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House Pages: 5469-5589, 10894-10946 **174**

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6435.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calendar Page 15, second order of the day, Calendar Number 674, File Number 615, 920 and 996. Substitute for House Bill 6600, AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN as amended by House Amendment Schedules A and B, Favorable Report on Committees on Public Health, Human Services, Labor and Insurance.

SENATOR HARRIS:

Thank you, Mr. President. Good afternoon.

THE CHAIR:

Good afternoon, sir.

SENATOR HARRIS:

Mr. President, I move acceptance of the Joint Committee's Favorable Report in passage of the Bill.

THE CHAIR:

Acting on acceptance and approve the Bill, sir, would you like to discuss it further.

SENATOR HARRIS:

I would, Mr. President. Thank you very much.

THE CHAIR:

Please proceed.

SENATOR HARRIS:

Mr. President and members of the circle, I'm going to state the obvious here for us today, but I have to do it. Our health care system is broken. It's in a shambles. We all know this. As a matter of fact over the past few years, there has been a snowballing consensus rolling throughout this nation and this State that realizes our system is broke and we have to fix it. From citizens to big businesses to small businesses to health care providers to patient advocates to elected officials and even insurance companies, yes, even insurance companies want to be at the table; want to be part of the solution.

In this country and in this State, we have the highest expenditures. That's right, we spend the most on health care than any other industrialized nation -- any nation in the world. And across the board, we at times achieve some of the lowest outcomes. In my mind and in many people's mind, there's a moral issue here -- a moral issue. How can we in a nation that has so much have a broken health care system in which people neglect themselves, neglect their health and wellness. A woman with a lump in her breast not going to get

care because she can't afford it until the point where she's at Stage IV cancer and is facing that ultimate question of death, how can that be? How can it be that we have our elderly that are sitting at their kitchen tables and we all describe this and are trying to figure out -- should I keep a roof over my head? Should I feed myself or should I get the health care that I need to be able to be healthy; to be able to be alive and a productive member of our community. How can this be in this great nation?

If you don't like that position, that moral stance which I believe strongly in, let's take it from self-interest. Let's take the fiscal impact. Let's look at the economics of the situation. In 2007, the total national health care expenditures was $2.4 trillion -- $2.4 trillion -- zero, zero, zero, zero, zero, zero, zero, zero, zero -- maybe some more. I don't know. Think about that number. Think about that. That's 17 percent of our gross domestic product.

In the next decade, by the time we get down to around 2017, it's projected that our total health care spending nationally will be $4.3 trillion. That's going to be 20 percent of our gross domestic product

and, again, spending so much with outcomes that are not up to par. In Connecticut alone, it's estimated that we have total health care spending of $22 billion -- 22 billion. That's about $6300 for every citizen in this State. And that's an important number to remember because one of things that you might hear in this very helpful discussion I know we're going to have today is about potential cost to the taxpayers of Connecticut. And it'll be term -- it'll be discussed in terms of impact to the General Fund. But you have to remember we pay in many other ways than just through taxes and the General Fund. We are now paying $22 billion for all of our health care spending, again 6300 for every individual in this State.

We actually have universal health care. We all know that. It's a sick care system. It's a system where people don't do what they need to keep themselves well on the whole -- to keep themselves in a good state of mind and body. And then when they get sick, they go to our universal health care delivery system known as the emergency department when they're the sickest and the costs are the highest and you and I as taxpayers pay for that.

The economic drag of this system I'm describing

is huge. You've heard it discussed in the context of the current financial crisis that we're engaged in. But just one example -- one company says it all, General Motors. General Motors in one of their cars, $1,525, 1500 plus, is attributable to health care. Flash over to Japan and Toyota, only $250 is health care in the cost of a car. As a matter of fact, in 2005, I was astonished by this. General Motors paid more for health care than they pay for steel. How -- how can we be competitive unless we deal with this broken health care system.

The good news is that we have this consensus. We have people from across the nation and from all perspectives -- all stakeholders -- that are ready, willing and able to become a part of this solution. And I'm going to make a plea here before I go into the specifics of the Bill. We need to collaborate. We need all stakeholders around the table. We need to have the Senate in addition to the House that is actively on a daily basis working on this. We need to have the Governor involved. And I want to give some credit, right now upfront, to the Universal Health Care Foundation for the work that they've done over the past three plus years to develop a grass roots

coalition -- to bring together small businesses, citizens, health care providers, doctors, lawyers, all different parts of the equation and everyone that we need to bring this to a solution.

But I do have a concern and I would be remiss if I didn't state this. And that is in the more recent period, there seems to have been a -- I don't know if it's neglect. I don't know why. I don't choose to actually go into how it happened or what happened. But we seem to be shutting the door perhaps on some of the real important pieces of this puzzle to get the job done. And there are a few different areas that I can elaborate on. But one in particular involves our insurance companies -- our insurance industry.

There are a lot of opinions out there about the insurance companies ranging from pure evil to the best thing that ever happened. The answer, like most, is probably somewhere in the middle. And I think we need to remember this and make sure that everybody including those companies have a seat at table as we move forward on the path that I'm about to describe.

If you think about it, how many of the people that we know -- there 25,000 jobs in the insurance industry here in Connecticut; how many people that we

know in our communities -- families, friends, neighbors are able to be productive members of our community, pay their taxes, send their kids to school, volunteer for organizations, contribute to charity and do good things because of the work of these companies. These companies have foundations that give away a lot of money. They volunteer their time. And the reason I'm saying this again is not to move people to think that these companies are all great, but just to remind people of the real situation that we have and how we need to have everybody around the table.

These companies -- these companies know how to access risk. That's what they do for a living. And the big job that we're trying to do here as you heard from the previous debate on pooling is access and deal with risk, right? They also know tremendously about a crucial piece that I'll describe of health care reform and that's the technological piece. As a matter of fact, Aetna alone has about a third of their employees, with good jobs I might add, in this State that are devoted to technology. So I go into detail on this because I really want to emphasize through this one example that we need to have everybody at the table now and as we move forward. And there has never

been -- and I challenge someone to point it out to me if I'm wrong -- never been a successful example of health care reform unless they've had everybody around the table putting stuff in and giving stuff up. If President Obama can invite Ron Williams, the president of Aetna, to the White House to discuss health care, I think we in Connecticut, because he's one of our neighbors, should be able to do so, too.

Speaking of President Obama, the second thing that we have going for us -- the good news besides that consensus -- is the fact that the Obama administration has put health care reform on the front burner and has assembled the best and the brightest in this nation -- the nation that's responsible for so much innovation throughout history -- around that table to come up with a solution. So with these two good factors, what is our job here in the Senate today, in this General Assembly, in the State of Connecticut. Our job is to set a goal, to pick a path, to take a step forward today away from that sick care system to a better health care system.

The Bill I'm about to describe, SustiNet, does that. It picks a path that is focused but flexible. We need to pick a path that will allow us to link up

with the federal reforms that are being discussed as we sit here on this Saturday afternoon in Connecticut. I believe there's legislation going towards markup in the Congress in the very near future on this. So we need a bill that will allow us to link up with those federal reforms. This Bill, SustiNet, specifically does that.

We also need to improve in this State on an area that we've lagged behind on and that is maximization of federal dollars -- bringing in more federal dollars to help our taxpayers here at home. This Bill, SustiNet, does that.

When you take a look at health care reform and you want to kind of break down on the 30,000 foot level, it seems to me that you can describe it in four different ways -- cost, quality, access and coverage. And members of the circle, Mr. President, the good news is that this Bill, SustiNet, focuses on all four of those areas. As a matter of fact, it's the first bill I've seen that actually does that -- that actually has a holistic approach that really addresses all four of those challenges we face.

What I'm going to give you over the next few minutes is a general description of the SustiNet Plan

-- of the path that we're about to move down together again in collaboration with all stakeholders. But I want to put on the record here and make sure everybody understands that today, we are not voting on; we will not be legislating a major health care reform to the extent that we will be implementing today by pressing that green button -- health care reform. We are picking a path. The final decision or decisions will be made by future General Assemblies -- first and foremost, as I'll describe, in 2011.

So what is SustiNet? To give you kind of a macro description of what it actually is. Again, addressing all four of those factors that I discussed, SustiNet is a self-insured coverage systems with, and this is crucial here, crucial, health delivery system reforms. We're changing the whole picture -- - the way that we do business -- the way that we deliver health care in this State when we go down this path and, ultimately, by what we legislate, as I say, in the future.

The delivery system -- a very important piece of this. Because, first of all, I think this is the piece that has the most consensus. I believe that if you take a look at this Bill, you know, you'll have most people in this State no matter what their

perspective agreeing on these parts of the Bill. And -- and I have a feeling that's going to come through in the debate here today. But through the use of this new delivery system, we will be able to lower that cost that I talked about that not only is effecting us individuals, families, businesses and our pocketbook, but is having the tremendous economic drag on our system. One of the key delivery system reforms is the use of medical homes.

