 dollars bill, I paid $300 dollars.

SENATOR LESSER (9TH): Yeah, no I hear you. They haven't taken -- they haven't taken your money and gone off to Florida. But the reason we're looking at this Legislation is because what is your company or other companies, who has it? Right? There are a lot of people in the state who are price sensitive. They're desperate for affordable options for consumption. They are buying, or writing on a money to company, and in some cases, they aren't full of the jobs. And --

RICHARD ZABLOCKI: And I'm sure. And by that --

SENATOR LESSER (9TH): Can I get insurance department?

RICHARD ZABLOCKI: Right. I'm sure there's bad actors. I'm just telling you my experience of a nine years without a bad actor.

SENATOR LESSER (9TH): Right, because they're not -- you're paying checks every month, but they're not promising to pay you anything so that's not a bad actor, "You give me money, you give me your money. I'm not promising anything in return."

RICHARD ZABLOCKI: Well that's not true. They say here, "I understand that the month -- any monthly shares but I looked at the contract." Yes, good point. I received will come directly from fellow members. By the way if you don't make the share,

they keep track of it. If you don't make the payment for two months, you're, basically, on suspension and maybe termination. It's kind of like an insurance company that I know if you don't pay your monthly bill, you're not going to have insurance.

SENATOR LESSER (9TH): It's more in ways. It's only a half the future because the -- with insurance, you got to pay them, but then they got to pay you. Under this arrangement, you got to pay them, but they don't have to do any. And that's the thing that sort of -- that's the thing that's sort of surprising to me that this is a -- this is a process. You got to pay them, and they can -- they can take some money and that's not any problem of ours. So quick question for you though how did you get involved with this idea? Did you -- did you or did you hear about them, how did you get involved? Was this -- was this through your church? I -- what was your involvement in --

RICHARD ZABLOCKI: Well, Bill, I had a tax client, and we're talking about those about 2012, and talking about the -- he had a family too, and we're talking about how -- and he's in -- he's in -- self-employed, basically. I mean -- I own the LLC, I work for it, but it's basically self-employed, not technically but basically. And what happened is the medical insurance bills are through the roof $1,500 dollars, $2,000 dollars a month. It bigger than the darn mortgage.

And so, he mentioned he said he found this. It was a friend of mine, not through the church. We -- and a client. And so he said he found. He said check it out. I looked at him I called him up in 2012 early, and they sounded good. My wife is usually the dubious one she's, "I hope this works. But it did work. You know? She was -- I was -- I was -- I wasn't pretty surprised but I was pleasantly surprised. And everything seemed to be on, "No problem." I mean I mean I would have paid on the

last nine years $1,500 dollars a month times 12, $18,000 dollars a year, $170,000 dollars. And instead I paid about like, not even $500 dollars a month on the average -- $6,000 dollars, which nine times six, $55,000 dollars. I mean it's different, you know, $175,000 dollars and $55,000 dollars over the last nine years. It's a lot of money and you could -- you know if you really super careful unlike me, you could bank that and keep a reserve like the HSA accounts that people have and you can just shove it into something like that.

Plus two interesting things up in the Northeast, these aren't really that well known, but in the Midwest -- and other parts of the country they are. But it's interesting. My daughter went to Providence College, and my -- the other daughter before that went to school in Philadelphia. They wouldn't take it when the older daughter, "Well, that's too weird or something like that." But the younger, it's getting more popular. So they said, Yep, that -- because when your kid goes to college, you have to have insurance. You -- otherwise you buy the college's insurance.

And so over the course of the nine years, one daughter they said, "No." And we tried. And the other daughter, they said, "Yep, it's okay." So what -- I mean, I'm just telling you my experience. I had no problem, so.

SENATOR LESSER (9TH): And you seem like an honest fellow and I understand it. You know we have a problem and we're well aware of, which is that if you're running a small business in the state, insurance is really expensive, but it sounds like you went looking for an alternative up -- affordable alternative to a regulated insurance product, which is a totally understandable thing to want to do. This wasn't motivated by a faith-based issue. You're not only opposed to insurance or anything like that.

RICHARD ZABLOCKI: Yeah, it's not, -- it's not -- I'm not against a face -- a faith-based.

SENATOR LESSER (9TH): Oh, okay.

RICHARD ZABLOCKI: In fact, I'll tell you a funny story. On the application, you have to say, you somehow have a connection with a church someplace, I don't think how do we enforce it, but I call it they have like two rules here. One is -- and the one I use. One of them I call a deposit rule, where you have to be a teetotaler. You can't drink any alcohol, and the other one I call it the Catholic well we could have alcohol, but you can't have too much you have to in moderation. So I guess there's certain areas of the country where there -- and I kept obviously the second one. But the -- these just depending. It's a funny thing. It's like, you know, I don't know where this came from. It reminds me, Senator Lesser, I think of the Amish. I mean I know hardly anything about the Amish but I heard they get together and they build somebody's barn in like two days or something like that. And this is kind of the healthcare, equivalent to that.

But there's another one, another big interesting thing, the percent -- because I researched this a little bit. The percentage of your premium dollar or share dollar whatever you want to call it, that goes to the medical side, the medical providers, and the typical large insurance company is under 60 cents. It's like, 59 cents. As far as I could tell, I'm no expert on that. And these guys it's 30 points higher. It's like 88% or something. So on $1,000 dollars bill, $880 dollars or something like that is going to medical buyers who the health care sharing ministries, I think. And on the big boys, the traditional behemoths in the industry, it's $580 dollars. That accounts with a lot of the savings in my mind. It's just an -- it's just, just more lean. It's lean mean operation.

SENATOR LESSER (9TH): I hear that. And I want to thank you for this back and forth, and I've had some fun with it. I know you have too. And I very sympathetic to the decisions you've had to make. We'll just say one thing on that last point which is, we know what -- that number that you decided that amount that goes to healthcare and proposed administration, we know what it is for insurance companies in the states because they have to report that, right? Those are audited. There -- it got a probably an insurance that looked over their books really, really closely. We know what those are, because these are licensed, regulated entities. And if they lie to the state, they get in a lot of trouble.

RICHARD ZABLOCKI: Right.

SENATOR LESSER (9TH): And far as I know, there's nobody looking at these guide books. So they say 99% of our money goes to patient care, maybe, I don't know but --

RICHARD ZABLOCKI: That's not 99%, 80 kind of --

SENATOR LESSER (9TH): I know. Right. But whatever the number is, there's no -- we're going on -- we're going -- we're taking their word for it. There is -- yeah.

RICHARD ZABLOCKI: That's a good point. I'm an accountant. So I asked them -- I wasn't sure they were nonprofit, but they are -- they're a 501(c)(3). And I said, "Well, all the tax returns publicly available." So unless they're lying to the IRS you can get your answers just by going to the IRS website and getting your 990. You can do it. I mean I didn't do it, I got to maturity. But the bottom line is you could actually find -- I bet you could find out from publicly mandated information what their percentage of that -- they not go to medical as far as provided is -- probably can.

SENATOR LESSER (9TH): Worth the -- worth an investigation, so thank you. Thank you, Mr. Zablocki. I appreciate your testimony and I will pass it back to the Chair.

RICHARD ZABLOCKI: Yeah, I just add, the bad actors though, the disruptors like my company said they, "I didn't know this." They don't do any brokers, they don't want any brokers, and I think that's a -- that's a good point. And I think if you pursue that that's maybe a partial answer to your problems. That's it.

REP. COMEY (102ND): Thank you so much, Mr. Zablocki. And we will see you on other days, I say. Thank you. Have a nice night.

RICHARD ZABLOCKI: Yep, okay.

REP. COMEY (102ND): No other questions, we will move on to William Halstead. And after that we'll have to Sena Wazer.

TED SCHROLL: Good afternoon, Madam Chair. My name is Ted Schroll. I'm speaking for Mr. Halstead. He's not -- was unable to make it so he asked me to sit down and do his testimony, if that's okay. Okay, okay.

REP. COMEY (102ND): Yes, thank you.

TED SCHROLL: Okay, I'm sorry. Good afternoon, Senator Lesser, Representative Wood, Senator Hwant, and Representative, sorry, Pavalock-D'Amato, my apologies, and Members of the Insurance and Real estate Committee. My name is Ted Schrool. I'm a 40-year retired fire volunteer firefighter from Wethersfield. I'm also the Legislative Representative for the Connecticut State Firefighters Association. I'm testifying on behalf of William Halsted, President of the State Firefighters Association, and he's often Fire Chief of the Sandy Hook Fire and Rescue Fire Department.

Connecticut State Fire Fighters Association represents approximately 26,000 career and volunteer firefighters in Connecticut. We also administer the operating budgets of the nine regional fire training schools in Stamford, Fairfield, New Haven, Derby, Wolcott, Middletown, Hartford, Litchfield and Willimantic. Our association, which is to support Senate Bill 1042, AN ACT CONSIDERED FIREFIGHTER TRAINING IN CRUMBLING FOUNDATIONS.

The fire departments have become more than just firefighters. The fire service has become more of an emergency services department on these ever -- emergency services could be a call for a crumbling foundation because that sometimes endangers the home documents. Sections 2 and 3 of the Bill -- of this Bill pertained to pain, where the costs for training firefighters. The cost of operating the train facilities have risen to strive to find some tuition for classes. The tuition for volunteer firefighter is now in the $1,000 dollars to $1,200 dollars range. It has been noted that some volunteer firefighters have had to pay their own food -- tuition, out of their own pocket. If this Bill can be passed, those concerns can be greatly reduced or even eliminated. This way a volunteer fire department obtains a new tool in their recruitment and retention toolbox, volunteer fire service is no longer just a cat in a tree, many parts service evolutions have become specialized someone smells an odor pod odor, we're supposed to be hazmat technicians, a hiker gets injured or stranded on a mountain hike, there was a high angle rescue. That same person gets trapped below ground, there was a confined space rescue. Batteries used to just illuminate your headlights, now a battery the size of your backseat and an electric card can be fatal to the untrained rescuer. A residential foundation falls -- fails, we respond. Firefighters must be trained to accomplish these tasks. If we do not, we become victims. The insurance industry directly benefits from professionally trained firefighters.

You pass this bill with Section 2 and 3 intact, the fire service will benefit, and the citizens of Connecticut would actually be the winners.

DAWN MARZIK: Excuse me sir, if you could wrap up, please.

TED SCHROLL: I am just finishing, I am going to get -- ask if there's any questions. I do have a couple one or two suggestions, possibly in the -- in the text or in the Bill legend, as you stated. On page -- as an -- as an amendment on line 151 -- from 150 to 151 it mentioned saw the commissioner of emergency services will perform several functions to get this function in operation. We would like to suggest our thoughts moving throughout our organization that will we suggest that the Chief -- the State Bar administrator, or his designee be involved with the Commissioner's group to be sure that the fire service is represented on whatever are they going to be able to put together as regulate -- rules and regulations.

And one more thing I want to make clear is, you heard Rick Hart testify in my work both for credit closely together. Many states do this. So this is not a new -- a new function is not something new. There are a lot of students out there that do this on a regular basis, and really have been doing it for a long time. I've heard of this before in my career with more than 40 years, probably at least 20 or 30 years ago, that there were towns that were or it's different states that were doing this exact same thing. So, we're gonna ask you to consider that to think. Thank you. Any questions though. Try to entertain.

REP. COMEY (102ND): Thank you very much. You can tell Mr. Halsted that he had a good fill-in for him.

TED SCHROLL: Thank you.

REP. COMEY (102ND): See you next time.

TED SCHROLL: Thank you.

REP. COMEY (102ND): Next question, Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair and thank you, Ted, for your -- for your testimony. Certainly appreciate the language suggestions and appreciate the importance of funding these regional FireScope, so look forward to working with you and making sure that one way or the other we can solve that problem, I noticed that problem, inside a problem for -- I really appreciate your testimony today and look forward to continuing to work.

TED SCHROLL: Okay, Senator respectfully to the -- suggest that amendment. As you realize, of course, we're very fortunate take -- we'd have several commissioners of the desk down there that -- we're worked very well with the fire service, but here's to the future where he knew, as we all know, that we just -- I think that we probably should have someone with a little bit of firing -- fire service experience to help only to assist the Commissioner, so we'd like -- we'd love to do.

SENATOR LESSER (9TH): That makes sense. Thank you.

TED SCHROLL: Thank you.

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

REP. DELNICKI (14TH): Thank you, Madam Chair and thank you for coming here, Ted.

TED SCHROLL: Thank you.

REP. DELNICKI (14TH): You made mention of the amendments that you would like to propose or have proposed. The -- do you have them committed to paper?

TED SCHROLL: No, I do not. It -- you know, we found out about this public hearing on -- actually only last Friday when the Bill came out and they just did some discussion back and forth amongst the most about it. So we don't have anything but we would like to think it'd be relatively simple that, yes, that the -- with the -- with the Commissioner, as it's stated now, the Commissioner shall establish and then goes into several functions that he would be doing. I guess we would only suggest that we get in collaborative -- something like in collaboration with the -- with the Chief State Fire Administrator and something, whatever. It is -- if any help where they got too busy. But we just really feel that someone within the fire service should be there again to assist the Commissioner.

REP. DELNICKI (14TH): Can you -- can you provide those suggestions in writing to the entire Committee, so that we have it?

TED SCHROLL: Sure. Give me a couple days and make a couple of phone calls, and then so we can work off wing.

REP. DELNICKI (14TH): I think that would be a big help for all of us to know where the folks that actually do the training and run the schools, and do the heavy lifting, what they'd like to see.

TED SCHROLL: Yes, in fact, Rick alluded to it. Further down your list number 54 -- your list of stat, this could be -- the Assistant Chief and the retraining in Fairfield, and he also is the administrator of the Fairfield Regional Fire School. So he's a -- he's a hands-on administrator firefighter actually, that actually run the school, but he's, on a day-to-day basis, working with fire trainees and whatever from around -- again so it's a regional school so he gets something from all over the area.

So, as you say, I've now retired out of the service for a little while, just trying to help out a little bit. Scotty is our guy in the ground. He's a -- he's -- he knows a bunch of you want to know about a fire school, so I suggest that maybe he's listening, maybe he isn't but pick his brain good because he's got some good ideas.

REP. DELNICKI (14TH): I certainly appreciate you coming forward today. And thank you for your testimony. And did you say you were Wethersfield Volunteer Fire Department originally.

TED SCHROLL: Yes, I was.

REP. DELNICKI (14TH): I had the pleasure of working with John McAuliffe years ago.

TED SCHROLL: Oh, John and I were like peas in a pod for a while. Him and I wrote back and forth to our Chief. So we're that close -- that John and I -- John and I were in high school together.

REP. DELNICKI (14TH): John's a great guy.

TED SCHROLL: Yeah. That was just a couple of years ago.

REP. DELNICKI (14TH): Yeah, I hear you. Take care. Thank you, again.

TED SCHROLL: Thanks, thanks.

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

REP. COMEY (102ND): Okay, awesome. Okay, see no more questions, thank you very much, Ted, and thank you.

TED SCHROLL: Thank you. Thank you, Representative.

REP. COMEY (102ND): Okay. Next we have Sena Wazer, followed by James Sweeney. Welcome.

SENA WAZER: Thank you. Good afternoon, Insurance and Real Estate Committee Chairs Lesser and Wood, Vice Chairs Anwar and Comey, Ranking Members Hwang and Pavalock-D'Amato and Distinguished Members of the Committee, thank you so much for allowing me this time to deliver my public testimony. My name is Sena Wazer, and I'm a 17 year old climate activist from Mansfield Connecticut, the Co-Director of Sunrise Connecticut and a junior at UConn. I'm here today to testify in support of S.B. 1024, AN ACT CONCERNING INSURANCE AND CLIMATE CHANGE.

As I'm sure you're aware, climate change is ever accelerating threatening our state, nation and world at large with unprecedented climate disasters from rising sea levels to the spread of disease in new places, to exacerbated food and water scarcity. You would expect that insurance companies would be divesting from fossil fuels, since otherwise they will be the ones bearing much of the cost for these climate change effects. However, quite the opposite is true. Insurance companies are investing in fossil fuels and pipelines and then the destruction of my generation's future. However, this Bill would ensure that the public is aware of how much companies have invested their money, and are able to see which companies support fossil fuels. It would allow prospective employees, especially young prospective employees of in these insurance companies to look into how the company is investing their money in fossil fuels or not in fossil fuels.

Although we need much more from both insurance companies in the state in terms of climate action, having access to information, being able to see which companies support what is certainly a step in the right direction. It is a step towards protecting communities of color and low income communities who are disproportionately affected by climate change. It is a step toward protecting my generations future which is also disproportionately threatened by climate tree by climate change. And

it is a step towards Connecticut becoming a climate leader. As such, I hope that the Insurance and Real Estate Committee will support this Bill and work to ensure the passage out of the committee, and through the General Assembly. Thank you.

REP. COMEY (102ND): Thank you very much, Sena. I think I've seen your satisfy a couple of times this point -- this year already. So Lesser, you have a question?

SENATOR LESSER (9TH): Yes, thank you, Sena. I just wanted to thank you for coming to the Insurance and Real Estate Committee. I know that you've done such all across the state of Connecticut so obviously I think this particular angle is really important to fighting the -- fighting climate change and also supporting our insurance industry, because they're not only are they involved in investments and underwriting but they're the first to pay out when we have to increase claims because of other climate crisis. And I think you're also right that companies that are really taking a lead in, in trying to take this seriously are also have a leg up in attracting new talent. I think it's something that a lot of -- a lot of younger workers that seem to care about. So my hope is that we can work together to sort of standardize how that disclosure works and really put Connecticut. I appreciate your testimony and I think it's a good conversation and, hopefully, we get some more.

SENA WAZER: Yeah, thank you so much, Senator. Yeah, I definitely think it is really important for students who are looking for jobs in these companies and like want to work there, that may be concerned about where you know where the money of these companies is, so definitely very excited about this Bill.

SENATOR LESSER (9TH): Thank you.

REP. COMEY (102ND): Thank you very much. Okay, thank you very much. Have a good night. Our next up is Jane Sweeney, followed by Brian Anderson.

JANE SWEENEY: Hi there, Senator Lesser, Representative Wood and all Members of the Insurance and Real Estate Committee. Thank you for the opportunity to speak today. My name is Jane Sweeney from Farmington, Connecticut, and I'm testifying in support of Senate Bill 1007, AN ACT REQUIRING HEALTH INSURANCE and MEDICAID COVERAGE FOR THE TREATMENT OF SEVERE OBESITY. I am currently the Clinical Manager for the surgical weight loss program with Harvard Healthcare Medical Group and also medical weight loss as well. I just want to give you a quick background and a history in relation to the disease, obesity for myself.

I am a registered nurse and I worked for 10 years in on a medical surgical floor in acute care in the hospital, and this is really where the journey began for me. I had many patients, and even on an average day I would say the majority of my patients were suffering from the chronic health issues that accompany obesity. These individuals were suffering the effects of not getting effective treatments for their disease, and were at the point where they were what we might call a frequent flyer, they were in the hospital for multiple visits, many medications. We were treating them for things like, you know, for type two diabetes congestive heart failure, chronic kidney disease, there's countless things.

And I, I guess for me, I feel like I'm, I want to represent them here today, because having gone through that with them as an advocate for them, I just want to mention that today. I know we talk a lot about numbers, but I also want to just mention, the people who have suffered and what I've seen and really that led me to the role I'm in today because, as a nurse, I just wanted to solve this problem. And so, you know, I'm so happy in the role that I'm in, because currently when I get to do is, as the

clinical manager for this program, I get this, you know, there's this amazing treatment and I also, I think what I'd like to do today because no one's really explained what the treatment is, I think we assume that it's just surgery, which is absolutely not the case. But if you ask a group of surgeons to speak, you're just going to hear about the surgery. But I just want to quickly make it clear what we do for our patients and what other patients aren't able to take advantage of.

But the treatment involves three at least three levels that we focus on which is behavior modification, nutrition education and exercise education. So we have multiple specialists from behavioral health to registered dieticians, some exercise physiologist that work with us and our whole team of providers, and we have a program set up that we are working to help change their mind, as well as their body. If you don't do that. surgery isn't going to do much. You know, it'll help with a metabolic and I know we talked a lot about metabolic surgery but there's a big component of this, which is also mind set and we also -- I want to make sure I touched on the fact that these patients are treated holistically and they -- it's a, you know, incredible program that you know I want everyone to be able to take advantage of. So I just wanted to at least --

DAWN MARZIK: If I could ask you to wrap up your three minutes for us.