Medical homes, basically if you like to kind of go back in history, it's really the concept of that old fashion country doctor with a black bag that comes to your house and gives you that personal attention that you need -- that every individual in this State should be entitled to a primary care doctor. Somebody that knows them; that knows their family; that knows their habits; that understands the challenges they have in their health care regimen. And that can help them not only through direct care that they give in their offices, but that can help them navigate the system; refer them if they need dental help; refer them if they have an issue of mental illness; refer them across the spectrum to other health care providers and coordinate that care so it works and so

it costs less -- so more efficient and more effective.

The next, which is -- and all of these actually are receiving a lot of attention, I might add, from Washington and the Obama Administration, the medical home model is on the front burner, too, is electronic health records, the use of technology to be able to help coordinate care so that we bring that country doctor with the bag from the 19th century effectively into the 21st century. So that everybody in this State will have an electronic medical record at each provider with all of their health data and this stuff -- this data -- will be aggregated into a much larger electronic health record that can be drawn upon by various providers across the health care spectrum. So that if you are being by doctors in the Hartford area but happen to have an accident in southwestern Connecticut, through electronic medical records those doctors can know what you're up against, what meds you're on, what you need holistically to be able to treat you effectively and quickly on the spot. SustiNet brings this to the table.

And the third very crucial part of the change in our delivery system is evidence based care guidelines. Actually practicing medicine based on the best

evidence -- what works, we do. What doesn't work, we don't do. And as a matter of fact, we've seen a lot of innovation in this area. Pitney-Bowes, a great company in the State of Connecticut, actually has valued based health care. A lot of this is based on evidence based medicine so that they use the appropriate treatments, the appropriate interventions, wellness, prevention; all of those terms we hear bandied about so that actually occurs. SustiNet accomplishes this change in the delivery system.

As far as coverage goes, we know that another major issue that we have is how we get people coverage. I will say that unless we deal with cost, access and quality, then the coverage is worth same as this piece of paper. But, nonetheless, coverage is tremendously important and SustiNet has a plan on how to get this done. Essentially, what the SustiNet Plan will do is under this one general authority, which will be set up based on a recommendation that will be made to the General Assembly in 2011, there will be three different silos of coverage. Our State employees that are currently in plan that they bargain for will remain in that silo and any changes to that silo will have to be negotiated, collectively

bargained through the processes that we have now in current law.

We will also group all of our public health care programs into another silo -- so Husky A and B, SAGA will be in another pool. And finally, and this is similar to, dovetails with and is complimentary to, the pooling Bill that we just talked about, we will have a third silo -- a pool in which small business, nonprofits, individuals, will be able to join and receive their health care coverage. This doesn't push out the private market because there actually is a fourth area that we'll still have and that is the private sector market.

And the idea here is, that a level playing field will be established and there will be competition -- a thing that's made this country great -- between the private sector and those silos that I told you about under SustiNet and together, through competition, we will reform our delivery system, reform our coverage system and lower cost to all of our citizens.

How do we get there? As I said before, this Bill does not implement SustiNet or any real specific part of SustiNet. This Bill does not put the taxpayers of Connecticut on the hook for one red cent at this point

in time. It just picks a path, invites collaboration and consensus building so that in the future, we can actually make some investments to keep people healthy and save taxpayer dollars. The General Assembly must again come back to the drawing board and craft legislation based on recommendations which I'll described to implement this.

So what does this Bill do? It sets up a nine member board with each individual having a particular area of expertise to meet the health care challenge. It sets up four committees of stakeholders -- health IT, medical home, again, that primary care piece that I talked about; the health care provider committee which will research and set clinical care and safety guidelines so that we create a uniform standard of care that is efficient, effective and safe for the people of Connecticut. And a very crucial one, the preventative health care committee which, again, will use evidence based medicine to insure that we do everything possible to have our citizens be well and prevent disease.

There are also three task forces - one in obesity which if you look at the data and we discussed this with a bill a week or so ago, obesity is one of the

major contributors to chronic disease. Obesity and the huge problem we've had with the explosion of obesity in the past two to three decades is putting a major drag on the health care system through chronic disease such heart and hypertension, diabetes, heart disease, stroke and even asthma. As a matter of fact, 12 percent of the people that have those conditions actually generate 70 percent of the cost to the system. So even just by attacking obesity and controlling those numbers, we do a lot to lower the cost of health care. Tobacco doesn't need to be explained. We know the cost that smoking has had on our people and on our health care system.

And finally, remember I described those four different areas, one other key area is access. I can give someone a piece of paper saying you have healthcare coverage and it's affordable. I can even lower the cost of health care to a certain extent but if I don't help people have a doctor that they can go to, a dentist that they can go to, places where they can get their care, real practical access on the ground, I haven't reformed the system. And the final task force addresses that. That's the health care workforce taskforce.

So this nine member board, in consultation and collaboration with these committees and taskforces will develop, shape certain procedures and guidelines, the benefit package, rates, etc. of the SustiNet Plan, and then make recommendations to the General Assembly. They're due on January 1, 2011 concerning those areas and the governance structure -- what the entity will look like that will oversee the implementation of the items I have been laying out, hand that off to us in the General Assembly.

While I've described the SustiNet Plan as moving towards implementation of a pooling structure for coverage, the Bill actually does more than that because it keeps other alternatives alive. It expressly says, as a matter of fact, and keeps and individual mandate alternative on the table. Something that's very important because this is one of those areas that is being seriously considered along with pooling by the Obama administration and the experts in Washington. So we're going to be under this Bill. So we're going to be under this Bill moving forward with our eye on Washington to again address the challenges of cost, of quality, of access and of coverage.

Let's flash back to that huge figure that I put out at the beginning of this discussion. We spend total public and private spending $22 billion in the State of Connecticut on our sick care system today. What will SustiNet do potentially down the road after we go through this period of study and implementation recommendations and if we inevitably go down that path in the General Assembly having another bite of the apple, at least one other bite, implement it, what will we get?

What people like to focus on is the fact that SustiNet would call for an additional $950 million of general fund investment in the year 2014. And that's a big number. It's a big number especially in the context of the fiscal crisis that we're now facing but it's just a big number in general. But the question is what do we get for that investment? What is the return on our dollars? And what that will do by implementing this system I've described is drastically decelerate that tremendous growth in health care costs that all of us have been experiencing in the past two decades. The delivery forms will give us some more efficient and effective systems. And as a result, business, households, you, me, our families, will save

$1.8 billion -- $1.8 billion. So, we invest $950 million and we save $1.8 billion. That's nearly $2.00 of savings for every dollar of general fund investment. I don't know about you but in any time, not even a bad time, I wish I could get a return on my investment dollars that was even half as good as that.

What we'll also get is an additional $800 million of federal funds. Again, something that we've been pretty much dead last consistently and historically in this nation. For every buck that we send over to Washington, we bring back on average somewhere between 65 and 72 cents. We need to maximize federal dollars. SustiNet will bring in an additional $800 million.

Again, I want to be clear. Today, we are not legislating all this to happen. We are not legislating to spend $950 million today. We are moving down a path and future General Assemblies and hopefully I'll privilege to be back here, will have to really do some of the more hard and detailed work to implement the hard work that's already been down by the Universal Health Care Foundation and their supporters that will be done by this board, the committees and taskforce and that we'll need to do more later.

But all stakeholders must have a place whether you like people or dislike people, everybody needs to have a seat at the table if we're going to get this done. And it's not too late. We're in this together and we're not going to succeed unless we work together. But we will succeed if we do.

So today I ask my friends and colleagues around the circle to take a step down that path together to a more humane, more efficient, more cost effective health care system. Thank you, Mr. President.

Senator Coleman in the Chair.

THE CHAIR:

Thank you much, Senator Harris. Senate Bill 6600 is before us. Will you comment further?

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President and I -- I thank Senator Harris for the comprehensive description of both the problem and the Bill before us. And I believe Senator Harris is right in saying that we do have a problem with our health care system today and there is broad consensus that we need to do something about it.

However, Mr. President, the Bill before us today is not the answer. The Bill before us today while Senator Harris is correct doesn't implement anything immediately, it does set us down -- set us off on a path as he said. Unfortunately it is a path that will lead us to a bad policy of more government run health care and an exorbitant cost to the taxpayer that's fiscally irresponsible of 1 to $2 billion dollars including the hidden costs within this Bill that will require us to raise the sales tax from 6 percent to 8 to 10 percent to pay for this -- a tax increase of up to $2,000 for every middle class family in Connecticut.

Mr. President, let me tell you a little bit about what this Bill presupposes because Senator Harris was very careful to say that nothing is mandated by this Bill. We're not voting today to do anything described in the original SustiNet proposal that went through our Committee system. However, the way the Bill is worded this does not set up what we would normally consider a feasibility study. This Bill presupposes the answer. And while there are some worthwhile aspects in this Bill, the core of it is the wrong answer that we have presupposed.