JANE SWEENEY: I'm just wrapping up. So, you know, I wanted to just mention also quickly that part of my job is I not only get to see the incredible transformations and the life-saving, you know, measures and how people get their lives back but I also have to talk to all the patients or many of the patients who are unable to get coverage. Just this week I spoke with someone who -- she's been waiting over a year she's got a job she works hard, she has no insurance coverage, and she's put weight on her

health deteriorating and, you know, so I represent her as well, here today. But, basically, you know, especially what we've seen with COVID as well, I just think now more than ever, this coverage is so important, and I, you know, just ask you to please pass Bill -- Senate Bill 1007 and sport in support of this coverage for the treatment of these lives with these life-saving measures. Thank you.

REP. COMEY (102ND): Thank you, Ms. Sweeney. And thank you for filling in those gaps that and watching all day so --

JANE SWEENEY: All day. Yep. I've watched all day so I thought I'd at least touch on -- I think it's important to understand what the treatment really is.

REP. WOOD (29TH): Wonderful. And thank you so much. Any questions from the Committee?
No, I think, we're good. Okay. Have a good one.

JANE SWEENEY: Thank you.

REP. COMEY (102ND): Okay next we have Brian Anderson, and then after that we will have David Arkush.

BRIAN ANDERSON: Good afternoon, Chairman Lesser, Chairman Wood, Chairman Comey and Members of the Insurance and Real Estate Committee. My name is Brian Anderson. I'm a Legislative Coordinator for Council 4 AFSCME, the union of 30,000 public and private employees. Our union strongly support Senate Bill 1043, AN ACT CONCERNING THE HARTFORD COURANT.

The destruction of newspapers is a problem across our country. President Thomas Jefferson warned Americans over 200 years ago, that democracy cannot survive without a thriving free press. Jefferson believed in this so strongly that he said, "We're left to me to decide whether we should have a

government without newspapers or newspapers without a government, I should not hesitate a moment to prefer the latter." The best antidote to corruption is a body of journalists bringing truth to the public. We should know this in Connecticut. The corruption of one of our longest serving governors John Rowland was first exposed by the Hartford Courant, The Journal Inquirer, and other newspapers. These papers show the Rowland turned state government into his own personal cash register. If not for these newspapers, perhaps, Rowland Rome would still be governor today.

The Harper Courant is America's oldest continuing newspaper. Sadly, it appears to be in the process of being destroyed by Alden Capital, a hedge fund with no loyalty to the staff or subscribers of the Courant or to the citizens of Connecticut. This was recently shown by Alden Capital would lay off over 150 local workers who printed the Courant. Alden Capital showed this when they severely slashed the reporting staff to the Courant. Alden Capital showed this.

When they closed the physical plan to the Courant, forcing reporters and editorial staff to work from home, rather than in a central office where journalists can compare notes, share information and form stories. Alden has showed a pattern of weakening and debasing the newspapers that is supposed to safeguard across the country. When such an unworthy steward is in charge of such a vital function, it is necessary in a govern -- in a democracy for government to lend a hand. Thank you for your consideration,

REP. COMEY (102ND): Thank very much, Mr. Anderson, taking us down memory lane now to --

BRIAN ANDERSON: Not such good memories.

REP. COMEY (102ND): Well, any questions from this? No? None from the Committee today. Thank you very much for joining them.

BRIAN ANDERSON: Okay.

REP. COMEY (102ND): I don't see number 43, so we're going --

YEVGENY SHRAGO: All right. I'm here.

REP. COMEY (102ND): Oh, you on? Sorry. I didn't mean to --

YEVGENY SHRAGO: Yeah, no problem.

REP. COMEY (102ND): Okay. So nice --

YEVGENY SHRAGO: Sorry, and, David, unfortunately, because of the hour had to step out. My name is Yevgeny Shrago, on the other side of the written testimony, I hope it's okay if I testify on his behalf.

REP. COMEY (102ND): Your name I'm sorry. I missed it.

YEVGENY SHRAGO: Yevgeny Shrago. So I'm testifying here today on behalf of Public Citizen National Public Interest Advocacy Group, with more than half a million members and supporters, and I'm here to testify in support of S.B. 1047, AN ACT CONCERNING INSURANCE AND CLIMATE CHANGE.

Adopting its disclosure and regulatory approach would establish Connecticut as a leader on climate change and insurance regulation. Climate change is already affecting the insurance industry adversely. On the underwriting side, climate change is increasing the frequency and severity of natural disasters. On the investment side, continued investment in fossil fuels exposes insurers to transition risks, from falling asset prices and

stranded assets. Insurers also face reputational risk from their fossil fuel underwriting and investments, as campaigners pressured them to abandon these activities.

And they are. Globally, at least 65 insurers with combined investments worth $12 trillion dollars have adopted divestment policies of some kind. But, unfortunately, many major U.S. insurers including travelers, which is domiciled here in Connecticut, continue to underwrite coal and oil and gas without any restrictions. This behavior exposes U.S. insurers to ever increasing risks.

U.S. state insurance regulators are also well behind in addressing climate risk. The NAIC's climate risk disclosure survey which is the main tool used today, yields only the bare minimum information for most insurers. To date, only New York has announced plans to supervise ensure climate risk in a deeper way.

In contrast, European regulators have been adopting robust disclosure requirements and began to incorporate climate risk into their assessments of ensure resilience. With the threat of climate catastrophe continuing to increase, this Bill 1047 recognizes that the status quo is unsustainable. The reporting requirements in 1047 use informative metrics that all insurers can provide today. Investment in fossil fuels is a good measure of transition risk. Data on fossil fuel underwriting kind of highlight ensures that face potentially massive liability for the effects of climate change on their clients. And as climate science advances, the Bill allows new metrics to be added by the Department of Insurance.

Disclosure is a good start, but it won't be enough. The Insurance Department will need to use the clear mandate in this Bill to integrate climate risk into the many tools it uses to supervise insurers today. It will also need to align insurer and activities,

it's one and a half degrees Celsius global target. If global temperatures exceed these targets, it's going to exacerbate the physical harms of climate change, which is going to cost insurers more money.

So insurers with activities that are inconsistent with errors targets actually increasing the cost of all insurers and as a result consumers and policyholders will fare in the future. Dying on vigorous climate risk legislation is going to harm the planet, and it's going to harm the future viability of the Connecticut insurance industry. We encourage the Committee to favorably report this bill and the General Assembly to adapt as quickly as possible. Thank you. I'm happy to take questions.

REP. COMEY (102ND): Thank you very much, Mr. Shrago. Any other questions from the Committee? Seeing none, we thank you for coming this evening.

YEVGENY SHRAGO: Thank you.

REP. COMEY (102ND): Okay, number 44, Mr. Gallitto. David Gallitto.

DAVID GALLITTO: Good afternoon, Madam Chair, Representative Wood, fellow realtor, Senator Lesser, always good to see you, and Members of the Insurance and Real Estate Committee. My name is David Gallitto. I'm the first Vice President for Connecticut realtors. I've been a realtor for 18 years and live in the City of Middletown. I want to thank you for the opportunity to submit testimony on behalf of Connecticut Realtors in support of House Bill 6624, but before I do so I want to thank all of you, your colleagues in the current administration for deeming real estate as essential and allowing us to continue to work throughout this pandemic in helping our in state residents, as well as out of state residents realize homeownership here in the State of Connecticut, all while helping Connecticut's economy.

REP. COMEY (102ND): There is no need to caucus at five?

DAWN MARZIK: Yeah.

REP. COMEY (102ND): Okay.

DAVID GALLITTO: With regard to House Bill 6624, many of you know that connected realtors represents over 17,800 members in all aspects of real estate in the state of Connecticut. This Bill proposes to modify the preconditions for issuing a real estate broker's license in Connecticut. Specifically, the Bill changes of time a person has been actively engaged as a real estate salesperson from two to three years, and requires that salesperson to have actively worked under the supervision of a licensed real estate broker in Connecticut for, at least, 1,500 hours during the immediately preceding three years. Current statutory requirements include that brokers have actively engaged in real estate, without a clear definition or ensuing compliance with that criteria.

Therefore, those who have not been -- not engaged in a manner of real estate, other than holding a real estate license are deemed qualified as actively engaged. This would now define the term to require the prospective broker to have represented either a seller, a buyer, a lessor or lessee in, at least, for real estate transactions that have closed during the three years immediately preceding the broker application date.

Real estate brokers, as Representative Wood knows has the required oversight of all agents and transactions within their brokerage firms. Presently, an individual can obtain a broker's license, without any knowledge of transactions, and by simply holding a real estate salespersons license, without spending even an hour practicing real estate in that time period. Canadian Realtors is concerned consumers, the most important piece, to

all of this cannot be served on what is their largest financial investment when involvement, or oversight includes zero experience with transactions or the practice of real estate.

The Department of Consumer Protection could establish form of submission of information, which could be as easy as attaching documents showing payment for transaction services, print outs indicating listing, selling, leasing agent in a closed transaction. I would kindly --

DAWN MARZIK: Excuse me, if you could wrap up.

DAVID GALLITTO: I will. Thank you. In addition, CTR also respectfully request to submit language in this Bill related to the issue of real estate teams. The Department of Consumer Protection has identified there are presently no statutes or regulations that permit the advertisement of real estate teams to the public. This amendment seeks to provide the definition of a team and requirements for the team names to ensure transparency to the public. It also establishes the supervisory relationship registration process, annual fees, renewal fees, change fees to cover the cost DCP to establish and maintain this new recording for (T). Connecticut Realtors worked closely with the Department of Consumer Protection and drafting this language, that the department has approved. You'll find it in the attached testimony. This should solve past difficulties DCP has identified. In conclusion, I asked for support of House Bill 6624, and with that I thank you very much for your time and attention to these matters.

REP. COMEY (102ND): Thank you very much. Representative Wood.

REP. WOOD (29TH): Thank you, Madam Chair. David, this -- it was great to hear your testimony. I would guess, but please verify that there are a lot of new agents coming into the industry now with the

tremendous amount of homes being transacted on the market.

DAVID GALLITTO: Well, I can't say, Representative Wood, that over the course and even the past year or two, there have been a lot of people coming into the real estate business in my section, which is Middlesex County and New Haven County. We have, as you know, real estate classes and people need to do register -- excuse me, they register to become an agent, and then they have to attend an orientation that our local association provides. And those, you know, at least four times a year, at least 70 people in the class, we've been experiencing. A lot of people coming into the --

REP. WOOD (29TH): Right.

DAVID GALLITTO: Not just because of what's happened over the past year.

REP. WOOD (29TH): Right. And are you seeing, you know, bad actors in the industry? Is that why this was put forward or is it really just more for the part of the consumer -- more of a stronger consumer protection Bill?

DAVID GALLITTO: This has always been all about the consumers, Representative Wood. It's important that we take our job very seriously and professionalism is very important to me, and I know to my fellow realtors. And to be able to increase the -- not only the education but the process to becoming a broker. Yeah, because those brokers do more than just house agents under their agency, they're responsible for everything -- training, the clients that each and every one of those agents represents.

So there's a lot of responsibilities that a broker has, and it shouldn't -- Process of getting there, should include much more education, which it was changed some eight to 10 years ago, and now to have the requirement to perform real estate and have so

many transactions under their belt is extremely important, as you know.

REP. WOOD (29TH): Yeah, no I really appreciate you guys, you know, setting up and bringing these stronger consumer protections, you know, to the committee and we look forward to working with you further. Thank you.

DAVID GALLITTO: Thank you very much.

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

SENATOR LESSER (9TH): Yeah. Thank you, Madam Chair. And thank you, David. It's been good to get to work with your years and come to rely on you is really a trusted source for real on the ground information about your industry and you are immensely knowledgeable. It's great to work with you and the realtors. Just I -- this is a small thing but I'm just looking at the testimony. I know that you said you submitted some suggested language addition that we work out ECP. We don't have that listed in our online testimony so I just wanna make sure that we actually get the language --

DAVID GALLITTO: We will get that to you.

SENATOR LESSER (9TH): Okay, great.

DAVID GALLITTO: That's right.

SENATOR LESSER (9TH): So we'll take a closer look at it and really appreciate it.

DAVID GALLITTO: Absolutely. We'll ensure -- let have Jim Heckman send that off to you. Thank you got.

SENATOR LESSER (9TH): Sure, thank you.

DAVID GALLITTO: You got it.

REP. COMEY (102ND): Okay, thank you very much. Seeing no further questions, thanks. Have a nice night. Is Samantha Dynowski here? Yes, Samantha, hi.

SAMANTHA DYNOWSKI: Hi. Thank you, Representative Comey, Senator Lesser, Representative Wood, and Members of the Committee for the opportunity to testify today, and for the attentiveness and care you take in considering the issues before you. I am very appreciative. My name is Sam Dynowski. I'm the State Director of Sierra Club Connecticut, and I'm here to testify in support of Senate Bill 1047, AN ACT CONCERNING INSURANCE AND CLIMATE CHANGE, on behalf of our more than 40,000 members and supporters in Connecticut.

Sierra Club is committed to solving the climate crisis with Justice Equitable Solutions that will result in a healthy world for everyone. The science is very clear that we must significantly reduce our fossil fuel dependence in less than 10 years to avoid catastrophic warming. There's also a growing body of research on the negative health impacts of fossil fuels. As a state, we have been responding Connecticut was one of the first states in the nation to pass a law to reduce greenhouse gas emissions in line with the science, the Global Warming Solutions Act. But while our state has taken action to address climate change, our flagship insurance industry has largely not taken action. It continues to play an outsized role in climate destroying fossil fuel production by providing insurance to, and by investing assets in fossil fuel companies.

We applaud the Committee for raising Senate Bill 1047, as an incredibly important step to improve the information available about investments in an underwriting of fossil fuels, as well as the risks associated. Given the current and predicted impacts of climate change shareholders policyholders'

employees, residents here in Connecticut and our decision makers have a real need to know this information. We urge your support and Senate Bill 1047, and thank you for consideration of our testimony.

REP. COMEY (102ND): Thank you, Sam. Anyone have any question? No? That will be it. Thank you. Have a good one.

SAMANTHA DYNOWSKI: Thank you. Good night.

REP. COMEY (102ND): Okay. Next we have -- is Elizabeth Kerrigan here? Don't see Elizabeth, but I do see number 47 Laura Hoch. So, thank you.

LAURA HOCH: Yes, thank you, Representative Comey, Senator Lessor, and Representative Wood, and Members of the Insurance Real Estate Committee. I am here today to submit my testimony on House Bill 6622, AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LIST OF COVERED DRUGS. My testimony is posted to the Committee page, I wanted to share a few key points.

My name is Laura Hoch. I'm a Senior Manager of Advocacy, the National Multiple Sclerosis Society based here in Connecticut. I would first like to thank Senator Looney, Representative Wood and Senator Summers; all who have introduced this concept for several years since your advocacy, as well as Senator Anwar who has introduced it this year.

When someone is diagnosed with MS, their clinical expired medication as a disease modifying therapy was used to modify the disease course relapses and manage symptoms. Finding the right disease, modifying therapy or DMP, that's most effective with least negative side-effects is an arduous process, and these drugs are not interchangeable. Switching for any reason other than medical necessities led to hospitalization or lengthy stays at rehab centers,

both of which are much costlier to the system than the difference in drug prices.

In this legislation, as Senator Looney outlined earlier were to prevent mid-year formulary changes often referred to as non-medical shifting, something important to note is that it would not prevent insurers from adding additional drugs to the formulary if they choose to do so.

People with chronic conditions like MS often base their decisions to enrol in a health plan on the available information about the medications they need.

Medications have an average premium price of over $91,000. And allowing insurers to essentially break the contract and change policy during this term is inherently unfair to the patients who need these medications.

I'd also like to touch briefly on the financial impact in the State.

House Bill 6622 is the same legislative language that's passed in 2019. It passed House, overwhelmingly bipartisan line in House Bill 6096.

The version of the Bill was amended to the language that’s currently existing 6622. Specifically, to decrease in limit any financial impact to the state.

Potential minimal cost less up to this point it amendment would also likely be offset by the savings dealing with patients who remain stable on medication, and perhaps will have to be admitted to the hospital or rehab facilities due to relapses or adverse effects.

If caring with a person's course of treatment poses dangerous threats to their health and safety and House Bill 6622 for the long way in protecting Connecticut residents.

We do encourage the Committee to amend this Bill slightly to require that insurance provides notice if they plan to remove a drag with formulary at the end of the policy term in addition to the rule set forth in the Bill currently.

This notice should be given before open enrollment begins so that the insured is aware of any changes coming and they're able to make the best decisions for them in terms of cost, moving forward.

REP. COMEY (102ND): Thank you very much, Laura. Thank you for waiting around and have a great time.

Okay, next, we have Beverlee Cholewa. After that, we'll have Sam Hallemeier. Beverlee.

BEVERLEE CHOLEWA: Hi, I was having trouble unmuting.

REP. COMEY (102ND): Would you like to turn on your camera.

BEVERLEE CHOLEWA: Oh, I'm sorry. Okay. My name Beverlee Cholewa. And I am -- I appreciate you guys having such a long day.

The Co-Chairs, Senator Lesser and Representative Wood and Members of the Insurance and Real Estate Committee are willing to still listen.

I am in support of Bill, Senate Bill 1007. And I feel that the bariatric surgery has changed my life in a positive way.

And I am fortunate that my insurance has covered it I had the sleeve and 2019. And then I needed a revision to bypass this past January 13, 2021 due to severe reflux.

And I think that bariatric surgery has improved my life by rating me. My blood pressure is better my

sense of value it has restored, my confidence -- I have five grandchildren that are my life.

My necklace around my neck is my entire immediate family. And I will be here for a long time to enjoy life with them.

And I think it should be mandatory that all insurance companies afford the people that are obese, to have the same surgery that I was fortunate enough to have.

Dr. Tishler is my surgeon and the surgery team has been awesome. Prior to that, I had another surgery team for the other one. But I think that bariatric surgery is saving people's lives every day.

And I think the insurance companies are in the business of saving people's lives. It seems it would be much cheaper in order to do the surgery versus long term dealing with someone that's obese and all the illnesses that go along with that.

And also I no longer have acid reflux. I woke up without that horrible feeling.

So if you have any questions, I'm here for that.

SENATOR LESSER (9TH): Well, thank you for your testimony and glad to see that you're doing well and really appreciate your testimony.

Are there questions or comments from members?

If not, thank you for being here today, and thank you for your testimony it makes a difference.

BEVERLEE CHOLEWA: Thank you for listening very much. I hope it passes.

SENATOR LESSER (9TH): Next up, we have Sam Hallemeier followed by Eric George.

SAM HALLEMEIER: Thank you Chairman Lesser, Madam Chair, Wood, and Members of the Committee.

My name is Sam Hallemeier, and I'm here on behalf of the Pharmaceutical Care Management Association, otherwise known as PCMA.

I'm here today to provide comments to oppose both House Bill 6622, which is the mid-year formulary changes, as well, Senate Bill 1045, which is step therapy.

PCMA is the National trade association representing pharmacy benefit managers, which administer prescription drug plan for millions of Americans.

I wanna start off by saying that PBMs exists to make drug coverage more affordable. By aggregating the buying power of millions of enrollees to their plan sponsors and payer clients, facilities, employers, health plans and public programs are not required these PB most choose to because PBMs help lower the cost of prescription drugs.

I'll start with House Bill 622, which would restrict the ability to make formulary changes during the contract year by mandating coverage for specific drugs, regardless of availability or effectiveness more for more affordable alternatives.

House Bill 6622 will increase healthcare costs for employers and individuals in the form of higher insurance premiums, premiums and drug prices.

This type of policy would cost Connecticut healthcare payers $70 billion over the next five years.

And for the state employee plan in Connecticut alone. With CVS, one of our member companies administers the prescription plan, this legislation will raise costs anywhere between 3.3 million to 7.4 million per year.

Although health plans use formularies. If a patient needs access to a non-formulary, drug health plans and PBMS have in place appeal processes for patients to request coverage.

The health plan or PBM works with the patient and their provider to access these non-formulary drugs.

Next, I want to move to Senate Bill 1045. Because we believe that it will move that's one of the tools we use to provide a high quality benefit that puts downward pressure on the rising cost of prescription drugs and this tool step therapy.

Step therapy requires enrollees to try medically appropriate first line drug, typically a generic alternative to a branded product when a new therapy is initiated.

Some drugs have many harmful side effects, but more often have a high list price and step therapy encourages them to use those lower, cheaper alternative drugs first.

If Connecticut implements prohibitions on step therapy, projected drug costs for the fully insured employers and commercial health plans would increase by 554 million in the state of Connecticut over the next 10 years.

Senate Bill 1045 also aims to reduce the use of mail service. CMS show that drug costs are 16% lower at mail service pharmacies, compared to brick and mortar stores.

Additionally, mail services contactless methods to ship medications to a patient's front door, even during a pandemic.

To conclude my testimony, it is in the interest of Connecticut patients and payers to not pass these Bills.

So we must respectfully oppose House Bill 6622. And Senate Bill 1045.

But I'm happy to work with the committee and key stakeholders on these pieces of legislation.

And I'm also happy to answer any questions of the committee.

Thank you.

SENATOR LESSER (9TH): Thank you Mr. Hallemeier and I appreciate your testimony, obviously, we have heard from an awful lot of people this year, and in previous years, who have felt that they've been victims of a bait and switch when it comes to formularies that change mid-year.

And I understand, you know, I understand the importance of keeping prices steady and someone's got to eat the cost if drug a company wants to raise the prices, mid-year.

Those dates don't align, we can't be the only states to wrestle with this, has anybody figured out a way to hold consumers harmless? So that if you opt in to a client, you don't find that you lost access to critical messages?

SAM HALLEMEIER: I can look into that. But off the top of my head, I'm not familiar of any state that you know, if a patient signs up for a plan, and then a job is removed, and your penalty the -- I can look into that further. Senator, but I don't know off the top of my head, specific states.

SENATOR LESSER (9TH): If it is anything. If you have a dispute with a drug company, you're trying to negotiate, we want to make sure that those negotiations happen.

I don't want to limit your ability to do that. But we got consumers we got to protect to sign up for a specific cost.

So I don't know if there's a you know, we've dealt with sort of analogous situations when it comes to surprise billing between payers and providers like we just – this is not the first time when we wanted to hold consumers harmless.

Is there a way you know? Is there an avenue to do that? Because that's what we're struggling with. That's what we're sort of being directed to do by -- justify here.

Because it seems to be a recurring issue, if people keep on having -- I'm just curious if there are any models that you're aware of.

SAM HALLEMEIER: Sure. I'm happy to look into it further. Senator.

SENATOR LESSER (9TH): Thank you. Any questions from Members of the Committee?

I can see a hand up. Yes, Senator Anwar.

SENATOR ANWAR (3RD): Mr. Thank you, Mr. Chair. Thank you, Mr. Hallemeier for your testimony.

So I wanted to ask you a question, I'm going to show you something from the Financial Times about the eight best selling drugs in the United States.

I hope people can see this. And if you look at the longer blue lines, these are the prices in United States and the smaller ones are in Canada and United Kingdom.

And what is suggested is that, your PBM is the causation for this.

So I was trying to understand why do America – we as Americans have to pay multitude factored more price of the medications?

And then when I tried to get people in the room? And I'd say, what is the cause everybody points at you. Now you're in the room I want you to point at somebody else but figure it out, why is it that we are paying about 1015 times more for the same medicines that we make?

And then as the US citizens, we are being charged the highest amount to the point if you're looking at getting the medicines, from Canada or any other part of the world if we can.

SAM HALLEMEIER: Senator, thank you for the question. It is -- I could barely see the graph. But I do understand the point, your question.

It may sound like I'm deflecting here, but PBMs don't set the list price here. We solely exist to drive down those costs, we pit drugs -- competing drugs against each other to get a lower cost, and pass those rebates on back to the plan to lower premiums.

SENATOR ANWAR (3RD): So when I'm sitting down with the insurance, and I know Eric, George is gonna see – they’re gonna point fingers at the pharmaceutical industry, the pharmaceutical industry will point finger at the insurance company.

And when we get both of them in the room, they point the finger at you. So it's like, how do we get to the solution for this, because this is the time when people retire, they are hoping to have a reasonable life.

But majority of their social security majority of their savings are going as copays or deductibles for their insurance, and it's not sustainable.

And I see people in other parts of the world who actually are enjoying their retirement. And they don't have the PBMs.

So again, I'm not trying to make sense of it. Our interest is to make the lives of our citizens better.

And we're not getting there. And the cost of drugs is a very big factor in this. And it's a complex process. I have a grasp of how you guys do what you do, but it's like so many middlemen in the picture that everybody even takes about three, 5%. That's just adding to the cost of that entire process.

So can you explain why we are paying 10, 15 times the price if at a minimum on some of the medicines in the United States?

SAM HALLEMEIER: Again, Senator Anwar, my answer would be we don't set the list price, we solely exist to attempt to drive down these costs.

I would point to the manufacturers who set these list prices on why your bar graph is so high compared to other countries.

SENATOR ANWAR (3RD): Okay, so it's the pharmaceutical industry, then?

SAM HALLEMEIER: The drug manufacturers, again, I hate to sound like a broken record here.

But we don't set the list price. We do everything we can to get that price lowered for us patients.

SENATOR ANWAR (3RD): Okay, thank you for your testimony. Thank you so much.

SAM HALLEMEIER: Thank you, Senator.

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

REP. NUCCIO (53RD): Good afternoon. How are you?

SENATOR LESSER (9TH): I'm great, good evening.

REP. NUCCIO (53RD): Good. Thank you, Chairman. I think, Senator Anwar and I agree on this. So I was wondering, we've had lots of conversations with drug manufacturers, insurance companies and everything else.

And when it comes to this medical this -- this drug costs, it does seem like a whole lot of not me, not me, not me. And we've heard drug manufacturer saying a couple of meetings ago, that --that they don't say, don't set the price. So now you're saying you guys don't set the price.

I know insurance companies don't set the price. So now I'm just wondering who sets the price. And who is the one that we can actually sit at the table to say, you know, and if you can also make the talk on how rebates play into all of this and how the rebates are facilitated and how they're not applied toward customer costs?

SAM HALLEMEIER: Sure. I'm, I'm shocked. To hear that a drug manufacturer representative said that they did not set the price, but--

REP. NUCCIO (53RD): Was it selling price or rebate price? I think maybe it wasn't retail price, I can't remember exactly, but they said they didn't have anything to do with the price at the pharmacy.

SAM HALLEMEIER: Pharmacy. Okay. Again, I'm gonna – they set a list price. PBMs have no control whatsoever of the list price of the drugs that the drug manufacturers make.

As far as rebate, the rebate discussion goes, that is a tool that PBMs have to lower drug costs for patients.

So if there's two drugs of the same class, essentially PBMs will pick them against each other to see who can get the lowest rebate.

And then with those rebate dollars, we can – PBMs collect them and then pass them back on to the plan to lower premiums for patients.

So while those patients may not get them at the pharmacy counter right there, it’s definitely passed back to their plan sponsors to lower premiums overall.

REP. NUCCIO (53RD): Okay.

SENATOR LESSER (9TH): Representative Nuccio, I'm just as interested as anybody else is, in trying to figure out prescription drug prices.

I just would remind all Members of the Committee; we're looking at specific bills here. And so while I'll grant members, some leeway to talk about figure issues, if we could try to confine remarks, and questions to the Bill before us.

I think that would help us get through a very long agenda today.

So I’ll allow you back, Representative Nuccio.

REP. NUCCIO (53RD): Thank you. Sorry, I was led down a path. I had to take the opportunity.

SENATOR LESSER (9TH): Yes, you’re right. Absolutely.

REP. NUCCIO (53RD): So in relation to the bill that we have in front of us with the formularies.

I guess I'm not really understanding the pushback and being able to assure a patient or a customer, you know, when they get into a plan that that plan

is going to be stable for a year, and or their policy period.

So I guess I am struggling a little bit with trying to understand why we would be okay with changing formularies mid-policy year.

SAM HALLEMEIER: Sure, there are some examples that I'd be happy to share with you. It's in my written testimony as well.

For example, Vioxx is a drug that PBMs removed from formularies, before the FDA determined that it was unsafe for patients.

So that would be an example that I would use. In the Hep C space, Sofosbuvir and Harvoni, those are ones -- an example of the rebate, where we pitted these two drugs against each other to get the lowest net cost, which is why we would choose the lowest cost to be put on the formulary. And again, that's also in my testimony.

REP. NUCCIO (53RD): Okay, well, I can appreciate the FDA piece of it. That part I've obviously seen. But I'm going to review your testimony on that and see if there's more in there. But thank you very much for your -- your feedback. I appreciate it.

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

REP. MESKERS (150TH): Well, if you've heard Senator Anwar and Representative Nuccio, you don't want me to go down the road about what I think about policy benefit managers, some.

And I won't go down the road but would beg your indulgence of Senator Lesser.

Everyone's got their hand in my pocket on health care costs, and no one is putting any money in it. You're emptying it?

So the question is, how do I stop so my wallet shuts.

The issue on the -- I'm willing to consider your concerns about the about FDA and efficacy and approval.

But when I have constituents who come to me on multiple sclerosis medicine, where they're finally flat-lined on their treatment, and they get a bait and switch.

I'm really not interested in having that dialogue. So I have concerns about medical efficacy as well. And Senator Anwar and I are on so many different positions on where we stand on certain things.

But there's a moral and ethical piece to this, that I'm just not-- I don't know how much flex I have?

And I understand your job is to manage the cost of the healthcare, the policy benefit managers, but I'm not even comfortable where that money flows, whether it's going to the pharmacy, or the insurer or my constituents.

So I'm not going to accept the prima facie that you're, you know, somehow -- the Pharmacy Benefit Managers or the Albert Schweitzers of the healthcare industry.

Because I'm lost in that model. Every time I asked who it is, it's like it's like when I read it, my children said who broke the cookie jar? And they all pointed at each other and they said the other one did it.

I'm reaching the end, and I assume for Susan has heard the lecture, at 50,000 grands, we're in a public option.

If my annual cost which is now 36 or 34, or 26 with a $10,000 deductible. If we don't take control of the hydra, we don't even need a good public option, we will be able to afford a private option.

So you should understand them in a constructive way. I'm trying to figure out one, what's going on. And in this case, I understand you're claiming there's a lot of savings involved.

You know, I'm compounding at 8% a year. I don't know, if you save me any more money at 8% a year, I'm bankrupt.

So I'm just -- it's confusing exercise for me, and I'm sorry, to beat you up. I' not the sole person of my IRA.

But I questioned the, you know, I'm questioning whether we're getting some places for fishing.

So I apologize.

SAM HALLEMEIER: No apology necessary. Thank you, Representative.

SENATOR LESSER (9TH): Thank you, Representative. And I hope we get control of the hydra.

Are there other questions or comments from Members of Committee?

If not, thank you Mr. Hallemeier, for your testimony.

Next up, we have Eric George followed by Susan Halpin.

ERIC GEORGE: Good afternoon. Thank you, Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato and Members of the Insurance and Real Estate Committee.

My name is Eric George, and I'm President of the IAC, where we represent the property and casualty and life insurance industries.

We do not represent the HMOs. I know that's a bit of a disappointment to some folks, but we do not.

I'm here to offer some testimony on numerous Bills, I'm going to get through as many as I can. As quickly as I can.

House Bill 6623, which is PNC insurance. On Section and 2 that deals with other structures. This is problematic. most homeowners have additional structures even if they don't own a shed, driveway, stone walls, fences sheds. Also, these are other structures.

And policies are standardized, to include some basic components. This is to make it much easier and user-friendly from consumers for comparison shop.

And we also want to make sure that insurers are protected from things that they might not think of. So excluding other structures could be very problematic.

Section 3 of that bill also deals with disclosures at the time of quote, it's important to understand the information that we know when we have the quick quotes.

We don't have all the information and the information that we do have has not yet been validated.

Carriers even the small ones receive hundreds of quotes every day, and out of those quotes, less than 10% ultimately purchase a policy. So that is a problem as well.

Finally, Section 4, would require the department to study ways to accelerate homeowners' claims. We don't think this is necessary.

Expedient processing of claims is mutually beneficial to both the insurer and the insured. Delay is costly to everybody.

The industry is already one of the most highly regulated industries in the state, in the country. We're under – and quite honestly intense scrutiny by our Department of Insurance, rightfully so, we're subject to review and market conduct examinations.

Moving on to Senate Bill 1046 long term care. We understand and appreciate the desire to lessen the shock of legitimate unnecessary rate increases in LTC policies.

But there are impositions in 1046 that are limiting on insurance that we view is arbitrary. We are worried that if we have these limitations in place, we're announcing the solvency of many of these companies may be put into question.

If the solvency of these companies actually comes to fruition, then we have major issues that policies won't even be offered in Connecticut anymore. Dome flexibility does need to be in place.

I would note that back in 2014, Public Act 14-10 is where we have the current limitation on LTC premium rate increases of 20% or more to be spread out over three years. We think that is a pretty fair balance.

Moving on to Senate Bill 1047, Climate Change, I want you to know that the PNC industry is very involved, and environmental risk and climate change issue.

We had certain principles and policies in place that we've agreed upon. That's in my written testimony.

Please review it, we are working very closely with the FDIC.

We do believe that uniformity in this area, and we're happy to work with you. Uniformity in this area on a nationwide basis is critical.

Moving on to 1042—

CLERK: Please Mr. Eric, if you could please wrap up your time is up.

ERIC GEORGE: I figured I wouldn't get through it all.

So there are several other Bills where I have my testimony on file. Please refer to it. They deal with a surcharge for fire. You are already paying for that. The payment of the fire schools in your budget. We think that's the correct policy decision to make and there are other issues as well, I'm just not going to be able to get to everything. We had seven bills that we were dealing with today here.

So I'm here for you guys, if you'd like to ask me any questions.

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

I'll just focus on the two that you were really able to – really the non-shed Bills that you were able to address in some detail.

So one, long term care insurance, you obviously understand the feedback that we've received from constituents who are seeing quite high premium increases.

The concern they have with the current use of the three-year phase and have increases over 20% is that if companies are able to get another bite at the apple, each subsequent year, that that becomes sort

of a meaningless statement, because you have a layering of increases on top of increases.

That's the available information that I think we've received from the Department of Insurance, that they wouldn't be able to prevent that layering with that being -- I think that's rarely done, and obviously, that limits their tools, but that's something that they would be able to deal with. And that other states seem to be moving in that direction.

Is that incorrect?

ERIC GEORGE: It's incorrect that the department is working on this and believes that they have a way to get to a better result—

SENATOR LESSER (9TH): Well, to protect. Well, obviously they're working on, but to protect, you know, to provide -- a way for them to prevent the layering of increases in each year, in a way that is actually really -- there's some inefficiency, anytime you limit any kind of -- any kind of rate increase.

Is that something that would that bring down the entire industry? Or is that something that they can—

ERIC GEORGE: I guess to your question. I talk to Paul Lombardo and his team quite frequently. And I have the utmost respect for them. While I am certain that they have initiatives in place, not only that they're working on it, but that they have the ability in place to address many of the issues, and I know that they're working on it, not only on the state, but also at the national level.

The NAIC is very involved in the LTC issue. So I would I would say that that statement is correct.

SENATOR LESSER (9TH): My understanding, I will defer to the department. But Mr. Lambardo, who is helping lead the long term care regulation issues

and rate increase issue on the national level, [mic off] department and work with the language that we have released in [mic off] If that's incorrect, I want to be very careful about the team but if we can make it work, my sense is that would be a huge benefit.

It is one of the most annoying things I know, for people who are struggling with these increases, glaring year after year after year, even though the law says you're supposed to have that [Mic off 08:29:30]

ERIC GEORGE: Please understand, Senator, I completely appreciate the position that you're in and the position that the department's in. And I appreciate where LTC policyholders are being very – are in a position of frustration.

You know, our issue is that if companies can't [mic off] under a system, they just won't be there. And if they're not there, then the issue goes away because there are no policies to be purchased.

And not and I don't think anybody wants to get to that. I think what you're talking about, which is an extended conversation, we would very much like to be a part of that.

Because I know that your head and your heart is in the right place, as is the department. So we would like to work with you on that if that's acceptable.

SENATOR LESSER (9TH): Absolutely love to work with you, and be sure that we've got a lot of work to do. There are very frustrated consumers out there. And we need a long term care insurance. It's a really vital tool for consumers out there. So look forward to that conversation.

With regards to climate change. As you know, this was the climate change working group and competency [mic off] current disclosures, I think date back to

2009. And they were kind of putting them – you know, some arguments that we need uniformity that we need to standardize the disclosure across the country I think makes all the sense in the world and I don't think it would be a good idea to have 50 different states passing 50 different laws.

That said, and the NAIC hasn't done a whole lot for this issue [mic off] but they are way behind the curve.

So what can we do to jumpstart that process where, you know, we are disproportionately important state, nationally on this issue, but what can we do to make sure that, you know, working with our colleagues in California or Washington or whatever [mic off].

ERIC GEORGE: I think recognizing the strength of your department is a great starting place, and especially the strength of your Commissioner, and the leadership position that he has over at the FDIC, because he is, he is in a position to it, if things move along to potentially be the president of the FDIC in due course.

So, I think that Connecticut has been a voice that has been heard at the FDIC for many, many years. And I expect the voice to get louder.

SENATOR LESSER (9TH): And you don't see a role for us as a Legislature, obviously, we have a great [Inaudible] been meeting the country in terms of other issues.

In terms of giving both a nudge to both regulatory [Inaudible] you don't see a role for Legislation?

ERIC GEORGE: No, I didn't mean to infer that I didn't mean to infer that I do not believe that there is no role for the Legislature.

If you look at my written testimony, what I think that we need to focus on are the principles that the

insurance industry has endorsed. And again, I'm not going to, we're in a later hour in the evening, I'm not going to go through and read all these are there at your disposal, I think it's a longer conversation. But I did not mean to infer if it was taken like that, and that was incorrect, that there is no role for the Legislature.

SENATOR LESSER (9TH): Okay fair, and we look forward to working with you.

ERIC GEORGE: And I share that sentiment.

SENATOR LESSER (9TH): Thank you Eric. Question and comments from the Members of the Committee. Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair. And good afternoon, it’s still afternoon. Good to see you there. A couple of questions. When insurance is issued for a building, what role does the quality, and when I say quality, the ISO rating of a Fire Department, play in the establishment of rates?
ERIC GEORGE: I am gonna have to say that I will not know that Representative Delnicki. I don't have that information.

REP. DELNICKI (14TH): Saying that fire is a substantial --

ERIC GEORGE: So fire is a substantial is a potential risk to all structures.

REP. DELNICKI (14TH): Okay.

ERIC GEORGE: So the point that you're making is that it is in the interest of the insurance industry to have a well-trained and staffed and resourced Fire Department.

I couldn't agree with you more, I could not agree with you more. We didn't get to, I didn't get to

touch on it too much, but I'll say this now, here's the issue with a surcharge.

A surcharge puts the insurance industry in the position of a bailiff. And if we were a bailiff for the money of the state of Connecticut, we become the tax collector for the state of Connecticut, where we conduit, the money from policyholders and then remitted to you.

That is not how insurance companies are structured. They were not created or ever envisioned to be a tax collector. We recognize that there's only one instance in homeowners where this is done and we all were very well aware of it in the crumbling foundations scenario.

I will say that is to see the precedent that the crumbling foundation surcharge has done, because now we're talking about training for fire, I would say and I would posit this to you.

I agree that fire training is paramount, and I think it should be a -- it is an item in the budget. And I think it should be perhaps a more well appropriated line item in the budget.

Understanding the history of Connecticut in terms of when we are in tough times that we have gone into funds, there perhaps are ways to protect those money.

But I would say that a surcharge on any type of paper and here we're talking about an insurance policy just isn't the proper way to fund that, and I think funding is important for these fire schools.

REP. DELNICKI (14TH): But you would submit if the ISO rating were better than a community that would reflect or lowering of the cost of insurance.

ERIC GEORGE: I will say that what you're referring to, the ISO rating on fire, I'm not gonna Comment on

because as I said, I don't, I don't quite follow what you're asking there.