Specifically, Mr. President, let me first talk about that core bad policy which says that the State should open up its health care pool to individuals to get more people on government run health care. Now Senator Harris accurately described some of the problems that we face with health care. And, to me, I would boil them down -- he had four -- I'd boil them down to two. And they're interrelated. One is cost. For the 94 percent of us with health insurance, we are facing escalating health care costs for our premiums and deductibles. The second problem, Mr. President, is for the 6 percent of us in Connecticut who do not have health insurance; we need to figure out a way to get them covered.

The bad policy in this Bill, Mr. President, says we are going to harm the 94 percent of us who have health insurance to help the 6 percent who don't. And that is the wrong policy because we could help everybody. The Bill essentially says that taxpayers will subsidize the government's pool -- the new government run health insurance to individuals who don't have it, hence, the billion dollar cost that Senator Harris mentioned. This has all of the problems that we mentioned in the previous debate.

First is the problem of adverse selection. Is the fact that of the 94 percent of us who do have health insurance, the only ones who would want to join this Plan, which is sure to resemble the gold plated plan that we have for State employees currently, will be those with higher costs currently, and hence, those that are more risky who will file more claims.

Secondly, for the uninsured, we are getting a new pool of highly risky people into this grand pool that Senator Harris has described in the SustiNet Bill. Both of these will drive up costs for the 94 percent of us who do have health insurance. So instead of solving both of the problems of higher health care cost for the middle class and covering the uninsured, it hurts one to help the other and there's a better way, Mr. President.

The better way is to focus on cost containment. To lower cost both for the middle class and to lower costs so that those who are uninsured can afford health insurance much like Governor Rell has done in the Charter Oak Plan. And there are good aspects to this Bill, Mr. President, and I compliment Senator Harris for calling them out. And Senator Harris did say there's broad bi-partisan support for those

elements of this Bill that are focused on cost reduction; health care IT to enable doctors to make better decisions; electronic medical records to reduce the cost of administration; allowing doctors to make better decisions jointly with their patients through the medical home idea; to try to provide better information at the point of service; and preventive medicine where we all know the old saying that an ounce of prevention is worth a pound of cure.

Those ideas are all in SustiNet. But they're ancillary. They form the core of the proposal which is all around expanding government health care. And I would invite, as Senator Harris said, all parties to come to the table to cost about cost containment and to talk about those areas of the SustiNet Bill that do enjoy wide popular support and that will actually solve the problem, Mr. President.

So because of the core expansion of government run health care which will result in higher costs for the 94 percent of us who do currently have health care, this is a bad policy.

But, Mr. President, the second reason, besides being a bad health care policy, is this is bad fiscal policy for the State of Connecticut. The estimates of

the cost of this, range from anywhere from 1 billion to $2 billion. Senator Harris mentioned the figure of $1,950,000,000. And the fiscal (inaudible) called out that that was just the core expected cost of the subsidy that we would need to provide to cover the uninsured. The other aspects of this Plan are all going to have costs associated with them as well, including, one of the major ones of creating this mega pool which will likely raise the level of health care in some of our pools that are outside of the State employee pool up to that level.

Senator accurately said that we cannot arbitrarily change the State employee health plan pool. It's -- it's collectively bargaining. But all of these other pools including SAGA and Medicaid will have to rise up to the level of the State employee pool in order for us to fulfill the SustiNet Plan.

Thus, if the cost is upwards of $2 billion, that equates to a 4 percent increase in the sales tax, from 6 percent to 10 percent which is $2,000 for middle class families. So, again, not only does the middle class face higher health care costs, but a massive tax increase -- bigger than even what we are thinking about in some of the proposals before us this year.

Now Senator Harris also says that this Bill does not do anything immediately and has no fiscal impact in the next 2 years and he is correct when he says that. However, the Bill sets us down a path towards government run health care. One, that is the wrong way to solve the problems that are facing Connecticut when it comes to health care and when it comes to the nation.

So, Mr. President, I stand in firm opposition to this but before continuing on, just for the purpose of answering some of these questions and for legislative (inaudible) through you, a couple questions to the proponent of the Bill.

THE CHAIR:

Please frame your question.

SENATOR DEBICELLA:

Thank you, Mr. President. Mr. President, the first question to Senator Harris has to do with legislative authority because the Bill seems to give the new SustiNet board quite a lot of power to actually craft the solutions that are presupposed in the Plan. Through you, Mr. President, will the legislature still have final authority to approve or disapprove everything and anything that comes out from

this SustiNet board? Through you, Mr. President.

THE CHAIR:

Senator Harris, if you care to respond.

SENATOR HARRIS:

Through you, Mr. President. Yes. What this Bill contemplates is this board in connection with the committees and the taskforces so that we have all the best and the brightest around the table to come up with recommendations for the legislature and to give those to us -- most of them, I believe, are by January 1 of 2011.

SENATOR DEBICELLA:

Thank you, Mr. President. Mr. President, the second question I have is let's assume that the fiscal note and the number in the fiscal note are the only costs associated with this -- (inaudible) $950 million. Through you, President, if that turns out to be what the actual cost is at the end of the day, how will we actually pay for this? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. That is going to be

a decision that will be made by a future General Assembly taking into account all of the economic situation that we'd be in at that point in time; taking into account the entire State budget and taking into account what are priorities are. I would say that this is a very real question I think that Senator Debicella accurately raises. But at some point when we're talking about the $22 billion of entire spending on health care in the State of Connecticut, and of all of the -- not only the moral issues -- but the economic drag that our health care system causes in the State of Connecticut, people are going to have to step up and decide whether an investment right now to save dollars to keep people healthier is worthwhile and we will have to grapple with that in a future General Assembly.

THE CHAIR:

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. And, Mr. President, I think that Senator Harris' comments; they tie back to what he said before about investment. And this is an area where you have to separate out the areas of the SustiNet proposal. Senator Harris is absolutely right

when he says that investments in preventative medicine, reducing obesity, doing more screening to catch cancer earlier, better medical records to reduce administrative costs, with all of those I believe there is a payback to those investments. But to simply create a government run health care system where we get more people into our State pool will not return its investment, instead, will cost the taxpayers an immense amount of money. So I separate those two things that -- that the good Senator points out.

And just one last question, Mr. President, before summarizing, the Bill seems to say that the SustiNet board may go out and get private donations and federal funding to carry out some of its activities. The question, through you, Mr. President, is would the Universal Health Care Foundation of Connecticut be allowed to donate to the SustiNet board under this current Bill. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President, I believe the Universal Health Care Foundation along with other

private foundations and other sources of funding would be able to help fund the efforts going forward based upon the language in this Bill.

THE CHAIR:

Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. I thank Senator Harris for the answers to those questions. Mr. President, one of the core issues that goes to the heart of the problem with this Bill is the Bill has been very cleverly set up to actually not cost us anything in the short run yet sets up not only the answer but the mechanism to fund it. Because the Universal Health Care Foundation of Connecticut is sitting upon millions and millions of dollars from a deal that was cut several years ago where in the demutualization of several insurance companies, they were actually given this money.

That money has been spent tirelessly, not on finding cost containment answers but on lobbying by going around to some of my colleagues and threatening my Democratic colleagues with primaries if they don't get on board with this Plan. And you better believe that the Universal Health Care Foundation will be

giving money to the SustiNet board to try to continue the influence the decisions of that board to move beyond what's even in this Bill. Because make no mistake, although what is said in this Bill today only takes us in the direction of socialized medicine; make no mistake that the end goal for the advocates is to have a European styled socialized system of medicine where every man, woman and child relies on the government for their health care.

And so, the Bill before us today does not do that. But some of the funding mechanisms underlying this will continue to lead us in that direction. Mr. President, today I stand and say no. That we need to do what Senator Harris had originally said -- to get all parties around the table to do the things that we agree on -- cost containment. That is where the solutions to our health care problems lie both for the middle class and the uninsured. And my hope is if this Bill is defeated that we can get together in a bipartisan way to work on cost containment in health care to help the middle class and the uninsured in Connecticut. Thank you, Mr. President.

THE CHAIR:

Thank you. Senator Kane.

SENATOR KANE:

Thank you, Mr. President. Good afternoon.

THE CHAIR:

Good afternoon.

SENATOR KANE:

Through you, Mr. President, just a couple questions to the proponent of the Bill.

THE CHAIR:

Proceed to frame your question.

SENATOR KANE:

Thank you, Mr. President. In Section 5, you spoke earlier, Senator Harris, about the electronic record keeping and I'm a little concerned, and maybe I'm wrong so hopefully you can correct me if I am, but I'm a little concerned about the actual electric -- electronic records that would be being kept. You know, in auto insurance, you look at a person's history and how they drive their car; how many accidents they had; tickets; infractions, that sort of thing. So I'm concerned about the electronic part of it on health insurance because then I feel that maybe these records would follow this person throughout their life and then be used potentially against them by their pre-existing conditions and the like.