REP. DELNICKI (14TH): Real simple, real simple if you have a better ISO rating in a Fire Department –

ERIC GEORGE: What I am saying is the insurance industry and insurance overall will benefit from a well-trained and well-staffed and well-resourced Fire Departments, and we support that, but we do not think going through an insurance policy to impose a tax is the right way to do it.

REP. DELNICKI (14TH): So, but you do acknowledge that you already are?

ERIC GEORGE: We do you [cross-talk] upon us a couple years ago, yes, you did.

REP. DELNICKI (14TH): And have there been problems?

ERIC GEORGE: Have there been problems? No. What we have become as we become your bailiffs, we become the state of Connecticut Bailiff for that surcharge.

REP. DELNICKI (14TH): I appreciate your comments. One last comment, or question. And I realized maybe this will get an answer one way or another.
If a Fire Department had a rating of 10 versus a Fire Department have a rating of one. Looking at the same communities, in that community, the Fire Department with ISO rating of 10, which is the worst?

Would it be an expectation that you would have a higher premium rate for that community versus if that community had a Fire Department rating of an ISO 1?

ERIC GEORGE: Without knowing specifically how that is impacted? What you said sounds reasonable, but I would not attest to that. Because I don't have the information.

REP. DELNICKI (14TH): I thank you for your comments there. I think there is an obvious connection, in my opinion, between the quality of the department, and how it would reflect the policy costs for insurance, for a structure. But I think we could debate that all night, huh?

ERIC GEORGE: I would feel bad for the people that are coming after me but it would be great.

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

ERIC GEORGE: Thank you.

SENATOR LESSER (9TH): Thank you Representative Delnicki. Representative Meskers, and I will just say because of a comment, I think you're right, we do have 30 more people left to testify, so hopefully we can I guess I'll take that under advisement.

REP. MESKERS (150TH): I'll take that under advisement thank you, Chairman Lesser. So I guess the issue on LTC is a problem, a mutual problem. The extra -- I guess you did a floating rate on the actuarial costs and the cost keep on rising and therefore the premiums keep on rising.

So we're stuck in a circular trying to cover healthcare for extended for long term care into a system that the prices are going through the roof?

ERIC GEORGE: And I mean, it represented Meskers you're making a very good point. If you look at so it's funny, I used to do health insurance, but I don't anymore, but my recollection, and I know that others coming after me will have a much better on the tip of the mind, recollection of this is that the overall cost of an individual's health care, you can see how the later portion of the life represents an enormous proportion, enormous portion of the overall cost of care for that person.

Going from the beginning, all through their other years, all the decades, and then at the end, that's where all the money is spent. And it's the way of life, that's never gonna – quite honestly, that's not gonna change, and I'm not going to advocate for that to change.

But if we look at it, long term care insurances is difficult, it's very difficult. I mean, look at the way it's marketed, it's very difficult, and in any state, Connecticut being one too.

REP. MESKERS (150TH): Yeah I cut you off because I accept the answer I just wanted to get there first. Second question, in relation to Representative Delnicki's commentary and questions, the opposite.

I'm not sure what the interactive dialogue is between yourselves and the insurance commissioner in the current framework. Hear me out, in terms of a fire insurance. Are there pieces of the code or pieces of that we should consider in Connecticut, that would have a material impact on premiums?

So apart from the standards that are that each state, each state sets standards, I'm not sure what the sensitivity point on standards versus premiums are. So we can reduce the incidence of fire reduce the cost of the fire incident, presumably who reduce the premium. Is there much better conversations along those lines?

ERIC GEORGE: So in the Broadwell, so our homeowner's insurance policies are a product and an evolution of the standard fire policy.

The standard fire policy is what as homeowner's insurance was evolved from. So we have Congress and we have conversations with George Grabner and his team, he's the head of DMC over at the DOI.

All the time about mitigation and on keeping structures safe and reducing costs, this is I won't say that it's only isolated at all to fire, I would say that it is a much a very broad conversation that we have.

And, you know, when you have coastline issues when you have other --

REP. MESKERS (150TH): I'll cut you off Eric again. So you suggest Representative Nuccio is dangerous as a mathematician and dangerous as a banker? I would like to make sure that we're having interactive conversations about regulatory framework that might have a positive construct on premiums.

So if there's stuff we need to consider as the Legislature for the individual expense of the individual homeowners that will have significant impact in driving down premiums over a 20 or 30 year period. I'd love to have the conversation about NP being some of those improvements.

ERIC GEORGE: I think that's a great idea. And I guess that at that broader level, those conversations happen a lot.

REP. MESKERS (150TH): Okay, perfect. And that was it, sorry Mr. Chair.

SENATOR LESSER (9TH): Thank you Representative Meskers for your testimony -- Thank you, Representative Meskers, thank you, Eric, for your testimony. Next up, we have Susan Halpin.
SUSAN HALPIN: Good afternoon, I guess, Good evening, almost everyone. Thank you for sticking out the day here with all of us, I appreciate your time.

For the record, my name is Susan Halpin, I'm here today on behalf of the Connecticut Association of Health Plans and I wanted to address my comments to a couple of Bills, in particular Senate Bill 1045.

And I apologize that some of my session, my section references are inaccurate in my written testimony. So I will, I will resubmit that at a different time.

Step therapy is a critical tool that health plans use that support evidence based treatment and support cost containment. I know there's been a lot of conversation about the cost of pharmaceutical prices today, and what we can do about that, one thing I can tell you is that if this Legislation passes, and some of the other pieces of Legislation that are before you, the costs will go even higher.

What carriers do is try to make sure that the use is appropriate, and if you just look at the underlying statute in a couple of the Bills that are being talked about, today.

You will see all of the things that the Legislature has done to protect in this area, and it's been significant. And I will tell you also that I -- my suspicion is that a lot of the folks that you're hearing from around formularies and around step therapy is most likely in the self-insured market.

I'm going to just draw your attention really quickly to 38 A-492S, and I'm reading it off my phone because I had it referenced in my testimony but not the actual section.

And it tells you that a carrier cannot deny coverage for any insured for any drug that an insurer removes from its list of covered drugs, If the insured was using the drug for treatment of a chronic illness, prior to the removal, the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and the insurance attending health care provider states in writing that the drug is medically necessary.

So if you look, folks in that instance, and in some of the other instances that are in the underlying

sections of these Bills, you will see that the Legislature has taken considerable action already.

Very quickly, the clinical tier sections removed the term “similar” from the “Similar or same specialty.” While that might seem like a minor change in the statute it is significant. And it would require I think some of the commentary suggested earlier that for every specialty that's out there that you have a peer review in that exact specialty which really will just find things to a halt from the purpose of Prior Authorization.

The section that changes the burden of proof flips that statute on its head and it really is -- there are matters of legitimate dispute for issues around medical necessity.

And Connecticut has one of the best external appeals processes in the country that Connecticut again led the way on, and this language was exported to other states across the country.

Typically, those external appeals ranged from a minimum of 50/50 response when they're conducted, which demonstrates that there is legitimate disputes around this area.

Just from a practical perspective, when you talk about a carrier determining or the burden of proof being placed on the carrier to determine medical necessity, the carrier does not have the access to the medical records that demonstrate medical necessity.

So if you look at a system of pack practical perspective, it doesn't work. And I guess this issue has been solicited.

DAWN MARZIK: Could you please wrap up; your three minutes is expired.

SUSAN HALPIN: Will do this issue has been considered a number of years in a row, I think it has never moved forward because it literally will represent the single most expensive mandate that ever passed, and I can't imagine that it will make it through.

And just one last thing, if you look at the formulary Bill, I did include in my testimony, an excerpt from a fiscal note from 2019.

That's to just the fiscal impact just for the state of Connecticut would be in the range of 7.4 million, and -- annually, so you know, the cost is significant, and we all know that the state employee plan has a very expansive benefit system. So that tells you what it would mean for the private sector. So thank you and thank you for the indulgence.

SENATOR LESSER (9TH): Thank you Susan for your testimony. I was with you for most of it. But at the end, did you just say that a Bill that was introduced by the Senate President, you can't imagine it getting through? I wonder if I understood your last point meant.

SUSAN HALPIN: Well, I said I think the reason it hasn't gotten through in past years is because of the fiscal note that would be attached to it.

SENATOR LESSER (9TH): Thank you.

SUSAN HALPIN: I would never suggest that a Bill from the Senate President wouldn't make it through if it was a priority. So if I said that, I stand corrected.

SENATOR LESSER (9TH): Thank you for clarifying. Representative Nuccio.

REP. NUCCIO (53RD): Thank you, Chairman. Hi, Susan, how are you?

SUSAN HALPIN: Good evening, good to see you.

REP. NUCCIO (53RD): Good to see you too. So you mentioned something there that I would like to see if you have anything that you could expand on.

REP. NUCCIO (53RD): You said if this portion passed, it would be the single largest most expensive mandate on insurance. So a mandate on insurance means an increase in costs across the board.

So can you give a little more detail or meat behind, what brings you to that conclusion and what you think it would do to health care costs across the whole entire insured populace?

SUSAN HALPIN: I mean, I think if you if you look at it in the context of how it would function on a practical basis, and any, any procedure that was put for by a provider was presumed automatically medically necessary.

First it would be hard to envision the scenario whereby, you know, how would a carrier appeal that, if they don't have the medical records, Right?

How would and where would that go to at that point in time for matters of legitimate dispute? Also, when you look at, you know, if you assume that, you know, let's just even say the charges, are there the procedures are there what I think, someone said earlier, what's the difference between getting an X ray or an MRI, right?

So you'd have to go back and you would have to justify why someone shouldn't get an MRI, but you don't have the medical information to make that justification at that point in time.

REP. NUCCIO (53RD): So yeah, that was me, I said that. So also, I think that this would open up doors to stuff that I think, precedes -- processes, like

medical necessity, were put in place for abuse of the system abuse of zoning, which then trickles also down to the person who's actually paying for their insurance or actually paying their cost share and everything else.

So from that perspective, it would also – is it your opinion, that it would also cross over into experimental treatments or you know, things that have not been proven or things that are considered to be risky across the board if there was no way for insurance to come in and to mitigate and to provide insurances for the insured was being protected?

SUSAN HALPIN: Absolutely, and, and I've been around doing this for way too long now, and some of you may like to see me go at some point. But the -- if you think that experimental treatments, I mean, I remember when I think it was bone marrow treatment was being used for breast cancer, and it actually ended up being harmful.

And, and I remember having a mandate before the Legislature at that point in time where we were, you know, making that case that, you know, the clinical evidence did not follow the treatment patterns around us.

And I think a lot of people felt it was very promising, patients felt it was promising. But that would be a perfect instance, where it was later determined that it was not.

Similarly, you know, we went through this with the opioid crisis. You know, I do remember when the pain management momentum was at the Legislature, and, you know, we were considered, you know, just looking out for the dollars when we were pushing back on some of those broad pain management proposals to cover opioids in.

And I remember, medical directors were at the time, the ones that were really raising the red flag

saying there's going to be, there's going to be repercussions of this kind of legislation. And in fact, we all know, fast forward, what happens.

So absolutely, I think those questions around medical necessity, and, you know, and it's not necessarily abuse, if people think what they're doing is the right thing. But it's the protection, it is a consumer protection at the end of the day as well.

REP. NUCCIO (53RD): Yeah, there was a there's a lot in this Bill, I think there's a lot of pieces of it, that don't necessarily kind of coincide. Is there anything in the Bill that you do agree with and think that is a good move forward?

SUSAN HALPIN: You know, I can tell you, we have been looking at the expansion of the covered under, I think it's sections 1 and 2, two dependents and stepchildren and I have not heard any response back that that isn't covered.

So, you know, we've been looking into that more and more, I feel like, again, there have been numerous pieces of Legislation that has passed around formularies and set therapy and we feel very strongly that, you know, moving these Bills forward will do more harm than good at the end of the day.

And I'm trying to think of the other section there. I don't have it in front of you, but I would be happy to get back to you with that, I kind of focused on the things that were raising an alarm, as opposed to the things we should have said, I'll be happy to get back to you with that.

REP. NUCCIO (53RD): That's fine. I do think there's wiggle room in the formulary. So I do agree that I think people who lose their medication during a policy year that there has to be some consideration for a path that is working for them and may make changes on a new policy year thing.

So I think there's some wiggle room in there. But as always, thank you, thank you for your input. And in bringing this information to the table, I appreciate it.

SUSAN HALPIN: And if I could just respond briefly, the Department of Insurance just recently adopted regulations around formularies that provide for specific notification to members so that they have time to look at it.

I think my concern about it, and I believe me, I appreciate it. I've had it happen to me, I understand it. But if you look at it from the global perspective, and there is no, we have to maintain the leverage to keep those pharmaceutical prices low.

Because if you just play it out here, January one, let's just say, the cost of you know, an EpiPen is $100. And in the marketplace, it's known that we have to keep it at $100 between now and December 31st.

There's nothing to stop on the other end of that equation, a pharmaceutical company from you know, upping the cost of that knowing that there's not going to be a backlash from the consumer, because they're going to be covered.

So I think, again, I understand the frustration I understand Representative Meskers' frustration, your frustration, Senator Lesser's frustration around these issues, but it really does, you know, they're in and there's a reason why everybody's, you know, kind of pointing fingers at each other because there are checks and balances throughout the system that aren't always working, but in this case, at least on the cost side, there's some check and balance that we believe is working. So happy to work with you always.

REP. NUCCIO (53RD): Thank you very much Susan.

SENATOR LESSER (9TH): Thank you Representative and thank you Susan, and I would just challenge you. As I mentioned to the gentleman from the PBMs, you know, this isn't the first time we've had to deal with consumers saying no to industry players, and I know that you aren't happy with solution of the Connecticut Legislature with surprise Billing.

So I would suggest what would be helpful for us if the industry could figure out a way to resolve video price increases in a way that most consumers you can live with, because this is an issue for pockets that are here.

And you can either join with us to help solve it or trust us to figure it out on our own. Based on the crazy stuff I've done in other issues; I suspect the former will result in a better outcome just as a policy matters.

SUSAN HALPIN: And Senator I appreciate that, and you've always had an open door on these issues. One other thing, I just want to raise is, you know, I do think and I think data would help you on this, because I do think a lot of the issues that you're hearing from, and I know, because I get them as constituent complaints are happening in the self-insured market.

So, you know, we do have protections in place for the fully insured market. And what would happen if we put these in place, is you're going to make it even more expensive for those most price sensitive folks that are in the small employer market that we're all trying to help, you know, currently, because those are the guys that are going to feel it. But I hear you and you know; I will we will look at that in response.

SENATOR LESSER (9TH): But I think the tools right that the CPAs in the self-intermarket are often

companies their licenses wouldn't be, you know, if we could develop a tool wiring negotiations are underway that could be used by insurance, fully insured plans, and also, I imagine you're looking at finding that Florida's important, rather than as opposed to getting hurt consumers, we figured out, maybe you're right, this is a huge problem for the villager market.

Forgive me, I got the mail being delivered somewhere, by but we need the solutions here and this is the [Inaudible]. Representative Meskers I believe I see your hand up. Is that second time?

REP. MESKERS (150TH): I don't believe so. But I'm willing to be corrected by Susan.

SUSAN HALPIN: First time, today.

REP. MESKERS (150TH): Sorry about that. Thank you, Mr. Chair. So Susan, I want to echo Senator Lesser's comments, I think question becomes, so we're trying to prevent this switch in the formulary.

But you're worried they're going to use that as a signal that they're stuck with that and use it as the pretext to raise the price?

SUSAN HALPIN: Yes.

REP. MESKERS (150TH): So it suggested some of the negotiations on what we call a free market, which doesn't allow me to buy drugs anywhere in the world, but from the guy who's marking them up, we need to figure out what the price controls, or, you know, the consumption or the contract that the insurance company has with the pharmacy, that they will commit for that period. And that contract for the board, so that maybe you can't get a ship, shop around for a cheaper alternative.

But you can switch for FDA, and you can't get the price jacked up on you, because we forced you to

continue to supply it to the-- to a constituent of ours. So I have to figure out a mechanism, because I understand that if I tell them, you, you have to supply that $100 cost and it goes to 400 you've got a problem in the system.

SUSAN HALPIN: Yeah.

REP. MESKERS (150TH): But what you haven't told me so I should be slacking. And that's probably the next level of conversation, which is how do we control the cost, the cost rises, you know, so I think that's a good conversation that I should leave to the Chairs and potentially Representative Nuccio, it's like how do we get those-- you know, if we're gonna wanna lock in the formulary, we need to lock in the supplier prices as well, I guess is what you're saying?

SUSAN HALPIN: Yes.

REP. MESKERS (150TH): Okay. Thank you.

SUSAN HALPIN: Thank you.

SENATOR LESSER (9TH): Thank you, Representative Meskers. Other comments or questions from the Committee? If not, thank you, Susan, for coming before us today.

Next up we have Scott Bisson from Connecticut State Firefighters followed by Ania Jastreboff. Pronounced your name completely inhumanly.

SCOTT BISSON: Good afternoon, respected Members of the joint Insurance and Real Estate Committee and thank you for the opportunity to speak. My name is Scott.

This and I'm testifying as the Chairman of the Connecticut State firefighters Education Committee, representing the educational needs of Connecticut

Fire Service and the current Director of the Fairfield Regional Fire School.

I'm a fourth generation firefighter. I am submitting this testimony in support of Senate Bill 1042, AN ACT CONCERNING FIREFIGHTER TRAINING AND CRUMBLING CONCRETE FOUNDATIONS.

Every day, Connecticut's firefighters respond to hundreds of calls for service including fires, chemical spills, rescues, and medical emergencies. The most important resource any fire department has are the trained men and women that respond to these calls, and provide community risk reduction.

Their ability to provide service safely and efficiently to the public is directly tied to the knowledge and experience gained through proper firefighter training.

Unfortunately, the high costs of both initial certification training and the personal protective equipment required for each member to safely respond, as well as the operations of the specialized fire training facilities where live fire training is delivered, have negatively impacted the fire services in Connecticut.

A well trained and equipped Fire Service has been proven through Insurance Services Office, ISO, to greatly benefit the community and reduce overall losses through responsible risk management.

This insurance-based organization sets our requirements for firefighter training exceeding 228 hours annually, including 18 hours of required fire training centers to receive the highest rating of class 1.

Senate Bill 1042 directly addresses these operational issues by providing aid to all Connecticut municipal-- excuse me, municipalities, and the Fire Departments in the jurisdictions.

The Fire Service has been looking for a long-term solution, not only to properly fund the operations of the regional fire schools, but make fire training more affordable for local departments.

Historically, the costs of this training has been borne by each fire department where decisions are made on how many people can be sent to training or how many spaghetti dinner fundraisers they need to run to buy gear for a new Member.

This is a challenge that impacts both career and volunteer departments equally. Working with a bipartisan fiery EMS caucus, I have testified more than once that this remains a top priority for the Fire Service.

Through this Bill and the creation of the new Connecticut Fire Safety Fund, we can finally fix a broken system of not just for one or two budget cycles, but for the foreseeable future.

Connecticut will not be the first state to use this model to fund firefighter training, other states such as Pennsylvania, Massachusetts and West Virginia have already created similar accounts for this purpose with much success.

This recognizes the natural correlation between having a properly trained and equipped fire department and reduce property losses from fire.

The Education Committee supports the previous UPFFA request for substitute language in Section 3 that adds the State Fire Administrator and the ability to request funds to purchase safety equipment on a grant basis, and is included in my written testimony.

The passage of Senate Bill 1042 will greatly enhance the ability of Connecticut Fire Service to recruit,

train, and properly equipped firefighters across the state.

It will ensure that the nine regional fire schools' operational budgets are fully funded and that they can provide low to no-cost training to all Connecticut firefighters and properly maintain facilities with safe equipment, as well as supporting other municipally operated fire schools bringing basic training up to closer to each community.

I respectfully request your support for Senate Bill 1042 and the entire Fire Service so we can focus on our core mission of saving lives and making a difference. Thank you.

SENATOR LESSER (9TH): Thank you, Mr. Bisson, and thank you for your testimony, and for joining us today. I see Representative Delnicki has a question.

REP. DELNICKI (14TH): Thank you, Mr. Chair, and thank you, Scott, for coming forward to testify. And I'm gonna ask you a question, kinda, on a love field, and it's the same question I asked Eric George.