So, my question to you on the electronic portion is who gets to see these electronic records -- the people setting the rates -- or it is just as you mentioned an example of someone being in a car accident and they needed assistance at a hospital. So that's where my concern is on the electronic records. Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. The electronic health records in the context of SustiNet as they're talked about in Washington or through some of our other bills here, are purely medical records used by health care professionals to be able to help achieve better outcomes. So these are not just general records that would be used, as you said, for other purposes. As a matter of fact, and this in some ways addresses some of the issues that Senator Debicella talked about with respect to use of health care records to try to, I guess, rate someone. I think that's what you might be getting to.

The Bill specifically talks about in one context applying the same type of factors, the five factors,

that are currently allowed in our small group market to be able to rate people. Those are their age, sex, geography, where they live, their occupation and the size of a particular group so that there is nothing more in this Bill that would someone have a nefarious use of those records to prevent coverage. As a matter of fact, what this Bill is about at its core, first I think, cost containment which Senator Debicella and I agree on and, secondly, about coverage. So the idea is not to keep people away from coverage. It's to figure out how to give people coverage.

And finally, because some of what you get to also deals with this issue of adverse selection. Section 10 of this Bill specifically addresses adverse selection and sets up a -- a series of -- of points that the board of directors are required to analyze and that would become part of the recommendations handed off to this General Assembly so that we avoid adverse selection. So I think that this Bill actually deals with that issue -- an important one -- head on. Through you, Mr. President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I thank the Senator for his answers because I think you can see where my concern was and that this could be used in -- as you mentioned -- adverse selection and preventing people from getting health care rather than providing it to people who need it.

My second question is about you invoked President Obama and the national scene in your comments. And I agree with you. I think that this is an issue that's going to be tackled and it is being tackled on a national level. I know that no other state has implemented this process like we are trying to do here. So if those two things apply, if no other state is doing this and the President and the national administration is taking action with this, why the need now for us to do it? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Thank you, Mr. President, another very good question by Senator Kane. I think that actually the fact that Washington is contemplating some of these very types of reforms makes it more imperative that we move down a path. And that is because if we are out

there in front, if we are leading like this State has done through manufacturing, through creating the first lollipop, I might add as one of the things, through all the lists of Connecticut firsts that we have, if we are innovative, we will attract federal attention. We will be able to help influence that federal policy in a way that's beneficial to our citizens and, also, this is a key piece of SustiNet, we will be viewed as leaders and attract more federal help, more federal dollars, helping the taxpayers and the citizens of Connecticut.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I thank Senator Harris for this answer. I actually disagree with him on that point, however. I think that the federal government has greater ability to take this on initially than we do. I do understand and know that no other state is implementing this procedure like we are and I believe that, as you said, putting it on the front burner on the national level, this will be solved on the national level. I have great confidence in our new President that he will prioritize this as one of his

biggest items on this agenda.

I stand in opposition of this proposal, Mr. President. I believe that -- I'm very much in agreement with Senator Debicella and about the costs of this measure. It is enormously costly. It is extremely broad and again, has not been implemented by any other state.

I have questions in regards to the board of directors that are going to make recommendations of this plan without any actuarial analysis and that bothers me as well. And the previous Bill, Senator Caligieri offered an amendment on -- on having actuarial analysis and it was defeated and I believe this is a very important step in this process as well and this is without.

From what I gather also through OFA and I guess there was a professor at MIT who did some work on this, that this legislation could cost up to a billion dollars. I won't say the amount of zeros afterwards, but it's a big number and I do believe that this legislation is very costly.

The authority set up will have vast power and control over the State's health insurance policy although their not a State agency. So I have very

deep concerns about that. I think we're creating another level of bureaucracy. It's estimated that this level of bureaucracy would be another $40 million for the administration of it. You know, to me it's -- it's -- we're creating bigger government and we should be reducing the size of government. We talked -- I talked earlier about the fact that we have an $8 billion deficit which we all know this gives us an opportunity to reform the way we do things here and we're not doing that. We're just going along that same path, down that same road and we're creating added layers of bureaucracy as opposed to reducing it.

You also talked, Senator Harris, about the cost and quality and access and coverage and I can understand a lot of those points. And I think in some way -- fashion we're going to have to fix the health care system that we have. I just don't believe this is it. You know, we are making a way towards a government run health care system and if you look at one perfect example, Mr. President, would be the United States Post Office versus Fed Ex. The U.S. Post Office is in shambles. They continue to raise rates yet they lose money where as Fed Ex, a private entity, does things on time, efficiently and for less

money and continues to make money and be more efficient.

So for those reasons I stand in opposition of this measure and I hope my colleagues will as well. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator. Will you remark further. It is House Bill 6600 that's before us.

Senator Frantz.

SENATOR FRANTZ:

Thank you, Mr. President. I appreciate that. I stand very much in favor of Senator Harris and the team's effort to come up with a solution that provides health care for as many people, if not 100 percent of the people, within the State of Connecticut. It's a noble cause. It's something that I think all of us subscribe to. The big question is how do we get there, Mr. President. How do we get there and how do we do that without destroying the very system that has delivered so many benefits to the people of Connecticut to date.

I think we would be better served if our energies were directed at the cost savings that could be achieved within the system. Electronic recordkeeping

is certainly a noble cause and specifically will -- that's been identified -- will produce some cost savings for the entire nation including the State of Connecticut.

I think we need to direct our energies to areas such as medical malpractice. I think we need to take a very close look at mandates. This body right here as well as the House in previous years -- the entire State of Connecticut -- has approved, pushed for and approved, so many mandates that I think we're within the top five of the 50 states in terms of the number of mandates that we require of our health care delivery system.

I also think we need to and it's a very difficult thing to discuss even in the -- even in -- in concept and that's the cost of our final years of -- our health care costs in the final years of life which is something that other countries have addressed and it's something that I hope that we as a body will at some point address in the not too distant future.

My opposition to the concept is more of a philosophical aversion to -- to the idea. I think that the more we become entrenched in the cradle of government, whatever the service might be, the more

dependant we become and the less -- the less careful we become in our own personal lives. The more we're taken care of, the less personal responsibility we take in terms of our own business affairs and in the case of health care, our health care affairs, as well.

There are areas that I have heard -- I cannot document this -- but, I've heard from numerous different doctors that if tobacco were overnight eliminated from the State of Connecticut we would save between 40 and 60 percent of our annual health bill here just in this State alone, perhaps in the country, because we have less smokers per capita than other -- most other states in the country. The nation could be saving a tremendous amount of money.

Add to that the whole area of obesity and diet and if that were a better situation throughout the land, we would be saving an additional 15 to maybe even 25 percent. Put those two together and it's pretty -- pretty darn compelling that we should be focusing our energy on improving in those areas before doing anything such as considering SustiNet which we know is going to cost a lot of money and not necessarily deliver the improvements in health for each and every one of us going forward.

I'm not sure government can take care of every need. We -- we try to. It's our altruistic and charged duty to take a look at these issues very hard. But we also have to ask the question every time we do try to come up with a plan that addresses every need of every citizen of Connecticut -- are we maybe taking it a little bit too far? Are we taking away from our own responsibility to take care of ourselves and whatever sense of the word that we're talking about?

We should be looking at ways to improve the system. And once again, Senator Harris, this is a good attempt at doing this. But I think there are some other -- at least on the philosophical level -- other ways that we could be doing this. We need to reduce the cost of the services that are delivered by the health care system to -- to people of Connecticut. We need to make it so affordable that there's no reason not to have self-purchased or corporate purchased or whatever organization you're working for purchased health care for all those you are in the employee of that particular organization.

With that I stand in opposition to the Bill but in favor of the concept of -- of making us healthier and having us better cared for. Thank you, Mr.

President.

THE CHAIR:

Thank you, Senator.

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. Good afternoon.

THE CHAIR:

Good afternoon.

SENATOR RORABACK:

Thank you. If I may, Mr. President, through you, a series of questions to Senator Harris.

THE CHAIR:

Please proceed to frame your first question.

SENATOR RORABACK:

Thank you, Mr. President. As -- first of all, Mr. President, before I pose the question to Senator Harris, let me say for the record that I don't think that there's anyone in this Chamber who could hold out the notion that what we have in today's health care delivery system in Connecticut represents the ideal.

Each of us has constituents who are effectively precluded from accessing quality, affordable healthcare because of the unreachability of -- of the cost of insurance premiums by many who are self-

employed, unemployed, underemployed. So I, for one, depart in this conversation from the truism that our system is in need of reform and in need of reform in short order.

So through you, Mr. President to Senator Harris, when I read this Bill one of the questions that comes to my mind is, when would the first real person potentially have the opportunity to benefit from what this Bill provides? Through you, Mr. President to Senator Harris.

The President in the Chair.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. The first answer in a series of answers -- the first person, I believe, starting after 2012 would be the time where you would start to see the actual implementation and people being able to take advantage of the benefits in the delivery system, etc. that SustiNet has to offer because, again, it would take approval and implementation in 2011 by the Legislature to actually

make this the law and to do any appropriations at that point that would be necessary. But, we would again be taking crucial steps to build on all of the actuarial work that has already been done by the Universal Health Care Foundation to build on all of the planning that has already been done by Universal Health Care Foundation and others to implement this.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And I would -- I certainly want to applaud the excellent work that has been done by the Universal Health Care Foundation in providing us with lots and lots of good information and good ideas on about how to address this phenomenon. I do think that waiting for three years is at some level holding out false hope to the people of the State of Connecticut. I get emails and phone calls from people saying I support SustiNet and I hope they're hear three years from now if this Bill passes to be able to take advantage of what it promises to deliver. Through you, Mr. President to Senator Harris, I was wondering if Senator Harris has ever had the opportunity to visit President Obama's website.

Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Not recently, I've been doing a lot of other reading.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Fair enough and it shows because Senator Harris did such a thorough and responsible job in bringing out this Bill. I, because I didn't have to bring up the Bill, had the luxury of going to President Obama's website to get a sense of what he is representing to the people of America. And through you, Mr. President to Senator Harris, would it surprise Senator Harris to learn that President Obama has committed to completing a health care reform bill in Washington before the end of the year? Mr. President, through you, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. No, not only would

it not surprise me but I do know that, as a matter of fact, there are currently proposals, I believe one that's going towards markup which is towards the end of the process in the Congress on federal reform. And that is exactly why -- exactly why in Section 3(b)(16) of the SustiNet Bill that it specifically outlines in the event there's an enactment of a federal health care reform, that this board that we're creating would be required to report to the General Assembly not later than 60 days after enactment on what has occurred so that we can adjust. Again, this is focused, but flexible. Through you, Mr. President.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President and through you to Senator Harris, does he share the understanding that I have that the U.S. Congress is committed to enacting comprehensive health care reform by the end of July before the August recess? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I share that understanding and it was confirmed this week in our caucus room by a visit through one of our former colleagues, now Congressman Murphy, that that is the case.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And when Senator Harris brought out this Bill, I think he rightfully recognized that in order for any reform initiative to be successful all stakeholders have to have a seat at the table. And through you, Mr. President to Senator Harris, does he believe that the board of directors that this Amendment or Bill offers does include representation from all effective constituencies? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. On the 30,000 foot level, yes and that's one of the struggles when we go down a path like this. You want to have a board that has sufficient expertise and perspectives without

weighing down that board. We've seen that happen on our taskforce and many times. So I think the board tries to take a broad cross section. But the crucial thing here, is the board is specifically supplemented by those four committees and those three task forces. So with all of that you're going to have everybody around the table and that is why I made that clear, clear statement that I want to make sure that insurance companies and everybody else are involved in this process going forward.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President, and through you to Senator Harris. Are -- is there representation from the insurance industry on the board of directors in the Bill before us? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

There is not specifically a representative of the insurance industry, but the Minority Leader of the House of Representatives that I assume has fairly

healthy attitude towards the insurance industry is allowed to have someone that has expertise in actuarial sciences and insurance underwriting so I don't know why that spot couldn't be somebody from the insurance industry.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. But -- but it's -- there's no specific -- there's no specific obligation to include someone from the insurance community in this conversation. Is that correct? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. That seems fairly specific to me but, no, it does not say from the insurance industry. And I will just add here that I share the concern and point that Senator Roraback is getting to because, as I said, every stakeholder must be around the table. This Bill, one, can be broadened at some point. But, also, again through those committees and through the taskforces, you're going to

be able to have the best and the brightest from all perspectives around the table.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. Through you, to Senator Harris. Is there representation of patients on the board of directors? Is there a patient representative? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. There is not specifically a patient advocate that is on the board of directors.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And I, for one, think that that oversight is one which is particularly regrettable because, for me at the end of the day any conversation about health care ought to be about the wellbeing of the patient because that's what I think

health care ought to be all about. So we can include insurance representatives or other people but if we leave out the patient, we leave out the person that has the most at stake in this debate. Through you, Mr. President to Senator Harris, are trial lawyers represented on this board of directors? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Specifically, trial lawyers are not on the board. But, again, the board is not the end of those at the table with dealing with the implementation of SustiNet because we have these four committees and three taskforce that will play an integral role in collaboration and consultation with the board of directors.

THE CHAIR:

Senator Roraback:

SENATOR RORABACK:

Thank you, Mr. President. And people might wonder why would trial lawyers -- why would you want to have trial lawyers with a seat at the table anyway. And for me the answer to that question is because when

I speak to physicians and health care providers they tell me that one of the driving factors in -- in raising the costs that all of us in Connecticut pay for health care is that we, as a society, pay for healthcare, is our existing tort system.

And, Mr. President, I don't hold any animus towards trial lawyers, but I think that they're presence on this board of directors might be able to enable us to begin to address a phenomenon which, in my judgment, if we work together -- and I -- I remember the senator who helped adopt their universal health care system in Vermont was here two years ago. And the advice he brought to us was, believe it or not, you have to get people who have never spoken to each other before in the same room, in the same place, at the same time if you're going to have successful health care reform, you have to bring in the trial lawyers and the insurance companies and make them agree on things.

And, Mr. President, by excluding the trial lawyers, I think we close our eyes to one of the things which is causing our country to collapse under the costs of health care. And so I think it's regrettable that there's not representation from that

constituency on the board of directors. And through you, Mr. President to Senator Harris, is there a representative of large manufacturer? When Senator Harris brought out the Bill, he -- I think he wisely reminded us that GM spent more on health insurance in every car they built or used to build than they do on steel. And, Mr. President, through you to Senator Harris, is there a representative of a large manufacturer or someone from the CBIA on this board? Through you, Mr. President.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. No, there is not specifically a member from CBIA, the business industry. But if you look at one of the appointments by the House Majority Leader, there is actually someone with expertise in health economics policies. So again, there are general descriptions that are being made in this to have a workable board, a steering committee if you will. But that could be someone from a business that has that knowledge that's defined in this Bill. But it also, again, works in conjunction with the four committees and the three

taskforces. You can't forget that.

THE CHAIR:

Senator Roraback.

SENATOR RORABCK:

And, thank you. I -- I for one wished that the answer -- I appreciate the answer -- not an answer that could be but that will be. because if we're going to be successful in this undertaking, Mr. President, we have to take people from varying backgrounds. Because there's so much we can agree upon when it comes to what ails our health care system. The CBIA and District 1199 could find much in common because the facts are incontrovertible that our health care system is too costly. It reaches too few people and it -- it is causing us to be uncompetitive in the world and uncompetitive in our own State.

So by deliberately excluding constituencies which are major players in this universe, I fear that this board is not going to come up with a product which is the -- which is -- which represents consensus. But rather the risk is they're going to come up with a product that creates division and debate. And I don't think that's the direction we should responsibly be heading. Through you, Mr. President to Senator Harris

and it pains me because I think this Bill has tremendous promise and I think if crafted in an inclusive way, it could achieve that promise. But when it's limited in its scope, I think we run the risk of setting ourselves up for much less success than otherwise could be achieved. Through you, Mr. President, Section 16 of the Bill creates a taskforce on obesity and through you to Senator Harris, why is that so?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Before I -- I answer if I could just have some liberty because I just want to let the Senator know that I do share those concerns. And I am more than willing to discuss these matters going forward and seeing how maybe we can broaden some of these or -- the board positions to specify that. That's one thing. And the other thing that I just wanted to -- to remind the Senator of is that this will have to come back to the General Assembly. And at that point you're going to be having a full hearing by all the committees of cognizance with all the advocates again working on the final

shape of the legislation. So while I do share your concern and feel that improvements could be made, I also do believe that we can get it done under the current form.

And with respect to obesity, obesity accounts for a huge percentage of our health care costs because it is directly related as I said before to Senator Roraback to chronic disease. As a matter of fact I had a 2003 figure that should -- and this was many years ago that I found actually on the internet so I guess I do go on the internet at some point -- that about 75 billion of all health care expenditures that year were directly related to obesity. And that basically if you take a look at health care inflation over the past two decades, about 20 percent of that health care inflation is attributable to obesity. That is why the SustiNet Plan goes directly towards that problem and doesn't avoid it.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I -- I very much appreciate that answer and that was kind of the answer that I was expecting that we're including obesity in

the Bill because it is an area that consumes a lot health care resources. And through you, Mr. President to Senator Harris, Section 17 has a taskforce on tobacco use. And would it be fair to say that we put a taskforce on tobacco use in the Bill because tobacco use is also one of the things which drives our health care costs and which, if we think about it responsibly, we have an opportunity to bring down health care costs if we reduce tobacco use and educate people about tobacco us. Through you, Mr. President, is that why that's in the Bill?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes, I believe so.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And in an effort to build upon those wise provisions on this Bill, Mr. President, the Clerk has an Amendment which is LCO 8900. I would -- if the Clerk could please call the Amendment and if I might be permitted to summarize.