And I realize you're not an expert in the cost of insurance. But logically, if you have a better trained, better equipped department that ends up getting a higher or a more advantageous ISO rating, wouldn't it make sense that would actually lower the premiums on insurance on structures?

SCOTT BISSON: It does, Representative. And thank you for the question. It is one of the standards that fire departments are working towards, and similar to Mr. Hart, who talked about up in the Waterbury Fire Department, the Fairfield Fire Department is going through a similar exercise right now of reviewing our training, our equipment, our water supply, and our dispatch systems.

They come in every five to 10 years, evaluate our departments and rate us and then insurance rates are derived from that as a part of the process through the Public Protection Classification System.

So we are all—Class 1 is the best department, they're are the fewest number of Class 1 departments around in the state. Class 10 is a fire department that has no water supply, very little communications, and very little training.

REP. DELNICKI (14TH): Well, I certainly appreciate that answer, and for one more follow up. In your position, have you seen funds swept from the schools for lack of any reliable funding?

SCOTT BISSON: Yes. And sir, as you know, 'cause I've seen you at the Fire EMS Caucus meetings, we've had this discussion annually for many years, talking about restoring firefighters. As a matter of fact, it was the number one priority of the Fire EMS Caucus about three years ago to restore funding that was completely zeroed out during the Malloy Administration. It's just a sign of the times.

We're trying to look for-- and the Fire EMS Caucus charged us with coming up with a long-term solution for this problem to avoid having to provide testimony every year at that Caucus to try to restore funding for the Fire School.

It benefits all of us, every municipality, to have trained firefighters and properly equipped firefighters in their communities.

REP. DELNICKI (14TH): So, I thank you for coming forward and I can tell you, we've been listening to you for quite a while and have taken it to heart. Thank you, Mr. Chair. Thank you, Scott.

SENATOR LESSER (9TH): Thank you, Representative. Other questions or comments for Mr. Bisson? Yes, Senator Hwang.

SENATOR HWANG (28TH): Thank you, Mr. Chair. And Scott, how are you today?

SCOTT BISSON: Very good, sir. Good to see you.

SENATOR HWANG (28TH): Good to see you. It's been a long day for the Committee, but was great to see you and what a beautiful backdrop of the Fire School and thank you for all the hard work you have done for the community.

So, talk to me about what the school does. You know, a lot of people just think the Fire School is just simply training firefighters, which is an absolutely important job, but share with me what that facility does for the broader community as well.

The latest example was the fact how that facility is a community resource and helped during the COVID pandemic of gathering people, collecting supplies, being a distribution center for a lot of the frontline workers and staff.

Talk to me how important that facility, beyond just the training center is a community resource.

SCOTT BISSON: Thank you, Senator Hwang, for the question. As you know, because you came down during the height of COVID and dropped off some PPE supplies to us to put in the pool to distribute to other responders in the community, we transitioned, once training kinda slowed down, we were first to be impacted by training because emergency responders that were going to training were also still responding to calls were getting exposed to COVID and then having to be quarantined.

So, we had to shift gears pretty quickly into an online or a hybrid environment to keep firefighters safe, able to continue to respond to emergencies. Additionally, we conduct a lot of medical training

for new emergency medical technicians down there and we had to shift gears for that as well.

One of the things we did specifically in Fairfield as we transition to supporting town government from a planning and operation side, planning meetings were conducted down here, it became a logistical drop off site and continues.

Just yesterday we had the USDA doing a food box drop off down here and distribution to nonprofits, so we utilized the facility to support the region in that manner.

We were part of the Health Department's PODG, Point Of Distribution Program, where we receive personal protective equipment, gowns, goggles, masks, sanitizers, and distribute that out to other health departments.

Just last week, I was training vaccinators, EMTs, taking the bridge class to become vaccinators to put shots in arms of people as more vaccine becomes available in the state. So we've really shifted gear that way.

Fire schools provide a very unique opportunity for firefighters, ‘cause the one place you can set a fire in a building and hopefully it remains safe while the people are training inside of it.

Too many times, people go out in the public and there's homes that are being donated, we call them acquired structures, and sometimes under the process to try to conduct live fire training of those, but it's not the safest way to do it. So, the fire schools provide that safe venue to keep firefighters safe.

Unfortunately, just today as I was online, ‘because I've been with you all day, since nine o'clock, I was also dealing with a firefighter injury at one of the fire academies today. So it just goes to show

you, even in safe locations, firefighters still get hurt, but we can manage the risk a lot better that way.

SENATOR HWANG (28TH): Well, let's hope that the firefighter that was injured is okay. And please extend my best wishes. And it's important, I know we're looking to look at the insurance surcharges to fund this and we're always looking for a steady revenue of money to be able to fund and provide adequate support for our fire schools.

But when you think, as we talked about all of these critical, community-based services that isn't just for one town, it's for a region, do you not think we should make a budgetary priority to put it into our budget instead of a surcharge?

SCOTT BISSON: I understand what you're saying, Senator, but our experience has been that we made that transition, we went from grants, and we did put it in the budget, but it makes it extremely difficult to get proper funding for the schools without burdening the taxpayers or having it go through.

Very often, we see percentage costs backed, and I believe 2017 it was zeroed out completely. So, the answers to the fire schools were, "Okay, we'll close our doors and stop doing training." That's not acceptable for a service that's 24/7.

So I understand what you're saying, I agree that there is some level of responsibility on the state to provide that, may have done that for some things like responding to state highways and protecting state facilities, but this is that long-term solution that we've been looking for a very long time that will avoid having to go back and look at this each time.

It'll answer the questions as far as what's the proper number, because it places the budgets under

the control of the DESP Commissioner and, hopefully, with some input from the State Fire Administrator.

SENATOR HWANG (28TH): Yeah, it is frustrating that we can't trust the budgetary process to prioritize what's important, that we have to go and reevaluate these types of strategies. This is not new, I know that, and we're always trying to make sure we fund you.

I just wish we did that in our budgetary process to understand and appreciate the hard work that all of your men and women do in providing greater public safety. And I think the key is, it is a community resource, it isn't just for the Fire Department. It is a community resource. And you point that out as well.

And I think the last thing I'll leave you with is, training is absolutely essential. One of the things I've learned from all of you, the great firefighters within the district is the fact that, fire safety and fire-fighting has changed so dramatically in the past number of years, because of technology products, rubber, that fires burn differently.

And in order to get our men and women to do their job but to be safe, they need to go through that experience. Having gone through one of those dark, smoky rooms with the training that you have offered some of us, wow, you can't describe that experience.

So, I wanna say my thank you to you for your excellent leadership and training to Chief McCarthy, but also to all the men and women, and your staff that support you all. Thank you very much. So, thank you. I'm glad I caught you, Scott.

SCOTT BISSON: Thank you, Senator.

SENATOR HWANG (28TH): Wishing you well. Thank you, Mr. Chairman.

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

REP. ROCHELLE (104TH): Thank you, Senator. And I just wanted to hop on real quick, I actually pulled over so I can speak to Mr. Scott and thank him for his advocacy on this issue.

You know, for folks that are not familiar with fire training, can you just share with some of my colleagues, the variety of classes that are taught at fire schools? It’s so much more than fire, it's, you know, car accidents and it’s gross work, and it's hazmat. Can you just share for my colleagues, the, you know, the amount of time that goes into these classes and types of classes that are taught?

SCOTT BISSON: Sure. Thank you for the question, Representative Rochelle, nice seeing you. And glad you're being safe pulled over.

We deal with all hazards, and that really is the catch-all phrase. The Fire Service always responds whenever somebody calls 911. If there's no-- if nobody knows who to call, it's usually us.

And we'll go out we'll troubleshoot and we'll figure out how to either fix the situation or guide the people in how to fix the situation.

Some of the classes that we want, I'll leave the firefighting part on there because that speaks for itself, emergency medical training is going on, we conduct community CPR programs, we just ran to this past week, we have apparatus operator programs and driver training programs to keep people safe out there, we have outreach programs with OSHA, we partnered with King State University to bring OSHA training for the construction trades and also people working out in the community to make that safer.

All different levels of training from in depth, in addition to the support for the Fire Service, for the region and coordination of activities.

Some of the other things I do down here is, I'm the Chairman of ESFF, Emergency Support Function for firefighting, we track and keep tabs on how many firefighters are quarantined on a weekly basis during the height of COVID. We're tracking how many vaccinators that are EMTs on the fire departments are gonna be available for health departments.

So, we really deal with all hazards, we deal with natural disasters, we deal with flooding, you know what the fire departments do, you can see it on the news, it's our job to provide the training to prepare people for doing that.

The best way I could describe it is, if you have to go to the hospital for surgery, you're not gonna go to a surgeon and have somebody who doesn't train or maybe they train four times a year, which is the minimum. You know, for a firefighter, it's a lot more than that. So we're constantly training and trying to be prepared.

REP. ROCHELLE (104TH): Thank you. And I also wanna thank you for the hospitality that Fairfield High School has shown to the Valley Fire school over the years while we hope to get our school built, hopefully sooner than later, but you've been a great partner at your school with letting us use your facility during that time.

And, you know, I hope that Bill will go a long way towards realizing funding that is so incredibly needed to make sure that our firefighters get the training they need to protect the community and protect themselves while they're doing their work. Thank you.

SCOTT BISSON: Thank you.

SENATOR LESSER (9TH): Thank you, Representative Rochelle. Other comments or questions from Members of the Committee?

Seeing none, thank you for your testimony this afternoon. And next up, we have Dr. Jastreboff, if I've pronounced that correctly, followed by Gilbert Tartaglino. And thank you, all, to all the folks who are to testify for your patience here this afternoon.

ANIA JASTREBOFF: Thank you, Senator Lesser, you pronounced my name exactly right. Chairman Lesser, Vice-Chair Wood, and Senator Anwar, and Members of the Insurance and Real Estate Committee, thank you for the opportunity to speak today, I'm very excited to be testifying today in support of Senate Bill 1007.

I'm very passionate about providing the best care possible for our patients with obesity. My name is Dr. Ania Jastreboff, I'm an associate professor at Yale University School of Medicine. I'm an endocrinologist, as well as an obesity medicine physician, and a physician scientist.

I've been at Yale for 15 years, focusing my clinical and research work on helping individuals with obesity.

In my clinical practice, I specifically use combination anti-obesity pharmacotherapy to help patients reach their health and weight goals.

As we know, it's projected that half of us in the United States will have obesity by 2030, that's in nine years. Indeed, how many of us have tried to lose weight only to gain it back and then some?

And as described this morning by Senator Berthel, it's incredibly difficult to lose weight and keep it off our bodies, fight it, mistaking and thinking

that we are starving, and this is the disease of obesity.

Unfortunately, until recently, obesity was not understood to be a chronic disease and patients were deplorably blamed and shamed for having obesity, and obesity was considered to be a personal choice.

If a patient could not reach and maintain a healthy weight, they were considered to fail. The patient was considered to be a failure.

We now know obesity is not a choice, it is a chronic metabolic disease with a complex underlying neurobiology, and that is the focus of my work. It is not the patients who failed, we failed them, Medicine failed them.

But now there is hope. We have comprehensive, safe and effective treatments for patients with obesity. You've heard from Dr. Floch and colleagues about surgical interventions, and I will share briefly about what we can do with FDA approved anti-obesity medications. I'll share the journey of one of my patients who lost more than 100 pounds.

My patient, for anonymity, we will call Mary. She was a 57 year-old woman when I saw her two years ago and she weighed 250 pounds when I first saw her. Her Body Mass Index was more than 42, classifying her as having severe obesity.

She was also being treated for hypertension, hyperlipidemia, obstructive sleep apnea and pre diabetes. I started her on medication one, and within eight months, she lost nearly 20 pounds.

I added medication two, and over the next eight months, she lost an additional 42 pounds. I started her on medication three, and over the next year, she lost an additional 41 pounds.

So in total, over a year and a half she lost more than 100 pounds. Her BMI decreased from 42 to 25, her weight decreased from 253 pounds to 151 pounds. She achieved 40% total body weight loss with anti-obesity medications. Her pre-diabetes resolved, and she no longer needed treatment for obstructive sleep apnea.

CLERK: You've reached your three minute mark, if you could just summarize, please. Thank You.

ANIA JASTREBOFF: Yep. With three medications, she achieved her goals. And her story is not unique, these treatments have to be available and affordable for our patients.

In summary, I ask that you give clinicians the opportunity to treat patients with obesity with all the available and safe and effective therapies, including anti-obesity medications. Let's make America a healthier place, and let's start with Connecticut.

SENATOR LESSER (9TH): Thank you, doctor, for your testimony. And I know that the addition of the anti-obesity medications is a new addition to the Bill from previous versions that have been considered in the past.

Does insurance typically cover the medications or is it really in a mess?

ANIA JASTREBOFF: Medicaid and Medicare do not, private insurance payers it's hit or miss and it's a huge barrier. And for this patient, they covered the medicines and she was able to achieve her goals.

SENATOR LESSER (9TH): And is there-- have there been cost benefit analysis about the medication interventions versus other things that can be done? I don't know what the cost to medication is.

ANIA JASTREBOFF: Yeah, that's a great question and it's something that we've been asking for. I know it was mentioned this morning as well. So some of those studies are ongoing, and I think really, the focus is down the line.

So not even, you know, six months or two years, but really lifelong. So, if we help to prevent Type II Diabetes or prevent cardiovascular disease, what is the saving in terms of life as well as monetary cost?

I can tell you that a lot of my patients who take these medications, they can come off of a slew of other medications.

So, they lose weight and they no longer need anti-hypertensive medications, they can come off their insulin. It's amazing and it's life-changing.

SENATOR LESSER (9TH): Yeah. Are there any other comments or questions from Members of the committee? Yes, Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Dr. Jastreboff, for your testimony. These medications, what is the usual cost of those medications? And are these lifelong or you are able to stop them after achieving goals?

ANIA JASTREBOFF: Yeah, those are great questions. And also, thank you for working with our residents at Yale, they love working with you.

And so the cost, it depends for the patient, if they're out-of-pocket, they can be hundreds of dollars and some of them can even be thousands of dollars per month. So it's not affordable out-of-pocket from those patients.

And that's not fair, right? It's not fair that some patients can pay for these and others can't, they should be available and affordable for all.

In terms of needing to seek them lifelong, yes, that's the case. So just like with any chronic disease, if you have high blood pressure, you need to keep on taking that medicine in order for your blood pressure to be normal, same thing with diabetes and blood sugar. So why would we expect anything different of obesity?

The goal is to decrease your body fat mass set point. So, the medicines each decrease where your body wants to be in terms of how much it wants to weigh. So for example, if we start a medicine and a patient loses weight, if we take that medicine away, they're going to gain back the weight, just like their blood pressure would go back up if we took away their blood pressure medicine.

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

ANIA JASTREBOFF: Thank you.

SENATOR ANWAR (3RD): And I'm hoping that the insurance industry would recognize that they'll save more money by adjusting in management of some of these aspects. So, thank you.

ANIA JASTREBOFF: Thank you. I was very happy to see this addition to Bill, which is why I'm here today. Thank you for your question.

SENATOR LESSER (9TH): Thank you, doctor. Other comments or questions from Members of the committee?

If not, then thank you for your testimony and your patience here this afternoon.

ANIA JASTREBOFF: Thank you.

SENATOR LESSER (9TH): Next up we have, Gilbert Tartaglino followed by Jason Prevelige.

GILBERT TARTAGLINO: Excellent. Thank you very much, Senator Lesser and Committee Members. I appreciate your time, I'll be brief, I know it's been a long day for you.

I'm calling in reference or I'm here in reference to Senate Bill 1041, the Healthcare Sharing Ministries. I've been a member of the Healthcare Sharing Ministry, particularly, Samaritan ministries, who's been in operation for 26 years, I've been a Member for 15 years.

And I understand that Legislation is being made because of some bad actors, and I would trust that the provisions in Senate Bill 1041 would not only protect consumers, like myself, of course, against these bad actors, but also protect us, who've been a part of a healthcare sharing ministry.

And as these Samaritan ministry will be-- Representatives will be coming on after me, they can let you know, perhaps, how many members are in Connecticut.

There's other very reputable and honorable ministries that do this as well, not just Samaritan ministries, and the costs have been tremendous, the service have been tremendous, efficient, cost-effective.

It would be a blow for our family for 15 years if they would not be able to operate here in Connecticut. And again, there's always, as our moms always told us, there’s always a bad apple spoils the bunch.

And we've been very pleased, the track record has been excellent and we've been very pleased with the service that we've been getting through Samaritan ministries. And I thank you very much for allowing me to speak on behalf of all of us who are involved in these ministries, these organizations, healthcare sharing ministries. Thank you.

SENATOR LESSER (9TH): Thank you, Mr. Tartaglino. To your knowledge, is Samaritan the same as a company also known as Eliera?

GILBERT TARTAGLINO: No.

SENATOR LESSER (9TH): Okay.

GILBERT TARTAGLINO: No. I'm almost sure they're not, but I just heard recently of them. But I understand--Eliera is a profit organization that's posing as a healthcare sharing ministry, 'cause I understand that there's been a company here in Connecticut that's been shut down in 23 states that poses as a healthcare sharing ministry. There's the problem.

Samaritan is not posing at all, we are and we are well pleased with our services. If you need any questions about how we operate, I'll be glad to answer those.

SENATOR LESSER (9TH): And just because you work for Samaritan? Is that--

GILBERT TARTAGLINO: No, no, no, no, no, no, no, I'm a member.

SENATOR LESSER (9TH): Okay.

GILBERT TARTAGLINO: I'm a member. Thank you for that question, thank you very much. No, I'm a member for 15 years. No, I live in Waterbury, Connecticut.

SENATOR LESSER (9TH): Sure.

GILBERT TARTAGLINO: I'm not employed by them at all.

SENATOR LESSER (9TH): And how did you get connected with them?

GILBERT TARTAGLINO: Through a friend. Back in the 90s I heard of them, but I didn't need to, my job provided it.

I pastor now in in Waterbury and so, it was very cost effective for my church, it was very cost effective for my family and we wanted represent our church family accordingly. So, it was just word of mouth and simply as that.

SENATOR LESSER (9TH): Did you previously had a employers-sponsored health insurance, and this was a--your church opted into it as a more affordable alternative to health insurance?

GILBERT TARTAGLINO: That's correct. That's correct, yes.

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

GILBERT TARTAGLINO: Thank you.

SENATOR LESSER (9TH): Any comments, questions from Member of the Committee?

If not, thank you for your testimony.

GILBERT TARTAGLINO: Thank you, sir. Okay. Hope everybody has a good day.

SENATOR LESSER (9TH): Thank you, you too. Next up we will have Jason Prevelige, followed by Andy Grimm.

JASON PREVELIGE: Esteemed Chairs, Ranking Members, and Members of the Committee, good evening. My name is Jason Prevelige.

I live in Fairfield, work at St. Mary's Hospital in Waterbury, and the past President and Legislative Affairs Chair for the Connecticut Academy of Physician Assistants.

First, I thank you for enduring such a long day and allowing us all the opportunity to bring forward our testimony.

Please accept this testimony pertaining to Raise Bill 6626, AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAL COVERAGE, ENABLING SERVICES AND COST TRANSPARENCY.

In concept, we appreciate and support the intent of this as Raised Bill, as it addresses a number of very important areas.

But as it is currently written, we respectfully ask for physician assistant, PAs, to be included in the newly added areas, along with physicians and advanced practice registered nurses.

As you're likely aware of, Pas are licensed to practice medicine, work across all specialties in practice settings.

PAs evaluate patients, diagnose disease, formulate and implement treatment plan. PAs use autonomously every day while working in collaboration with physicians and the rest of the healthcare team.

PAs are well-educated and trained to perform some functions. Specifically, House Bill 6626, Sections 25 and 26. But that’s section the statute that exclude PAs with regard to breast cancer detection.

RPAs included are similarly excluded in other areas of statute. And these areas have been valuable stakeholders such as the Connecticut State Medical Society, and the Connecticut Hospital Association with unanimous agreement on illicit inclusions.

The problem is inadvertently omitting PAs from certain with statutes is increasingly causing confusion to administrators implying that PAs cannot perform a function that they otherwise should in fact perform, simply because the PA is not listed.

Such interpretation creates healthcare disparities by limiting access to care. And the patients are then forced to see other providers to obtain the services that they need.