THE CHAIR:

Would the Clerk please call LCO 8900 to be designated Senate A?

THE CLERK:

LCO 8900 which has been designated Senate Amendment Schedule A as offered by Senator Roraback of the 30th District.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

I move adoption.

THE CHAIR:

The question before the Chamber then is adoption of Senate A.

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. My understanding of what this Bill -- the guiding principles of this Bill are access, quality, and affordability. And through you, Mr. President, looks like Senator Harris -- I'll give him a minute to get his hands on this Amendment or I can even share my copy -- but through you, Mr. President, to Senator Harris. Is it fair to say that access, quality and affordability are the (inaudible) stars of this Bill?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. In addition to cost, affordability -- you got there -- for quality and coverage, yes.

SENATOR HARRIS:

And thank you, Mr. President. And to the extent that the tobacco provision and the obesity provision go to cost, what -- what this Amendment does, Mr. President is to address both quality and cost. And when you control cost, access becomes more achievable. Mr. President, what this Bill does is create another taskforce to focus on developing evidence based medicine. Mr. President, through you to Senator Harris, is he familiar with the term called defensive medicine? Mr. President?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes.

SENATOR RORABACK:

And through you, Mr. --

THE CHAIR:

Senator Roraback.

SENATOR HARRIS:

Through you, Mr. President, to Senator Harris. In his mind, what is the term defensive medicine mean? Through you, Mr. President, to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. In my understanding that is when health care professionals perhaps take certain actions that may be additional tests; prescribe maybe differing prescription drugs in an attempt to shield themselves from liability.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. And I have a common understanding about that term and through you, Mr. President to Senator Harris, would he agree that defensive medicine has the effect of driving up health care costs irresponsibly? Through you, Mr. President to Senator Harris.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes. And that is why I was very happy despite the fact that I am a lawyer that the -- the initial Bill of SustiNet so it's still in the hopper with respect to what this Plan is getting at -- directly address that through some reforms to prevent defensive medicine.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

And thank you, Mr. President. I -- I, like Senator Harris, found that provision of the Bill to be particularly promising and I'm glad that Senator Harris liked that provision because this Amendment includes that provisions.

Mr. President what this Amendment does is create a taskforce to come up with standards which would enable us to provide immunity to providers who follow best practices. Mr. President and -- and this is all about quality. What we want to say to our physicians and our providers and -- and -- is this is how you do things right. And if you do things according to the book, you don't have to worry about being sued.

Now, Mr. President, to help Senator Harris, this

Amendment doesn't contain the immunity provision in the body of the Amendment but rather it creates the committee to devise those best practices which we could later inoculate health care providers from liability if they were to abide by these best practices. So through you, Mr. President to Senator Harris, does he think this is a good idea?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. Yes. I do support that concept that you have in your Amendment. As a matter of fact, if you take a look, Senator Roraback, at Section 7 of the Bill which does establish under the current draft a health care provider advisory committee. It's all about clinical care and safety guidelines. And one of the pieces that the Bill specifically says that the committee shall continually access is the quality of evidenced related to the cost, risk and benefits of treatment and guidelines. So I really think that your good concept is right in this Bill here.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President, and through you to Senator Harris. Does he think this would be a better Bill if we were to let the provider community know that if they follow these standards they will have the benefit of being protected from lawsuits?

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Through you, Mr. President. I think that the Bill contains this concept already as I said and that this would be the exact job for the board of directors for the committees that are formed under this Bill and the taskforces to actually flush out the specific provisions going forward which then would be in the form of legislative recommendations and brought to the General Assembly in 2011. So I believe under this Bill the health care provider community will have that very notice and comfort that Senator Roraback so rightfully seeks.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I -- I would ask that

we have a roll call on the Amendment.

THE CHAIR:

The request is for a roll call. When the vote is taken it will be taken by roll. Senator Roraback, do you have the floor.

SENATOR RORABACK:

Thank you, Mr. President and I -- I'm just looking at this Amendment and I think I'm realizing that the -- that the Legislative Commissioner's Office did not draft the Amendment that I requested and that this Amendment may, in fact, be the language that it's in the underlying Bill. So I've just signed the correct Amendment and so I will -- with the permission of the Chamber -- I would withdraw this Amendment and wait until the correct Amendment is before us.

THE CHAIR:

I believe the request is to withdraw Senate A without objection. So ordered.

SENATOR RORABACK:

Thank you, Mr. President. I -- and I've just signed the Amendment so I'll just wait a minute. When it's been distributed I'll offer the real Amendment. Thank you, Mr. President.

THE CHAIR:

Senator Meyer.

SENATOR MEYER:

Thanks, Mr. President. I think it's quite remarkable that in this Chamber whether you're a Republican or a Democrat that each one of us is talking about the great importance and priority of health reform. We -- we tried that last year with some promise in the Charter Oak Program proposed by Governor Rell and unfortunately that has not been well -- it has not worked well.

Today we have had two proposals before the Senate, one the Health Partnership proposal and the second is SustiNet. I may have missed something but I don't know of any other reform proposals that are before the Connecticut State Senate except for the Health Partnership proposal and SustiNet. And I have had issues with SustiNet. Senator Harris and I indeed have chatted through some of my concerns.

What SustiNet does though and why I'm going to support it and would urge people who may be on -- still on the fence about it to support it -- is that it confronts the three major factors of health care reform. It confronts access and remember we have 350,000 people in Connecticut who have no health

insurance. It confronts cost and our cost is highest -- highest in the country or close to highest in the country and it confronts quality and we believe there are quality of medicine and health care in Connecticut is good.

Also, the Bill gives us choice. In discussion just today with representatives of the Governor's office, I -- I focused again on the importance of us having choice and choice is competition. I'm a big rooter for the private insurance -- health insurance companies to give us good health care that's affordable and that's accessible. But SustiNet will give us a further choice.

And finally I urge support of this Bill because of the process as Senator Harris has well articulated. It's not a process that's going to -- it's going to grab us this year in 2009 but it's a process that's built upon thought, taskforce, reporting back to the General Assembly and to the Governor and moving forward step by step over several years. So on balance, this is an important proposal. It's the major game in town as we say. It's something that we have to consider because health care remains so important to every citizen of Connecticut. Thank you,

Mr. President.

THE CHAIR:

Thank you, Senator Meyer.

Senator LeBeau.

SENATOR LEBEAU:

Thank you, Mr. President. I rise very briefly to endorse this concept. I'm very pleased with the -- where this Bill has gone and what it has become. I was afraid that similar to Senator Meyer and his remarks -- and I'd like to endorse his remarks -- similar to the good Senator's remarks that perhaps we're getting in front of ourselves; perhaps we -- we were going to be out there so far in front of the nation that we would raise our costs in Connecticut and make ourselves uncompetitive with other states.

But I'm pleased with what the -- what is currently in the Bill and this path that it is bringing us down which is a path that hopefully will intersect with the larger -- or maybe it's a stream -- maybe it's a small stream that will intersect with the -- the larger river of health care reform that is about to take place at the federal level. And I think that this Bill positions us well for that intersection; that we will be ready in Connecticut to

take advantage of a federal plan; that we will be able to utilize the resources that will be available from the federal government; that we will -- that we will have the kinds of technologies in place that are needed and that we will without hesitation move ahead to be in line with the federal legislation and to allow the best health care that we can get for the citizens of our State.

And I want to thank Senator Harris for bringing this out and for working on this. I know there has been some difficulties and it's been a tough Bill to work on and I appreciate all his efforts over the past months. He has done a great job and we are very appreciative in the circle. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator LeBeau.

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. For the second time, the Legislative Commissioner's Office has happily returned the Amendment as I had intended it be and the Clerk has the Amendment which is LCO Number 8909. Will the Clerk please call the Amendment and might I be permitted to summarize?

THE CHAIR:

Will the Clerk please call LCO 8909 to be designated Senate B?

SENATOR RORABACK:

Thank you, Mr. President.

THE CLERK:

LCO 8909 which has been designated as Senate Amendment Schedule B as offered by Senator Roraback from the 30th District.

THE CHAIR:

Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I move adoption.

THE CHAIR:

Question before the Chamber is the adoption of Senate B.

SENATOR RORABACK:

Thank you, Mr. President. The points that I made in the earlier (inaudible), I won't restate. I will stand by them.