I think in this patients and physicians are placing additional burden on both, especially during these current times of the pandemic when healthcare is oftentimes harder to obtain than previously.

So if you could please help improve the access to care that our patients deserve by including PAs as one of the providers that can provide the services named in this Bill.

I thank you for your time on this matter, and your dedication to the citizens of Connecticut.

SENATOR LESSER (9TH): Thank you, Mr. promises a testimony.

I guess – are you talking about the underlying Public Health statute about Scope of Practice? Or you're talking about specifically the insurance statute is for?

JASON PREVELIGE: [mic off] Senator Lesser—-

SENATOR LESSER (9TH): Typically, we don't do scope-– the reason I ask, I have a lot of respect for PAs. I know they do an excellent job. But typically we defer to another Committee, the Public Health Committee that determines what the scope of a particular profession is.

What a PA can do what a PA can't do. This Committee, we determine what insurance pays. And so we try not to tell the Public health folks how to -- what the scope is.

And although Dr. Anwar is capable and practicing medicine, I'm not sure that the rest of us are.

So that's the reason I was asking. This was an insurance -- it it's there's something in the insurance statute, that's limited the scope.

JASON PRVELIGE: So to my knowledge, no. In fact, we actually have a Bill raised in the Public Health Committee that addresses number of inclusions for PAs this year. Including actually the sections that these two new additions are going into.

However, it doesn't include these additions. These are now new areas. And as they're raised here, that's why we felt it pertinent to bring forward to this Committee tonight, as this is where they're being presented.

The areas that we are looking to already have includes, you know, within this section already.

SENATOR LESSER (9TH): Thank you. Any comments, questions from members of the Committee?

If not, thank you for your testimony.

JASON PREVELIGE: Thank you, have a good night.

SENATOR LESSER (9TH): You too. Next up, we have Andy Graham followed by Lauren LeClaire.

ANDY GRAHAM: Thank you, Senator, Lesser Thank you, Members of the Committee. I appreciate your time, and I'm very impressed by your stamina.

My name is Andy Graham. I'm President of Chicago News Guild local. And for the last year, I've been working on a project for the news Guild, our International Union, which represents about 16,000 journalists in the United States, as well as about 50 at the Hartford Courant.

So I'm here to speak in favor of Senate Bill 1043. You guys have already heard from some excellent

experts and Frasier Nelson and, and Penny Abernathy, you'll be hearing from some folks that work at the Courant. So what I just like to share with you is some of what I have noticed in over the course of my research in the last year, and as exactly as any Abernathy said, "A successful newspaper can bridge the gap from changing business model to the digital age, if they have ownership that is trying that is committed that is mission-driven."

And there are examples that they've mentioned as well, the Boston Globe, the -- recently the Salt Lake Tribune where Frasier Nelson had once work.

So there are models out there and the future for the Hartford Courant can be something along those lines. What you have in the other dominant business model and trade are these large chains that are either saddled with debt mostly from acquisitions and consolidations that generally harm news coverage. Or they have a very extractive profit model.

Alton Global Capital is the dominant shareholder in the Tribune Company, the parent company in Hartford Courant.

In an era when we lost about 50% of our – well, the industry lost 26% of its journalists in the five-year period from 2012 to 2017.

During that same period at Alton Global Capital's newspapers, the decline was over 50%. So they cut jobs at a higher rate than folks in the industry. They extract profits and what you would do with 1043 here is dis-incentivize that behavior.

Tribune company was paying out dividends instead of investing in its newsroom. Taking on additional debt is just cost.

Connect, the largest newspaper company in America is currently spending all of its profits and laying off

employees to meet the burden of a $1.8 million loan that financed a merger two years ago.

So I'd also like to comment on the folks from the industry side that were talking about the government's role in deciding what the Hartford Courant does with its business.

And I would say that the you know, the legislature has intervened in the long history of the Courant and they've -- because they've seen a public policy benefit, and a public good that was being served that would not be served as well.

And I submit to the Committee that that legacy is one that we all enjoy, and what everyone in Connecticut can benefit from, and so you can intervene, and there are ways to intervene.

The legislature, there are certain industries. I am not sure how things work in Connecticut, but I would imagine that you cannot close an unprofitable emergency room in an underserved neighborhood, if you meant -- if you run a hospital in this state.

I would also note -- I think I did the research correctly here that you charging sales tax on newspapers and periodicals.

All of these are preferences that benefit the industry. And I think this would benefit both for long term future of the Hartford Courant, and it's a long history.

CLERK: Excuse me sir. You've reached your three-minute mark. If you could just summarize, please.

ANDY GRAHAM: Certainly. So we benefit both the citizens of Connecticut, at large, and also helps Tribune shareholders and Tribune Company.

So, with that, I will hold it.

SENATOR LESSER (9TH): Thank you, Mr. Graham, for your testimony and appreciate your passionate full disclosure.

My dad, about years ago was a shop steward, in what was then called the newspaper Guild.

So are there Comments or questions from members of the committee?

If not, thank you very much for your testimony. Really appreciate it.

ANDY GRAHAM: Thank you, folks. Appreciate it.

SENATOR LESSER (9TH): All right. Next up, we have Lauren LeClaire, followed by Chris.

LAUREN LECLAIRE: Great, thank you. Good evening, Senator, Lesser, Representative Wood and members of the Insurance and Real Estate Committee.

My name is Lauren LeClair, and I'm an undergraduate student at Yale University.

I'd first like to thank you all for your time and for allowing me to testify today. I know it's been a really long day for everyone.

It's a pleasure to be here and I'm honored to add my voice to the support for House Bill 6622. AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LIST OF COVERED DRUGS.

The currently authorized practice commonly referred to as non-medical switching affords undue power to insurance companies, and it puts our state's most vulnerable citizens at risk.

Countless citizens of Connecticut rely on constant consistent access to their medications.

As if living with illness and finding the correct treatment plan was not hard enough, members of our community are forced to live at the whims of the insurers.

This practice results in stable patients being forced to switch medications or human to stop treatment due to these items repeated costs.

This issue isn't just theoretical. As drug prices continue to rise, more and more drugs are removed from coverage each year.

In 2018, the citizens of Connecticut made their voices heard in an electronic survey, which reported one-fifth of residents find it difficult so for prescriptions, and likewise, 20% may be incredibly difficult decision to either cut their dose in half or not fill their prescriptions penalties fees cost concerns.

As a New Haven resident, this bill hits close to home for me and my family as well.

I have several friends and family members who rely on prescription drugs to survive, including my mother who recently battled breast cancer.

Already tens of thousands of dollars in debt to various hospitals, my family would simply not be able to afford the cost if you were to increase on her medicine, let alone know what to do with her prescriptions if were removed entirely from a formulary.

We need to value people like my mother, the brave souls who have submitted personal testimony and the other citizens to Connecticut as we hold insurers accountable, and end the bait and switch.

Every member of our community deserves the right to health care, not just the rich or wealthy who can afford these Meteor price spikes.

I ask the Committee to please vote favorably on this crucial necessary measure. And I thank you all for your time consideration today.

SENATOR LESSER (9TH): Thank you very much. Lauren. Are there any comments or questions from members of the committee?

Well, thank you for your advocacy tonight. Is this -- is the first time you've testified before the Connecticut General Assembly.

LAUREN LECLAIRE: This is my first time so thank you all for having me.

SENATOR LESSER (9TH): You've done a great job. That was great. It was really great to see you undergrads [inaudible] Take care.

LAUREN LECLAIRE: Thank you so much.

SENATOR LESSER (9TH): Next up we have Chris Baxendale and then after Chris, I think we have Olive Rucker. We have a couple other people who are signed up between them.

CHRIS BAXENDALE: Good evening, Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato, and the Members of the Insurance Real Estate Committee.

My name is Chris Baxendale. I'm a licensed public adjuster and Vice President of Connecticut Association of Public Insurance Adjusts – CAPIA.

On behalf of our organization, I would like to offer comments regarding raised House Bill 6625. AN ACT REQUIRING THE INSURANCE COMMISSIONER TO ADOPT REGULATIONS ESTABLISHING CONTINUING EDUCATION REQUIREMENTS, FOR PUBLIC ADJUSTERS.

We very much appreciate that you've raised this concept for reviewing. This legislation is straightforward and designed to have regulations promulgated that established the contracts of continuing education program.

The property and casualty sector of the insurance industry is complex and is constantly changing. Continuing Education should be required for public adjusters to stay current with the latest developments in policy change, law, technology and importantly, ethics.

We believe the Public Adjuster Continuing Education will benefit the Connecticut consumer. Our sister states, New York, Massachusetts, and Rhode Island require 15 hours of continuing education for public adjusters every two-year license term.

The Massachusetts and Rhode Island public adjusters continue education is industry self-monitoring with no fiscal burden, to the insurance.

Every year, the CAPIA Board of Directors meets with the Department of Insurance. We repeatedly hear from the Department of Insurance, the number one complaint they receive on Public Adjusters is they sign up a claim, and they do not file a detailed claim in a timely manner.

CAPIA members are held to a strict code of ethics and conduct that addresses this issue. We believe ethics training within the continuing education will address this issue with Public Adjusters that are repeat offenders.

We look forward to discussing this issue with you in further more detail and would appreciate your support for House Bill 662.

I would be happy to answer any questions you might have.

SENATOR LESSER (9TH): Thank you very much Chris for your testimony. Have you had the opportunity to talk to the Department of Insurance about this proposal?

CHRIS BAXENDALE: We have. We've had talked about in the past. Yes.

SENATOR LESSER (9TH): Is there -- do you have a sense of where to where their position is currently -- I noticed that he didn't testify one way or the other on the proposal today.

CHRIS BAXENDALE: You know, I don't -- I think in different I don't -- you know, I don’t know if that was needed or not. We really kind of wanted to stress the fact that it really kind of addresses the bad apples and the problems that they were having that was the biggest claim that wasn't before is that Public Adjusters were kind of disappear, certain Public Adjusters would kind of disappear. So we think that this kind of – would kind of addressed that issue.

SENATOR LESSER (9TH): Got it. Other comments or questions from members of the committee?

If not, thank you very much for your testimony.

CHRIS BAXENDALE: Thank you very much.

SENATOR LESSER (9TH): And for everyone's patience. This is a long hearing. All right, thank you.

And next up we have, actually, REBECCA LURYE from and then and then after Rebecca will hear from Oliver.

REBECCA LURYE: Thank you for letting me speak. My name is Rebecca Lurye, I'm a reporter at the Hartford Courant and the Union Chair for the Hartford Courant Guild.

It represents 43 journalists at the newspaper and I--

SENATOR LESSER (9TH): Rebecca, I'm sorry, is your camera on? I don't know if you require it. Oh, there you are. Go ahead.

REBECCA LURYE: Can you hear me now?

SENATOR LESSER (9TH): Yes, we can.

REBECCA LURYE: Apologies, sorry. As you've heard today, this bill would protect the public interest from Alton Global Capital, this predatory hedge fund that is poised to take ownership of the Courant.

Last spring our union has been campaigning to find new responsible and civic-minded ownership for rebuild our staff and redouble our commitment -- journalism.

We've seen tremendous support from the community and this still sends one of the strongest messages you've seen yet that Connecticut is in this fight to preserve local news.

I've submitted written testimony about the deep cuts our newspaper has experienced in the last year alone including the permanent closure of our newsrooms, the outsourcing of our news printing operations to Massachusetts and the loss of 151 printing press jobs.

Last January, the Courant also lost 20 newsroom positions through buy-outs attrition, including the jobs of two investigative reporters and editors who directed coverage of community news breaking news, the Hartford Magazines, our opinion page and features.

We can't let us see the new reality of our free press, that's happening to the Courant, and we can't stand by while bad—

Thank you Members of the Committee and if there are questions and happy to try to answer them. And if not, I thank you for your time.

SENATOR LESSER (9TH): Thank you, Rebecca, and although the publisher of the current had wrapped this up, I could say representative, the reference in the First Amendment, arguing that this was an attempt to trample on it.

I would note that the reporters don't seem to share that view. Do you believe is that a good faith attempt to save local news?

It sounds like you do. But I just think that that's been the concern that we've heard here today is whether or not this is an attack on the First Amendment [inaudible] charter, on the current public?

REBECCA LURYE: Yeah, the journalists with the current, you know, represented by the Union have no concerns that this acts would infringe on our rights as a free press.

As you said, I don't see any anything here trying to sway our coverage, it wouldn't work anyway. And really see here just an attempt to stop the destruction of local news. And so that's where we stand.

SENATOR LESSER (9TH): Thank you. Other comments or questions from Members of the Committee? If not, thank you for your testimony. Next up, we have Paula Rucker followed by Katy Talento. Ms. Rucker, are you there?

PAULA RUCKER: Here I am. I think I'm here.

SENATOR LESSER (9TH): You're here.

PAULA RUCKER: Thanks, guys for taking the time to hear me today. I appreciate your time, and I apologize for any background noise. I've had to leave my quiet office as the building is closed.

I'm here to talk to you today about supporting S.B 1007 new weight loss surgery for the morbidly obese. I have been dealing with this for a good part of my life.

And only recently have I looked into the ability to potentially have the surgery and working with Dr. Aaron Alsop.

It has been a battle, and I've heard many people testify today a couple of the doctors making comments that insurance companies have commented to them to have their patients stop being lazy to exercise better.

And another doctor commented how this is not necessarily a lifestyle choice. This is not a choice I've made to be like this and to be heavyset in my life.

I have worked aggressively, especially the last few years, spending money in treatment, counseling. I've been paying for private and semi-private training, going to counseling taking the medication, we cannot get my diabetes in check.

We've made progress with the medication alone, diet alone and exercises not doing it. Reaching out my employer and working with Dr. Era now. My employer and my insurance company has chosen to decide that they know what's best for me over my doctor and myself.

The battle has not been easy, and by no means having the surgery is not the easy way out. Just starting this process.

I've already been to three doctor's appointments, had an upper GI continuing on with counseling. I have diabetes checks, I have meal plans to make meals to track I have dietitian consults to do and the surgery itself, coming out of that surgery is a month of rehabilitating myself, training myself to do things differently.

I don't know anyone that volunteers to go in for surgery. I'm not going in because I want to lose weight I'm going in because I want to be healthy, and I want to live to a decent age.

I want to be able to play with my grandchildren when I have them. This is not an elective thing for me. I have reflux very badly the medication is not controlling.

And I honestly had my diabetes in check until the insurance company said hey, guess what the medication you're taking is no longer in the formulary.

So now unless I want to pay an outrageous amount for medication, I switched meds and in the three months in which I switched meds, my A1C has gone from close to seven, which is still not perfect, but it's good to 8.3.

So exercise every two or three--

ZOE GLUCK: You have exhausted your three minutes if you could just summarize your testimony, please.
PAULA RUCKER: I will thank you. Exercise three times a week, including core training and weight training and eating right and tracking my food in my calories.

That is not enough for my situation. So I really truly help you take into consideration all of the testimonies for today. This is not about losing weight; this is about becoming healthy.

And I just want to thank all of you for your time and your consideration and looking into this and hopefully getting something passed for all of us.

SENATOR LESSER (9TH): Thank you, Paula, for your testimony and for your patience today [inaudible]. Representative Dathan has a question for you actually.

PAULA RUCKER: Okay.

REP. DATHAN (142ND): Thank you so much, Paula, for sticking it through today. And thank you for sharing your, your testimony, it's really heartfelt. And it's good to hear from people like yourself who, you know, have been exploring this and really explained to the Committee that this is not a, you know, quick fix, weight loss regime that you're looking at, this is a full on life changing thing that people don't go into lightly.

I think one of the things that is important to me when we looked at this surgery is the kind of follow up and some of the things that you address that you need to do post-surgery.

In your -- if this was covered by your insurance, but the follow up care and the some of the routine things that you talked about weren't covered, would that change your approach at doing the surgery? Or would it change any outcomes for your continued focus on what you need to do post a surgery to increase success?

PAULA RUCKER: I'd say I don't believe anything would change. I'm going to now I'm paying a lot of money for private and semi-private training, trying to work with them on my eating habits. You know, what do I do? When is the protein drink right, what should I be eating, what should I not be? What should I eat before working out so that I have the stamina to get through the workout?

The surgery itself is the heart is the most expensive part. After that, it's really what you learn to the process from the first meeting with Dr. Aaron now, which was great.

You're not drinking soda; you're drinking smoothies with natural sugar. How about we get rid of that sugar too? The guidance of his office, and I'm going to tell you, I've been on a weight loss journey all my life.

But I met with him to the very first time last Thursday, I had a support group meeting, I did a upper GI yesterday, I am on the track and I am determined.

The only thing that will hinder that is the ability to cover the cost of it. I can make protein shakes, I can do smoothies, I can modify food for the rest of my life. But I can't get the surgery and the medicine working is always a waste of my time.

And that's what it comes down to. I'm looking at a potential surgery right after my vacation. Well, in order to be approved by the dietary staff, I need to maintain for three to four months a certain level of eating and weight loss and learning and developing my future lifestyle.

I'm going to do that while I'm on vacation. So that means that I can't burn that glass of wine I try to hire and that I'm eating veggies and everyone else is eating chips in dips and I'll be eating veggies on vacation, I am dedicated to getting this done.

I'm 52 years old. And I need to in want to be able to watch my grants program grow and I want to be able to play with them. And I want to be able to not go to counseling and be constantly trying to raise myself up because there's a stigma with being happy. There's a lot with being obese. And while there are other reasons I go to counseling, my self-worth is a

part of that. I don't need to be skinny, I need to be healthy.

REP. DATHAN (142ND): I'm so glad that you're fed On the health aspect of it, because you know, I do think you know, you probably spend, your insurance company probably spends quite a bit of money every month for your medications and you're paying for the out of pocket.

Any idea about what your medication would cost and an out of pocket basis?

PAULA RUCKER: I retrieved the return on investment, obviously, you know, I do payroll, and I work very closely with our benefits department. And I helped to analyze our benefits from year to year.

So, I have access to some of the numbers I have done the return on investment of the surgery, my company will see a return on investment in one and a half years, my meds will go from 12 a day, to potentially nine a day.

One of the reasons we have heard from our broker to us who obviously they're guiding us in what we should do is the provider, and to our employees, there is no guarantee that weight loss surgery will work, there is no guarantee that a bypass stomach bypass will work.

Well you know what, there is no guarantee that my ankle going into a heart valve is going to work. There's no guarantee that he's not going to need open heart surgery three years later, we're working in a medical field, we're working in a world where quite honestly, everything's against us, I'm affording to do all these things like the personal training and stuff, and now I'm also looking to find the money to not only do the personal training and how someone's diabetes educated, but now how do I afford all that really healthy food, and on top of

it, save for a surgery? At some point, we tap our funds, the Bank of fry.

REP. DATHAN (142ND): But I appreciate you giving that that insight. And I think it's definitely food for thought for the Committee. So thank you so much, Paula for your testimony.

PAULA RUCKER: And I appreciate your time. And I have given in my testimony and writing my contact information, Senator Anwar, I know you represent the area that I live in, so if there's anything I can do, or you'd like to have further conversations, I am an open book, if it means that we're able to become a healthier society.

REP. DATHAN (142ND): Right. Thank you so much for your testimony. Thank you, Mr. Chairman.

SENATOR LESSER (9TH): Thank you Representative. Other questions or comments from Members of the Committee? If not thank you Paula for your testimony.

PAULA RUCKER: Thank you very much, have a great night.

SENATOR LESSER (9TH): Next up we have Katy Talento, followed by Joel Noble.

KATY TALENTO: Hello thank you very much. I want to thank you Co-Chairs Lesser and Wood and the Members of the Committee for having us here.

I am Katy Talento and I represent the Alliance of Healthcare Sharing Ministries. We represent or work directly with the majority of the large CMS certified ACA defined health care sharing ministries in operation across the United States.

Alliance member ministries serve more than a million members nationwide and more than 5000 Connecticut

residents and managing their health care expenses, and they have been faithfully serving for decades.

My colleague Brad Nail submitted our written testimony earlier today regarding Senate Bill 1041 and I commend that to your attention.

With my oral testimony, I'd like to address some of the concerns I heard today and answer any additional questions you may have.

Senator Lesser, you've expressed skepticism about the fact that ministries do not make a promise to pay and do not transfer risk.