Mr. President, what this Amendment does is that it encourages us to develop a body of best practices for the health care provider community and it says to that community if you adhere to the best practices,

you don't need to fear liability from law suits. But it also says to patients who are -- who suffer adverse outcomes even when best practices are observed there will be a no fault compensation scheme for you. So, Mr. President, this passage of this Amendment I think will take us very far towards reducing health care costs, improving quality and therefore improving access.

I urge members to support the Amendment and I ask when the vote is taken it be taken by roll.

THE CHAIR:

The request is for a roll call vote. A roll call vote will be taken at the time.

SENATOR RORABACK:

Thank you.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

Thank you, Mr. President. I rise in opposition to this Amendment. I do actually support the intent of the Amendment. I think it's a very important issue and ultimately any effective health care reform will have to deal with, in some way, shape or form, the issue of defensive medicine.

The reason that I oppose this is that because I think this is actually in the Bill. And as I try to impress upon the circle when I describe the Bill, this is a focus Bill and yet it is flexible. This is picking a path and allowing this board of directors, the four committees established and the three taskforces to put meat on the bones. To be able to further develop and drill down on these important issues and I think Section 7 from a larger or a higher level, 30,000 foot perhaps or maybe just 15,000 in this case, actually gets to this issue.

I will also say that because of that I really do like the flexibility. There is another Bill, Senator Meyer actually, that I introduced, Senate Bill 678 that involves the establishment of a public utility model to deal with chronic care management and care coordination; something which I believe is also generally within the prevue of this Bill and will be considered going forward.

Part of that Bill had the concept of shared decision making which is a new way to look at the doctor patient relationship; much more of a give and take; much more consumer friendly. And there are certain safe harbors within shared decision making.

And I think that should be on the table, too. And that's why I don't think we need to limit the way we're going with a specific Amendment like this but we should leave it to the best and brightest around the table going forward to get this done. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Amendment B? Will you remark further?

If not -- Senator Harris.

SENATOR HARRIS:

I asked for a roll call please, Mr. President.

THE CHAIR:

Absolutely, I heard that. Thank you. If not Mr. Clerk, please call for a roll call vote. The machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber? Immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber.

THE CHAIR:

Have all Senators voted?

If all Senators have voted -- if all Senators have voted, please check the board to make sure your vote is correctly noted. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of Senate Amendment Schedule B.

Total number voting	35
Those voting yea	11
Those voting nay	24
Those absent not voting	1

THE CHAIR:

Amendment B fails.

Senator McKinney.

SENATOR MCKINNEY:

Thank you. Mr. President, here we are on a Saturday. One of the rare Saturday sessions in my 11th year in the State Senate debating what may be one of the more important issues of our day and a Bill before us which may probably be outside of a budget the most expensive single proposal that I've ever had the opportunity to vote on.

Clearly, Mr. President, all of us in this circle,

all of us in the State of Connecticut, look for the day where we have a better health care system, a less costly health care system and a health care system that provides coverage -- sorry, Mr. President I was having a hard time hearing myself.

THE CHAIR:

Senator McKinney and I are having a tough time hearing each other. If we could bring the noise level down in the Chamber, I would greatly appreciate it. Thank you. Senator McKinney.

SENATOR MCKINNEY:

Thank you, Mr. President. Clearly, we all look forward to a day that all of us in this State and in this country have health care coverage. It is in many ways a basic right of all of us.

The Bill before us is more than just a study, however. The Bill before us is clearly designed to implement the SustiNet Plan. A plan, quite frankly, that does look similar to some of the plans and much of the discussion that's happening down in Washington, D.C. I think we should use those deliberations down in Washington as our guide. There is confidence in our nation's capital that our President and our Congress will finally move on an acting comprehensive

health care reform.

One of the evidences of that confidence is the fact that the President himself had at a meeting at the White House insurance industry representatives, hospitals, doctors, pharmaceutical companies, labor unions. All of the players necessary to reach agreement in our health care system were invited by the President down to a meeting at the White House. And we have not done that in this proposal. We have not had all of the players at the table and we do not put all of the players necessary to accomplish this goal.

And that is somewhat surprising. As one who has been an often harsh critic of some of our managed care companies, we are home in the State of Connecticut to managed care companies that employ over 25,000 people in our State. It's an important business, nonetheless, yet President Obama invites them to the table for a seat to discuss health care reform and we, in Connecticut, don't. Another message that we send to businesses and employers in this State that you're not really wanted.

That's a surprising turn of events for this proposal before us. Senator LeBeau and others,

Senator Meyer, I believe, talked about not being too far out in front of what the rest of the nation is, but I think the question is why are we out in front of what President Obama and our Congress is looking at? Why aren't we putting together a team of all players at the table; the best and brightest minds not to implement SustiNet but to monitor what is happening in Washington and be ready upon immediate passage in Washington to implement that plan here in Connecticut. That would perhaps be the better way to go.

We have a pretty good health care system in Connecticut -- better than most. Over 90 percent of our people do have health coverage. Our first responsibility, I think we've all talked about this, should be to make sure that -- that those that don't have health care coverage, whether it's 6 percent to 10 percent, get health care coverage. That should be the first responsibility of this Legislature. We should start with our children. We tried to do that with HUSKY and then work on to parents families.

With respect to the 90 percent plus that do have health care, clearly there are issues related to access. Clearly there are issues related to cost. We have all seen skyrocketing costs in health care over

the last decade. But I think it's fair to ask the question under the SustiNet Plan, why do we throw out what's working for so many of that 90 plus percent in order to get a system that captures the remaining percentage who have no health care coverage.

Several have talked about the ability to compete and that competition is good. Senator Meyer referenced that. I agree with him completely. And there are so many good things to this SustiNet Plan. But I also think when you combine massive public subsidies, you have unfair competition. You tip the scales too far in one direction so that in many ways you really don't have the choice that we all want. We see that a little bit. I won't digress too much but we see that a little bit in our public financing. Most of us chose to do because the restrictions on your choice not to are so prohibitive.

So while there is a choice, while there is competition, I don't think the playing field is exactly level. And I would like to see a level playing field where we in government could have a product that provides coverage and would compete with the private sector because that would both improve our product and the product offered by the private sector.

There is clearly much concern about the cost. Senator Harris mentioned $900 million. Senator Debicella addressed the costs and the fact when you look at many of the good things from the medical records and the like; the prevention issues; things that we've all worked on; the cost could be far in excess of a billion dollars. Now that cost doesn't happen in 2010 and it doesn't happen in 2011. But that $1 billion at a minimum cost happens in 2012. Well isn't that just as bad? What's going to happen to this State in 2012? We will have $1.4 billion of our rainy day fund that we will use for our biennium budget. That's $1.4 billion of a budget that we won't have the money, a hole that will be there in 2012. We have over $2 billion in federal stimulus money that I think even those of us who are most hopeful about what may happen down there, can't assume is going to be there for the State of Connecticut in 2012. So we're looking at a minimum of $3.4 billion hole in 2012 and that's when we come in and say we're going to spend a billion dollars on SustiNet or more. Those are scary numbers and that's why I rise to oppose this because I don't know that we can afford it at this time.

I just want to share with you one last

conversation I had. Our family, my wife and our three kids, had an opportunity to go Quebec City this winter for our kids' February break. My son was staying (inaudible) with a family in Quebec while he was playing in a hockey tournament -- stayed with them for 10 days. It just so happened that he was actually staying with an American family, a couple that was from Vermont and he was Vermont. She was Colorado. They moved to Quebec City to open up a business, a bed and breakfast and they were raising their three kids. And we had a conversation about the health care system in Canada. And they were excited when they moved to Canada.

They had two children, a third on the way. They were excited and comforted that they knew once they arrived they had health care coverage. They knew. It was universal, single payer, government provided health care and that was very important to them. But it didn't take long until they saw the many shortcomings of that system. And they described at dinner the differences between our respective systems. And the principle one being that in a government run health care system, in a mandated single payer system, you're treated as expenses. You're treated as

expenses. So I said, well what do you do when your son or daughter is sick? And they said well it'll take about three weeks to get her a doctor appointment. So you have to engage in triage.

Now clearly there are many people in our system especially those -- even those with coverage -- that can't get to see access to their doctor quickly. That's why we've tried to over the years increase reimburse rates so people on HUSKY and the like can get to see their doctor. But imagine that. And then they talked about the more dangerous aspects of the system upon in Canada. And that is if you're someone that has a terminal illness, someone with cancer. And they knew a very good friend who had cancer who had to wait over eight months to see a doctor and get treatment -- over eight months. And that's why we hear and it's not anecdotal, it's true. So many people north of the border move down to the United States to pay for those types of treatment. But guess what, only those you can afford it can do it.

And it was a remarkable conversation and it informed me very much on this plan because there are some good parts to this. I was open-minded in my first examination on this. And I would encourage all

of you as we gone down this road, as our nation goes down this road; find somebody who lives in a country with universal single payer health care. Talk to them about their system and I bet you, I bet you that despite all of our faults here, you will come away with the conclusion that the system we have here for all its flaws is much, much better. And that's why I think right now this is the wrong bill at the wrong time. It's going to cost us too much money and there's no need to jump ahead of what Washington's going to do. We should be prepared to implement what Washington is going to do. Thank you.