We do live in an insurance world and it's sometimes hard to relate to a non-insurance faith-based model, but for some members of faith communities, the approach we take in health care sharing ministries is a wholly familiar one.

You know these communities they often come together and provide meals to families with newborns and like yours, and we do schooling together and homeschool co-ops in the healthcare sharing ministry model were morally obligated similarly, but not contractually obligated to one another.

That said the Alliance does support requirements for legitimate health care sharing ministries, combined with the recognition that these religious charities are not insurance.

Now, not all organizations claiming to be healthcare sharing ministries are in fact health care sharing ministries. The ACA definition reflects the value of having a long standing record of faithfully serving members.

And that's probably one of the elements of that definition, the federal definition is that these ministries must have been continuously sharing since 1999.

All the bad actors that have been mentioned today, including for profit entities that you know, reportedly have marketed so called health care sharing ministry memberships, their new organization. It does suggest some wisdom and foresight in the ACA definition. They have some have a safe harbor for legitimate health care sharing ministries from the inference code based around the ACA definition have still been able to robustly go after these bad actors and have certainly done so.

Virtual Health care Sharing Ministries are upfront with consumers and transparently described to consumers how they are not insurant and what to expect in order to prevent confusion. We support robust transparency with the public and with our members, including notification and disclosure requirements that have been adopted by many states with our endorsement. The alliance condemns any and all fraudulent and misleading tactics in the marketplace, including those for profit entities masquerading as Health care Sharing Ministries.

As I talk to policymakers and regulators around the country, they almost always cite complaints in court cases related to for profit entities and the non-profit groups that those for profit entities leadership's have reportedly allegedly started.

ZOE GLUCK: Ms. Talento, you've reached your three minute mark. If you could just please summarize your testimony.

KATY TALENTO: Great, thank you. We're a little bit worried about some of the wording in the -- in the bill that it might be overbroad and put some of our practices out of business, in terms of we use paid staff and paid third-party vendors to administer, to negotiate bills, legitimate ministries do this, almost all of them. So, in closing, I wanted to mention that all the ministries, we represent do share bills for COVID testing and treatment, I know

that came up earlier; and also that we are neutral on the issue of commissioned, vendors and licensed agents, so I want to make that clear.

With the Sharing Ministries may not be a fit for everyone but they should continue to be an option for Connecticut residents who prefer this as their health care solution; hope they are for the residents of all the other states. We're looking forward to working with you to achieve your important policy goals on this matter. Thank you very much. Happy to answer questions.

SENATOR LESSER (9TH): Yes, thank you Ms. Talento. I appreciate your testimony and for clarifying some of the things that we've heard earlier. I appreciate your attempt to distinguish the not-for-profit ACA compatible ministries from other ministries. I would not completely sell on the argument though, that -- that the only bad actors are necessarily post 1999 for-profits. I have a constituent, for example, who was paying -- this was covered in the news, was paying $500 dollars a month for her Health Sharing Ministry, and it didn't not-for-profit. And she went to get a COVID test and want them getting stuck with a $20 dollars to $30 dollars bill because they simply refused to pay for the cost of the COVID test.

You know, I guess I would feel more comfortable if this were only in one particular segment but I haven't gotten that same strong sense of feel. It -- I guess, I -- I guess, if I wouldn't try to phrase this in the form of a question. We've heard from a lot of folks today who purchased these products or sent money, who started a relationship with a ministry; by their own words, in search of a cheaper alternative to insurance and so would you say that this is -- I guess where would the -- if folks are looking for this as an alternative to health insurance? Or what point does it stop becoming an insurance policy? What's -- what's the sort of the driving line that we can look at as to distinguish

that from something that would normally be regulated by the company?

KATY TALENTO: That's a great question. So, I think a key distinguishing feature is that there is no transfer of risk, we're not pulling funds and assuming that risk on to the pooled funds. We're not -- we're not entering into a contractual arrangement. We -- you know, our existence is around religious exercise. And so -- you know, I think you're right in that; some people come for the affordability and they stay for the faith, some people come for the faith and stay for the affordability, most people are there for both, and appreciate both very much so.

So -- see, I wanted to address something about what you mentioned, with respect to the non-profit organizations. It is true -- it appears to be true, based on the court documents that I have read; so I am no expert in these other entities. But what I have read in these court documents is that there are for-profit entities that -- whose leadership reportedly allegedly start or established or spin-off a non-profit entity that they market allegedly as a Health care Sharing Ministry; and -- so we would just argue these are not Health care Sharing Ministries. One of the best ways to know if -- if an organization is legitimate Health care Sharing Ministry is if they have a letter by the Centers for Medicare & Medicaid Services; they meet the -- nothing is perfect, this process of getting a letter was never perfect but -- you know, it does show that you meet the federal definition, and that is one effective differentiator.

SENATOR LESSER (9TH): Got it. Just -- at the risk of putting one company on the spot, you -- are you familiar with the Alliance for Shared Health?

KATY TALENTO: I am somewhat familiar with reports about the Alliance for Shared Health, yes.

SENATOR LESSER (9TH): It seems to be a legitimate or illegitimate health care image?

KATY TALENTO: So, I -- I can't comment on whether they are not; I do not believe that they would meet the ACA definition, but I don't want to speak for them, and they're certainly not a member of the Alliance of Health care Sharing Ministries. I do not believe that they're on the list of Health care Sharing Ministries that have received CMS determination from the Federal Government.

SENATOR LESSER (9TH): Got it. Okay, very helpful. Thank you very much.

KATY TALENTO: Thank you.

SENATOR LESSER (9TH): Other comments or questions from anyone listening. And if not, thank you. Next up, we will have Joel Noble, followed by Rory Whelan.

JOEL NOBLE: Madam Chair, Mr. Chairman and Members of the Committee, my name is Joel Noble, and I'm testifying on Senate Bill 1041, AN ACT CONCERNING HEALTH CARE SHARING PLANS AND HEALTH CARE SHARING MINISTRIES. I'm here representing Samaritan Ministries, a Founding Member of the Alliance of Health care Sharing Ministries, and one of the largest Sharing Ministries among the over 1.5 million Americans using health care sharing.

I've been blessed to have been serving with Samaritan in the health care sharing industry for nearly 20 years. For over 26 years Samaritan Ministries have been serving its members as Christians, bear one another's burdens to health care sharing, and that includes hundreds of individuals in Connecticut. We have over 280,000 members nationwide and our Members have shared over $2.3 billion dollars for medical bills in our history.

Congress recognize the value of this non-insurance approach to meeting medical expenses by granting Members of Health care Sharing Ministries an exemption from the ACA's insurance mandate. To our knowledge, no Member of Samaritan Ministries has ever made a complaint to the Connecticut Department of Insurance nor the Department of Insurance or any regulatory agency or consumer advocate in any state. However, in recent years, new sharing organizations have started engaged in practices that concern those of us who have been operating Health care Sharing Ministries for years.

We applaud the sponsors desire to prevent bad actors, including for-profit entities, pretending to be Health care Sharing Ministries from tarnishing the important ministerial work we do. If the sponsor simply desires to prevent Health care Sharing Ministries from using compensated or commission insurance producers; we would be supportive of that as we believe that prohibition will not only help prevent consumer confusion, but prevent regulatory conflicts. However, S.B. 1041 goes far beyond that, and as written, would make operating any Health care Sharing Ministry, including Samaritan Ministries, impossible to serve it's Connecticut members as it literally prohibits any person from receiving any compensation for participating in any aspect of the activities of Health care Sharing Ministry.

Section 2 of Senate Bill 1041 makes it unlawful for Health care Sharing Ministry to use paid staff to recruit or enroll members. It can be assumed that the DOI could interpret that drafted language of selling or soliciting as any activity relating to recruiting enrolling members, including responding to an incoming phone call. Additionally, it makes it unlawful to use paid staff to administer a health care sharing plan since every staff member of every ministry is participating in the administration of a Health care Sharing Ministry; Section 2 of Senate

Bill 1041 will shut down every ministry in Connecticut as they currently operate in their form.

Also Section 2 affirmatively places Health care Sharing Ministries under the insurance code. While Health care Sharing Ministries engage in voluntary sharing and not contractual transfer of risk, they are not insurance. Health care Sharing Ministries are under the oversight in general regulation of both, the IRS and Attorneys General, since they are a 501(c)3 charities. Health care Sharing Ministries as ministries…

ZOE GLUCK: Mr. Noble, you've reached your three minute mark. If you wouldn't mind summarizing your testimony. Thank you.

JOEL NOBLE: Thank you. So Section 2 does not use the term Health Care Sharing Ministry, but it broadly describes that's coming within its prohibition and arrangement with the same charitable activities as Health care Sharing Ministries.

And, in closing, I appreciate the opportunity to share our concerns with Senate Bill 1041. And look forward to working with the sponsor to fix the Bill in a way that prohibits -- that provides consumer protection while still protecting the ministries. I appreciate your time and I'd be happy to answer any questions about Samaritan Ministries or Health Care Sharing in general.

SENATOR LESSER (9TH): Thank you for your testimony. Any questions or comments from Members of the Committee? Being none, thank you very much for your time. Next up, we have Rory Whelan followed by Jimmy Iacobellis.

RORY WHELAN: Good evening, Senator and Members of the Committee. Thank you very much for this opportunity. I have submitted written testimony so I assure you I'll be brief. My name is Rory Whelan. I'm the Regional Vice President of Government

Affairs for The National Association of Mutual Insurance Companies, otherwise known as NAMIC. I would like to comment, firstly on Raised Bill 1042. I don't think this is -- I agree with the previous speakers who rightfully posited that a properly trained properly resourced fire system, fire teams is really a societal good. And therefore, that is something that the legislature ought to commit to in the annual budget process.

I'd also say that, you know, the insurance property policy protects his or her financial security, but it also protects employees, customers, neighbors, etcetera. I think a better way to look at if you're going -- if you're not going the route, where you want to enhance other ways of funding is to look at the causes of fires. So why not put a surcharge on chemicals? Why not put a surcharge on heating equipment, electrical wire? These are the main causes. I won't go down the line of Christmas trees and candles but those are on the Top 10 list of the causes of fires. I think when we think about the $7 surcharge for something that will -- necessarily, the cost of this equipment in trading will increase year after year, so it won't be long before we're back here talking about a bill that increases it to $15 dollars, $25 dollars, $50 dollars.

And then, I will speak very quickly on the Raised Bill 1047 regarding climate change reporting mandates. NAMIC is -- agrees climate change does affect the insurance industry, but I cannot understand why in this Bill we are singled out amongst all of the other regulated industries that are affected by climate change. And I don't -- and I -- we would reject the idea that insurance should standalone in this type of reporting.

And with that I'm happy to take questions, but very quickly I'll echo previous comments, Raised Bill 1044. I'm not sure if that's a taskforce charged with health care, insurance; but if it is property and casualty, I would request for the amendment to

have industry representatives on that taskforce. Thank you very much.

SENATOR LESSER (9TH): Thank you, Mr. Whelan. And I think with respect to the last one, that is what is known in this building, at least, are building we're virtually in, and as I don't mean that I don't know this. Just with respect to your testimony on the climate change, and it should -- obviously, this Committee oversees the Department for Connecticut Department of Insurance which oversees insurers and I guess the bail bonds industry for us, but I'm aware that the bail bonds industry is a major player in employment.

So, if we're not developing other industries, I guess I'm just trying to figure out what you're suggesting that we do?

RORY WHELAN: Well, I mean I would leave that to the legislature to decide, but it also presupposes that all insurers are the same and they're very different in terms of their size, their geography, their investment strategies. And I don't think it would be an appropriate measure.

SENATOR LESSER (9TH): And does that -- did I -- it might sort of to read into your comment that you don't support the work of the NIIC on climate risk exposure?

RORY WHELAN: I think the work that they have done; it has been 10 years or so. And we are -- Members are cooperating and contributing, and I think that is the better -- a national focus is the better route to go, whether that's through the NIIC or night coil or in coil for some model legislation.

SENATOR LESSER (9TH): I think we're going to work with -- I think they worked with both organizations. But you had sort of indicated that you didn't think this was a specific issue for the insurance industry, so that's one.

RORY WHELAN: Agreed. To be singled out, no; I don't think so. I don't think it's the proper place to start.

SENATOR LESSER (9TH): Well, I think we might respectfully disagree on that one, but I appreciate your testimony. And we'd invite any comments or questions from Members of the Committee. If not, thank you for your testimony.

RORY WHELAN: Thank you.

SENATOR LESSER (9TH): Next up, we have Jimmy Iacobellis followed by Jennifer Violette.

JAMES IACOBELLIS: Good evening, Senator Lesser and Members of the Insurance and Real Estate Committee. My name is Jim Iacobellis. I'm the Senior Vice President of Government Relations of the Connecticut Hospital Association. It's my pleasure to be here this evening to testify on Senate Bill 1048, AN ACT CONCERNING REIMBURSEMENTS FOR CERTAIN COVERED HEALTH BENEFITS.

Before I get into my testimonial, I just want to take a minute here and praise and applaud the hard work of all the health care professionals who have been working extremely -- extraordinarily hard for the last year. As I like to say they've been operating at a sprint but really for the length of a marathon. And their hard work and dedication is something that we applaud, something that we are proud of, and something that we have in mind.

Now, I'd like to turn to on Senate Bill 1048 which says, there is two things; we've isolated more detailed testimony but I'm just going to summarize it. It does two things, the first thing it does is it asks the Department of Insurance to set rates for A&M and E&M codes, and drug infusion codes. So form of rate setting for those types of services. Secondly, as the Department of Insurance -- what it

is doing is, it is rate setting to do it on a safe and neutral way. What that means is, they will take the site out of their calculation and notwithstanding whatever site the service is performed at, whether a physician office or provide a base facility, urgent care center, ambulance service that -- it will be the same -- the same reimbursement.

We are opposed to the rate setting aspect of this. When the state or federal government set rates; for example, in the Medicaid and Medicare program, as you've heard for years, they do not cover the cost of those services. Secondly, we are opposed to the site neutral aspect of the Bill. We believe that the site neutral aspect is one that is problematic. For years, we have come in front of this Committee and testify with concerns over site neutral proposals and one of the things that we've talked about are the responsibilities that hospital have in emergencies and emergency preparedness, and I think I can more easily, simply describe what hospitals have been doing since March of 2020.

We have been a critical foundational partner with the State of Connecticut in fighting this pandemic. We have expanded facilities, we have expanded capacities, we have created alternate care sites, we have set up countless COVID-19 testing facilities, and now we are a key component of the State vaccination program. This is different than any other health care setting and reimbursement should recognize that.

I thank you for my comments and I'm happy to answer any questions.

SENATOR LESSER (9TH): Thank you Jim for your testimony. Are there comments or questions from Members of the Committee? There is none, that's pleasing to me.

JAMES IACOBELLIS: Thank you. Everybody, have a good night, and thank you for putting it all the time on this hearing today.

SENATOR LESSER (9TH): Thank you. You take care. Next up, we have Jennifer Violette, followed by Bonnie Hall.

JENNIFER VIOLETTE: Good evening members of the Insurance and Real Estate Committee, my name is Jennifer Violette and I'm here to show my support for House Bill Number 6626, specifically for Sections 3, 4, 16 and 17 which would see to require insurance coverage for cochlear implant surgery, as well as the associated audiologic care. I will refer you to my written testimony pertaining to the facts and figures of hearing loss, as well as the cost effectiveness of treating hearing loss.

Insurance companies provide stringent guidelines for determining medical necessity in -- for cochlear implant surgery. One area where we see this pertains to single sided deaf patients. I personally have experienced with this scenario, as I have a son, who is single sided death. He was diagnosed at the age of two with a mild hearing loss and was treated with a hearing aid. A year later, his -- on his audiologic testing, it was determined that his hearing had degraded from a mild to a profound loss, thus rendering a hearing aid in effective. Our only viable treatment option at that point was to pursue cochlear implant surgery. My husband and I travelled down to NYU to pursue cochlear implant surgery for him.

He was deemed a good surgical candidate. However, our health insurance determined that this was not a medically necessary procedure. I worked over a period of several months with the surgical coordinator to try to overturn this decision. Finally, our insurance did overturn their decision, just two days prior to his scheduled surgery. The surgery has dramatically changed his life; he went

from being able to hear only a third of what is said on his affected side in a noisy environment to now with the use of his processor being able to hear over 80%.

My son's experience has also helped me become acquainted with other parents of single-sided deaf children who have not been as fortunate as my family. The reason cited for their health insurance is not approving their surgeries include age restrictions, the surgery being viewed as experimental, and the lack of medical necessity. There is a growing body of literature, however, that shows that there is a benefit to cochlear implant surgery in single-sided deaf patients. And in 2019, Meadows cochlear implant was approved for single-sided deaf and asymmetric hearing loss.

Access to sound is not something that should be an option, it is a basic life function that is necessary to navigate the world and to communicate with others. This proposed Bill can help the hearing impaired access the world through sound, and dramatically improve their quality of life. Thank you for your consideration.

SENATOR LESSER (9TH): Thank you for your testimony tonight. And I'm glad to hear that your husband is doing well, you were able to get it covered. Any questions from Members?

REP. WOOD (29TH): Thank you, Jennifer. Thanks so much for coming out tonight. Next up, we have Bonnie Hall, followed by Arthur Helmus. Is Bonnie here? Yes, Bonnie. I can see you talking, if you just unmute, we can hear you. Thank you.

BONNIE HALL: Good evening, Chairman and Members. My name is Bonnie Hall and I'm from Westport, Connecticut. And I fully support Senate Bill 1007. I believe this bill would be a lifesaving and/or life extending opportunity for many people.

I was morbidly obese and separate from diabetes, high blood pressure, high cholesterol and gastro reflux. I went to a presentation by Dr. Jonathan Aranow of Middlesex Health, where for the first time I had hoped that there was a way to reverse my diabetes. Over the next several months, I went for a number of tests and the results of all these tests were forwarded to my insurance company. My insurance policy did not include coverage for gastric bypass. I feel that the insurance company would be better served to cover this procedure rather than pay for a lifetime of complications from diabetes, heart disease, reflux problems and associated obesity health problems.

Dr. Aranow confirmed that my test results showed that I was an ideal candidate for gastric bypass probably eliminating my diabetes, hypertension and reflux problems. All supporting documentation was sent to my insurance company and they denied and subsequently denied and appealed. My last resort other than to pay out of pocket $25,000 dollars was to appeal to the Connecticut Insurance Commission. The Connecticut Insurance Commission forwarded my case to an independent out-of-state third-party for review. My appeal was supported by the findings of the third-party and the Connecticut Insurance Commission directed my insurance company to pay for the procedure.

As a small business owner, I pay 100% of my insurance premiums, which is $1800 dollars per month for my husband and myself for a $7500 dollars per person deductible policy. It would be virtually impossible for me to pay for this surgery out of pocket. I would have been relegated to a life of living with diabetes and hypertension, which was devastating for me as -- sorry -- as I watched my father suffer from diabetes for 35 years, his eyesight -- suffering a heart attack and stroke, and a joint amputations.

Today, after seven months after my surgery, I am free of all medications; I do not have diabetes, I do not have hypertension, I do not have high cholesterol, and I do not have reflux. I have lost 103 pounds and I've gained amazing health. I whole heartedly support this Bill, and I thank you for your support as well.

REP. WOOD (29TH): Bonnie, thanks so much for coming and sharing the story, and congratulations on this journey.

BONNIE HALL: Thank you. It's my pleasure. Thank you.

REP. WOOD (29TH): Do we have any questions from the Committee. Great. Bonnie, have a wonderful night. Thank you.

BONNIE HALL: You too. Thank you.

REP. WOOD (29TH): Arthur Helmus? Richard Riddle?

RICHARD RIDDLE: Good evening. Thank you Representative Wood and Senator Lesser, and Members of the Insurance and Real Estate Committee. I am Richard Riddle, a dentist, practicing in Connecticut since 1984. I've submitted written testimony which you can read. I will simply hit the high points in reference to your time.

I'm currently the Co-Chair of the CSGA's Legislative Council. In that role I'm tasked with helping or leading a group of volunteer dentists. We're trying to help our colleagues help their patients. This Bill, House Bill 6589, which I support, so graciously put forward by Representative Candler and co-sponsored by Senator Anwar, is designed to create transparency for our patients and help them avoid surprises. My colleagues, Dr. Lee and Dr. You have already testified that this Bill would basically specify the circumstances and the concerns about network leasing of dental plans.

The key points in this Bill are that it creates transparency for the patient, this legislation has passed in 20 states with similar language. We submitted the language endorsed by NCOIL, The National Council on Insurance Legislators in its December 2020 meeting. And Delta Dental of New Jersey and Connecticut supported this bill when it was presented in New Jersey. The way this affects our patients is as follows; a patient presents with a broken tooth; we try to determine their coverage. They are presented a card with whom we have an agreement. We give a ballpark estimate of what will be needed to get them out of pain. We proceed with treatment and it turns out the card they presented was that of at leased network; one with which we didn't even know we had an agreement.

The coverage is not as favorable to the patient, and now we have a rift or break of the doctor patient relationship through no fault of the doctor or the patient but due to the lack of transparency on the part of the third-party carrier; the trust is broken and difficult to retrieve. The patient has had a big surprise, as has the doctor. This year, more than ever, this legislative session is trying to address the issue of transparency. I've been listening to this, and so many of the issues brought up before you today have to deal with transparency and making sure there are no surprises. And basically, I would like to say that we're willing to work with you in any way possible, and we even have more ideas on how to achieve the transparency.

More importantly, I'm just thankful you took the time and are still here after all this time today. Thank you. If you have any questions, I'm happy to stay on and answer them. Thank you, again.

REP. WOOD (29TH): Thanks, Richard. And thanks for taking your time to wait with us all today. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you, Dr. Riddle for your testimony, and we are hoping that this would be a common sense law, it is complex to understand, but it's pretty straightforward that the people who are providing the care are not getting paid and the ones who are getting or receiving the care actually end up paying more than they should, and this is because of some things that we can at least legislatively fix; so I thought I just thank you for your testimony.

RICHARD RIDDLE: Thank you so much, Dr. Anwar. We appreciate all the efforts that you've been doing on transparency.

REP. WOOD (29TH): Great. Next up, we have Thomas Burr followed by Jonathan Aranow.

THOMAS BURR: Yes. Good evening Representative Wood, Senator Lesser and Members of the Insurance and Real Estate Committee. As the Community and Affiliate Relations Manager the Connecticut State Office of The National Alliance on Mental Illness, also known as NAMI Connecticut; I am testifying today regarding S.B. 1045, AN ACT CONCERNING STEP THERAPY, ADVERSE DETERMINATION AND UTILIZATION REVIEWS, AND HEALTH INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN.

Before I get into my testimony, I just want to say that I appreciate and echo Senator Looney's earlier comments this morning. And yes, I've been in and out listening to this all day. His testimony on S.B. 1045, as it relates to step therapy and the doctor-patient relationship and creating the presumption that treatment as ordered by a physician is medically necessary.

NAMI Connecticut Members know all too well that getting on the right medication regimen can be a long and challenging process. But getting the right medication is often what makes the difference between disability and stability. New advances in

medications and their combination with other services and supports allows people with mental health conditions to lead healthy and productive lives. Psychiatric medications are not interchangeable and providers must be able to select the most appropriate clinically indicated medication for their patience. While psychiatric medications may have similar effectiveness overall, they are unique in their mechanisms of action and effect each person and range of symptoms differently. Patients respond differently to different medications and it often requires multiple trials and many months, if not years, to find inappropriate drug regimen to stabilize a person's condition.

According to the NIMH, individuals have unique responses to psychiatric medications and need more, not fewer choices. For people with serious and persistent mental illness or those with co-morbid conditions, providers must be able to select from a full range of drug options to maximize treatment efficacy, minimize side-effects and avoid drug to drug interactions. Access to the full spectrum of psychiatric medications is an essential component of Community-based care. Advances in medication and other services have enabled the care and treatment of serious mental illness to take place in the community leading to a decreased reliance on in-patient facilities. Community-based services are less expensive to the state and its taxpayers than institutional care.

People with mental health condition can access the most appropriate clinically indicated psychiatric medication experience higher rates of ER visits, hospitalizations, and utilization of other health services. Policies restricting access to medications have been shown in a variety of published studies to cause increases in hospitalizations, lengthier hospital stays, more emergency room visits, more outpatient hospital visits, and more physician visits. A study by Joyce West, PhD in General Hospital Psychiatry analysed

Medicaid data from 10 states and found that psychiatric patients who reported problems with access to their medication visited the emergency department 74% more often than those that note difficulties with medications.

I'm sorry?

CHRISTINA PEN: Your time is up. Can you please summarize?

THOMAS BURR: Sure. So anyway, to summarize, these findings, highlight the reasons why people with mental illness need to access the full array of treatment options to achieve the best health outcomes in a cost-effective manner. Attached to my testimony is documentation that lays out the business case with references and citations as to why step therapy is often harmful to patients and does not result in any net savings to either the State of Connecticut or any health insurance provider. So as far as we're concerned, NAMI Connecticut, our members are fully supportive of the elimination of step therapy for mental health and behavioral health conditions as outlined in Senate Bill 1045.

So, thank you so much for taking the time. It's been a long day, I know, and I appreciate your time and attention. And I will gladly answer any questions you might have.

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

SENATOR LESSER (9TH): Yes. Real quick, I have a question about a Bill you did not testify on. Thank you for your testimony tonight. 6626 have a provision; it maybe you did testify and I missed it. But no problem gambling, is it -- is that already covered by parity laws? That was a question I had about four hours ago and I don't know I got it cleared.

THOMAS BURR: You know, I don't know, to be honest with you. But can I get back to you; that was 6662 you said?

SENATOR LESSER (9TH): I think it's 6626; that's a giant and a [inaudible] that covers a whole bunch of different things, but there is a section of it that…

IVELISSE CORREA: Well, it's on video or something?

THOMAS BURR: All right. I'll look at that and I'll send you an email Senator. I don't know off the top line.

SENATOR LESSER (9TH): Thank you.

REP. WOOD (29TH): Thomas, thanks for joining us. Have a great night.

THOMAS BURR: Thank you. You too.

REP. WOOD (29TH): Next up, we have Jonathan Aranow followed by Ivelisse Correa. Jonathan, you're on mute.

JONATHAN ARANOW: That'll help, thanks. Thank you Members of the Committee for this opportunity to speak to you in support of S.B. 1007 regarding the health insurance coverage for obesity treatments. First off, I gotta say Doc, Senator Lesser, you've got the cutest baby ever. So, let me dive in onto factual stuff that I'm here to present.

As I said, my name is Jonathan Aranow. I've been practicing bariatric surgery for 20 years at Middlesex Health and I'm the Director of the Medical and Surgical Weight Loss Program. This is actually my fifth time testifying before this Committee in an effort to obtain individuals access to bariatric surgery. This has been a recurring efforts since 2006 and 2007 when legislation at that time was sponsored by Senator Joe Crisco, and also then State

Representative Chris Murphy, who both sponsored similar bills. In light of the testimony I've already heard through this very long day, I'll focus my testimony on Connecticut population data as well as cost effectiveness data regarding this proposed legislation. And I've encouraged you to review my written testimony for details regarding the literature that I -- and statistics that I referenced.

Currently, surgical weight losses endorses lifesaving and life preserver by all major medical societies. Since 2006 Medicare and Medicaid have continued to cover bariatric surgery. In addition, large group employers can currently purchase a rider for bariatric coverage from third-party insurance. State employees and most municipal employees also have coverage, many large self-insured businesses also carry the health care rider. Despite overwhelming evidence supporting these procedures; in this state, as opposed to every other state in the northeast, bariatric surgery is excluded from the general policies of all private party insurers, including the index policies for the Affordable Care Act. Therefore, no self-insured individual or small group employer has access to bariatric surgical coverage, and as a result, there is a significant equity to the access to these proven therapies as my patient, Bonnie Hall, just spoke about.

In my written testimony abstract data from recent published population data, employment statistics and CDC data to determine that half of those individuals in our state with severe obesity have no covered treatment options; that's between 179,000 to 215,000 constituents that do not have insurance coverage for these proven treatments. This number is consistent with the 30% to 50% of my -- of patients that my colleagues and I are forced to turn away due to policy exclusions. Off note, current state-wide surgical volumes per year hovered around 3,000 procedures annually. If a mandate were enacted, I'd

project an increase in volume by an additional 1,000 to 3,000 cases per year.

With regards to the cost effectiveness of this of these procedures, compared to healthy weight individuals those suffering from obesity have substantially higher health care costs, prescription costs and primary care costs. Obesity raises annual medical costs by over $2,741 per year. Lifetime medical costs…

REP. WOOD (29TH): Jonathan, if you could just wrap up your testimony; you have reached your limit. Thank you.

JONATHAN ARANOW: Okay. I'll come back to the cost saving data with questions and answers. The bottom line, the cost savings is that, after an initial buying in, in about five to seven years, we could be seeing $9 million dollars to $12 million dollars of annual reduction in health care costs by eliminating obesity related illnesses. And I'd like to highlight just two quick studies related to my testimony.

New England Journal of Medicine published a large population study of 4,000 individuals, half of which underwent weight loss surgery, and a half are managed non-surgically; 16 years after the start of the study, there were 30% more deaths in the group that didn't receive surgery. And another paper I referenced in the study; looked at the survival when insurance related issues delayed or prevented access to surgical care. Over a 10 year span they found a three-fold increase in mortality in individuals who could not obtain surgical access. So, the question I really want to ask today is not what is the cost of covering these procedures but what is the cost if we do not?

And again, I thank you for your time and patience for this very long day.

REP. WOOD (29TH): Yes, it has been a very long day and we appreciate you sticking around to give your testimony for so long. Do we have any questions from the Committee? Thank you very much for your test, and I look forward to reading it as well. Ivelisse Correa, followed by Gregory Allard.

IVELISSE CORREA: Okay. Are you guys able to hear me?

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

IVELISSE CORREA: Okay, yes. I'm actually in a demonstration against H.B. 6462, but I am testifying in favor of S.B. 1045 and S.B. 1043. I believe it is a waste of time to have a doctor order medication or exam just for the next step to be to go to the next provider to then go to the insurance who wants to re-verify what the doctor already ordered. Little experimentation is basically what it is a cost savings that can cause -- get to funding breaks, it can -- you know, delay necessary treatment; and you know, people don't have time to sit there and play with different types of insulin or asthma medications, if something works, it works.

Also in regards to S.B. 1043, it is the nation, the Hartford Courant is the nation's oldest continually published newspaper and a historical symbol, right here in Connecticut; it's older than the United States itself. In a time when there's been increasing mistrust national news, local news outlets according to studies and polls are already more trusted than national news outlets, be outdone global capital is already responsible for job losses in Hartford by outsourcing printing to Springfield and laying off one-third of its reporting stuff. The last thing we need during an economic recovery is more job losses and the lesson for the population.

Also in regards to H.B. 6622 and S.B. 1045, on patient benefit managers according to studies drive

up costs, someone has to pay for a pharmacy benefit manager, and they do determine which pharmacies will be included in prescription plans and what they are willing to pay. So they are not able to really toss off the blame to pharmacies because they select the pharmacies based on price and what they negotiate with them. So…

REP. WOOD (29TH): Ivelisse, thank you so much for your testimony. Let's open it up for questions from the Committee. Great. Thank you so much for hanging out with us. I see you're very busy, so thank you. We appreciate it.

IVELISSE CORREA: oh definitely, very much.

REP. WOOD (29TH): Thank you.

DIANE KUBECK: Next up, we have Gregory Allard followed by Donna Pepe.

GREGORY ALLARD: Good evening Senator Lester, Representative Wood and Members of the Insurance and Real Estate Committee. My name is Greg Allard, and I am the President of the Association of Connecticut Ambulance Providers, and the Vice President of American EMS PRO Service. Thank you for the opportunity and all of your time throughout the day today.

I had filmed and checking in and can only imagine being part of the hearing as long as you have. My testimony today is regarding House Bill 6626; our Association supports Sections 22 and 23 of this bill with as suggested amendment but would oppose Section 27 of the legislation. Section 22 and 23 of the bill contains a requirement that medically necessary ambulance transportation be covered; however, due to the undefined nature of in-network level of cost sharing and what that means, we would request that be changed to the maximum allowable rate established pursuant to Section 19A-177 of the gentleman statutes.

Connecticut already has rate protections in place that 40 other states do not. The Department of Public Health sets ambulance rates on an annual basis for us. We need to submit report showing our costs and incomes and from that a fair and equitable rate is determined, we say that we're controlled utility, in that much like other utilities whose rates are established by a governing body. EMS Services needs to justify ourselves by sharing a type of balance sheet application in order to get a rate increase; no application, no increase. Optimally, we would like the insurance to recognize this process in Connecticut, and that it exists and that they pay the established rates and not try to negotiate reasonable unnecessary rates, whatever they are.

With regards to Section 27; we oppose the languages drafted in Sub-Section C2 which would require email providers to disclose potential cost to patients prior to transportation and receive written consent from these patients to provide such transportation; this is problematic for a variety of reasons. And EMS Service, who is a primary service area holder, has an obligation to respond to all calls received through the Emergency Management System is difficult to know prior to a 911 response whether it would be classified as an emergency transport. We find that there are many people who believe that if they call 911, the cost will be covered by their insurer, unfortunately that's simply not true.

It is also highly likely that this provision would cause delays in hospital discharges as it will require all non-emergency ambulance transports to obtain written consent; this would become burdensome for all hospital discharges, nursing homes or other health care settings. Further, this could also negatively impact underinsured or uninsured individuals who may not have access to non-emergency medical necessary transports from the hospital; these individuals may just simply opt out for

medically necessary transport due to costs; ultimately, this will delay transport and care for many people in Connecticut. We urge you to amend Sections 22 and 23 of the Bill and strike Section 27 from it, though.

Thank you for the opportunity to provide this testimony. And I would encourage you to read my and my colleague [inaudible] written testimony. Thank you.

REP. WOOD (29TH): Thank you, Gregory. We have a question from our Representative Comey.

REP. COMEY (102ND): I find often don't remember how to do it. Good to see you. Thanks, Gregory. So I had -- I had a couple constituents and maybe -- maybe there's another way to go around this sort of issue that were not seen. You know, the non-emergency transportation that the ambulance services provide, they -- some constituents of mine have said that they were not aware of the charges, they were trying to get from -- you know, one long-term care facility to another facility or home or something like that, and then the referral was to take an ambulance. And then, of course, they received that this was available to them, and then they received the bill at a later time and we're shocked.

Is there a better way to make sure that people understand that your services would not be covered under their insurance policies? And that perhaps there are better ways to get, say a wheelchair from point A to Point B or if you're bedridden and things like that? I guess I'm trying to do a little -- you know, deconstructing what the real issue is here.

GREGORY ALLARD: Sure, and I think it's an educational piece on a lot of people's part. I think it's part that the insured themselves understanding their policies and what's part of the policy, what's covered. As part of the insurance company providing that education to that person I

think it's an understanding of -- on the hospitals part what that person's coverage is before they start making the call to us to figure out what that is. Typically, we're offering the service or doing the service and then figuring out what their insurance is after the fact; so we don't know ahead of time typically what their policy covers or whatever we may get an insurance company name and ID number or something like that in order to be able to build a patient from the hospital, well, we don't really know what their coverage is prior to.

In some cases, we did -- do get prior authorizations but that doesn't necessarily mean just because we have the prior authorization number that we're going to get authorization after the transportation is going to play, so it is a very complex issue and certainly be willing to sit at a table and have conversations with whomever to try and figure out the best process through all of that.

REP. WOOD (29TH): Representative Comey are you done?

REP. COMEY (102ND): I'm sorry again, I unmuted. Yes, thank you. Okay, I appreciate the input and your willingness to work with us on that. Thank you.

REP. WOOD (29TH): Thank you. Gregory, thanks for staying with us late tonight; we appreciate it.

GREGORY ALLARD: Yeah, no problem. Thank you. Good luck.

REP. WOOD (29TH): Thank you. Next up, we have Donna Pepe followed by Adam Marchand.

DONNA PEPE: Hi. Can you hear me?

REP. WOOD (29TH): We can hear you, we just can't see you.

DONNA PEPE: I am fortunately starting the video, it says your zoom access camera -- I get to go into settings but I -- I would like to do a verbal if I can, just so I can get through this. I want to thank everybody for the opportunity to offer my support for Senate Bill 1007. My name is Donna Pepe, and I'm a Connecticut resident. I am a 52 year old business owner and I have been -- I have been denied coverage for gastric bypass. I'm fortunate to be able to afford bariatric surgery but there's so many people who cannot. Passing this Bill will help so many that need bariatric surgery due to a bit obesity issues and co-morbidities. I would like to add that my mother died at the age of 65 weighing in at 400 pounds in 2005. If she was given this option she may still be with us today. So I'm speaking for those who cannot afford this life saving surgery.

In 2008, I shattered my L1 vertebrae while horseback riding and needed spinal fusion. Prior to this accident I was quite active but I gained a tremendous amount of weight and exercising always set me back. In 2017, I decided to get the BAT gastric sleeve, I was denied by my insurance, so I paid out of pocket. I lost 75 pounds, but soon thereafter I developed this degenerative disease below my spinal fusion. As you may know, chronic pain can make even the simplest task hard to endure, let alone exercising. I've had numerous chiropractor visits, lumbar injections, and even an epidural; nothing really seemed to help. I'm currently investigating alternative options to relieve the pain such as spinal cord stimulation but I've been told that an additional spinal fusion may be the best option.

Needless to say, the constant lumbar pain has decreased my physical activity and then my knee replacement slowed me down even more. In addition, I developed severe acid reflex and was told a small hernia has formed above the sleeve. I contacted my bariatric surgeon, he said the best solution to

relieve the acid reflux and the hernia is gastric bypass. My insurance denied me immediately due to the exclusion of my policy, they would not even give us a case number. After several days of calling and speaking to numerous people at my insurance provider, I finally reached somebody who gave me the chance to submit my clinical data. I felt that if they heard my medical background they would agree that the surgery reduce, if not eliminate future surgeries etcetera, and save them money in the long run; they denied me again.

I am currently in the appeal stage awaiting the response; I guess I don't give up too easily. I will find out soon what the appeal response will be but I am prepared to pay out of pocket again because I know that it would eliminate a lot of health issues that could worsen if I did not get the surgery. Without the surgery and time I could very well become a burden to my family, increase my dependence on my insurance. Again, many others are not fortunate as I am, they will continue to suffer from co-morbidities because they're unable to afford the surgery.

A few -- here are a few important benefits of the surgery for me and maybe others; weight loss would decrease tremendous daily back pain, eliminate possible future spinal fusion. It would eliminate acid reflex that without treatment could cause severe damage to my throat, or worse, cancer. The medication that I take with the acid reflux could very well cause cancer as well, this is what I was told by my primary care doctor. Above all else -- above all else gastric bypass would provide me the healthy, active independent life that I desire. My biggest inspiration is my 83 year old father who is active, healthy and thriving. And there is no doubt that with this gastric bypass that I could change my life; I could live a healthy life, and I can live past my mother at the age of 65. So there is no doubt that bariatric surgery could give somebody a

second chance to live a healthy life and maybe even save their life.

Please pass Bill 1007. Thank you for your time. Any questions?

REP. WOOD (29TH): Donna, thank you so much for your testimony and sharing your story. It really does help us here, so I want to thank you.

DONNA PEPE: Thank you.

REP. WOOD (29TH): Any questions from the Committee? Great. Donna, thank you. Have a wonderful night.

DONNA PEPE: Thank you.

REP. WOOD (29TH): Next up, we have Adam Marchand. Do we have any other people wishing to testify? And any comments from the Committee? We will be looking to have meetings next week, potentially Monday and Wednesday, and those will be posted this Friday. And with that I want to thank the staff for hanging out with us so long, thank you to the Committee Members for great questions. And do we have a motion to adjourn?

REP. COMEY (102ND): I make a motion to a journey. Sure.

DIANE KUBECK: Motion made by Representative Comey. Do we have a second?

REP. NUCCIO (53RD): I'll second it because I want to go with her on a journey.

REP. WOOD (29TH): All of those in favor?

REP. NUCCIO (53RD): Aye.

REP. WOOD (29TH): Aye's opposed. And we are adjourned. Thank you. Have a wonderful night, everybody.

DIANE KUBECK: Thank you. Have a great night.