THE CHAIR:

Thank you, sir. Will you remark further?

Senator Prague.

SENATOR PRAGUE:

Thank you, Mr. President. Mr. President, I rise to support this concept. I support it very strongly.

We have so many people in this State that don't have health insurance that we basically pay for because they need to have health care when they're sick. The cost of our health insurance premiums is substantially higher because the cost to care for the uninsured is included in the cost of our premiums.

When are we going to take this issue seriously? When are we as a Chamber going to begin to recognize, both Republicans and Democrats, that this is a huge problem for our State. The uninsured are not getting their health care free. Each and every one of us is paying for it and it is time that we tackle this issue and did something about it.

I'm hoping that this Chamber will come together and support this issue. It's a critical issue for us and the time is overdue. Thank you.

THE CHAIR:

Thank you, ma'am. Will you remark further?

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President, very briefly. It's imperative that I just comment on the leadership of Senator Harris and regards to this legislation and also our former colleague, Ron Figaro and his staff. And when you put everything on the table and look at the final product, it really is a brilliant piece of work. While there are still some questions to be answered, we have the time to do it and I think it's a great beginning to an issue we've been addressing too long. Particular as the number one insurance state in

the country, we should be the number one state in insurance coverage. Thank you, Mr. President.

THE CHAIR:

Thank you, sir. Will you remark further? Will you remark further on the Bill?

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Speaking in support of the Bill, first of all, I wanted to greatly commend Senator Harris and the other advocates who have -- have brought this forward and been working on this -- this concept for a considerable period of time. And, Mr. President, there are a number of important principles in this SustiNet Plan and I think that it has a number of pillars that are important.

First of all, it has the goal and principle that health care coverage should be universal and should be continuous and be affordable both to individuals and to families and health insurance strategy should be affordable and also sustainable for society and should enhance health and well being by promoting access to care that is high quality, effective, efficient, safe, timely, patient centered and equitable.

So as Senator Harris said in bringing out the

Bill, Mr. President, the pillars are responsible cost, access, quality and coverage. Those four essential principles need to be met and this Bill provides for a holistic approach to move toward that goal. It contains an opportunity to build and -- and fully develop ideas and work and actuarial analysis that have gone forward. And it does create another -- an alternative. It is not a -- it does not compel everyone to be enrolled in a -- in a single system; creates an alternative and is also not true that there is a single mandated benefit level or -- and there will also be obviously options for variable pricing as -- as we go forward.

Again, the federal government, as we know, is -- is undertaking a reform plan of its own the outlines of which are only gradually beginning to take shape that President Obama is advocating and is providing leadership to Congress and moving forward on. And clearly, the federal debate may ultimately be compelling and may in the end be more controlling in terms of ultimate policy making.

But what this Bill will allow us to do is to -- is to prepare to move forward and be ready for a reform system so that by January 1st of 2001, we will

have legislative recommendations on all of the policy areas that Senator Harris noted in outlining the Bill at the beginning.

So it is, I think, a significant initiative. It is one that does provide for -- for long range planning. Obviously, deals with one of the most compelling issues of our time and that is -- is health care; the affordability of health care; access to health care; reasonable cost. We know that one of the great concerns is that the system has to -- we have to find some way to control cost within the system and at the same time provide quality care and access to care so that we want to have the advantages of a system that -- that meets a very high level of obligation on all of those and all of those principles, not just a few of them. And that's why it is so difficult to find a system that -- that is both high quality and affordable and also is responsible in terms of controlling costs.

So this proposal will help us move toward that goal incrementally over a period of time and that by 2011, again, the board of directors that would be set up under this Bill, will have to make legislative recommendations in all of these areas. And it is

important again to remember that the proposal still all must come back to the General Assembly, that all stakeholders will have a place in the deliberations and the negotiations in this collaborative process.

So, again, I want to thank Senator Harris and the -- and the number of others who have worked on this issue and urge passage of the Bill today. Thank you, Mr. President.

THE CHAIR:

Thank you, sir. Will you remark further?

Senator Williams.

SENATOR WILLIAMS:

Thank you, Mr. President. I rise to support the SustiNet Bill that's here before us, also to thank Senator Harris, Senator Crisco and everyone who's worked on this. You know there have been advocates. There have been folks from the private sector, health care professionals, whole variety of people who've been very concerned over many years about our health care system in this State and across the country. A consortium of folks related to the insurance industry put out a report a few years ago said that in 19 -- in 2006, in the State of Connecticut, we spent about $23 billion on health care.

We know that there are inefficiencies in our health care system. We know that there can be vast improvements in the delivery of health care to everyone who needs it in the State of Connecticut. I'm encouraged that there are exciting things that are happening in Washington, D.C. I'm encouraged that President Barrack Obama has made this one of the top priorities as he goes forward searching for a national solution. But at the same time we can't ignore the problems, the waste, the inefficiency in our system here in the State of Connecticut and the fact that hundreds of thousands of folks in this State go without health care because they do not have health insurance right here in the State of Connecticut.

The SustiNet Bill points us in a direction where we will address the inequities, the inefficiencies, the waste and the lack of opportunity for all to have quality health care in this State. In addition, while it provides choice, it also is part of a package of health care legislation. Earlier today, we voted on the Partnership Bill otherwise known as the Pooling Bill and I want to thank Senator Crisco and others for that.

Senator Harris has also worked on a number of

health care cost containment bills because he is right and I agree him and the SustiNet Bill agrees with this concept that we cannot sustain an increase in accessibility to all unless we reduce the costs and ring out the waste and inefficiencies in our health care system. So I look at this as one piece of a variety of bills and legislation moving forward this session that will reform our health care system; that will make it more efficient and increase access to all. So for all those reasons, Mr. President, I support the Bill before us. Thank you.

THE CHAIR:

Thank you, sir. Will you remark further on the Bill? Will you remark further? If not, Mr. Clerk, please call for a roll call vote. The machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber? Immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber?

THE CHAIR:

Have all Senators voted?

If all Senators have voted please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on passage of House Bill 6600 in concurrence with the action of the House.

Total number voting	35
Those voting yea	23
Those voting nay	12
Those absent not voting	1

THE CHAIR:

The Bill passes.

Mr. Clerk, will you call -- Senator Looney.

SENATOR LOONEY:

Mr. President, there is no further action --

THE CHAIR:

Okay.

UNKNOWN VOICE:

--(inaudible).

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes, thank you, Mr. President. We might stand at ease for just a moment preparing a couple of other

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GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2009

JUNE
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So, Senator Looney, you -- oh, it's here. The Senate will stand in recess.

On motion of Senator Looney of the 11th, the Senate recessed.

The Senate reconvened, the President in the Chair.

THE CHAIR:

The Senate will come back to order. Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Thank you very much. Mr. President, the Clerk is now in possession of Senate Agenda Number 5 for the reconvened session of the 2009 General Assembly.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Mr. President, Clerk is in possession of Senate Agenda Number 5 for the reconvened session of the 2009 General Assembly dated July 20, 2009, business from the House, substitute House Number 6600, AN ACT

CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr. President, I move all items on Senate Agenda Number 5, dated July 20, 2009, for the reconvened session of the 2009 General Assembly to be acted upon as indicated and that the agenda be incorporated by reference into the Senate Journal and the Senate Transcript.

THE CHAIR:

There is a motion on the floor to move all items on Senate Agenda Number 5. Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Yes. Thank you, Mr. President. On Senate Agenda Number 5 if the Clerk would call, under business from the House, substitute House Bill Number 6600.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Mr. President, item Number 1 on Senate Agenda Number 5, substitute House Bill Number 6600, AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN,

Public Act 9-148.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr. President, having been on the prevailing side on that vote when it was passed in this Chamber, I would move for reconsideration of substitute House Bill 6600, Public Act 9-148.

THE CHAIR:

There's a motion on the floor by the prevailing side to reconsider House Bill 6600. Without objection, so ordered, sir.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr President, I would yield to Senator Harris for purposes of a motion to repass the bill.

THE CHAIR:

Senator Harris, do you accept the yield, sir?

SENATOR HARRIS:

I will, Mr. President.

THE CHAIR:

Please proceed.

SENATOR HARRIS:

Thank you, Mr. President. Good afternoon.

THE CHAIR:

Good afternoon.

SENATOR HARRIS:

Mr. President, I move to repass Public Act 9-148.

THE CHAIR:

There's a motion on the floor to repass House Bill 6600. Without objection, please proceed, sir.

SENATOR HARRIS:

Thank you, Mr. President. We had some very detailed and good debate on this bill back at the end of May. So I just want to briefly go through the reasons that Governor Rell vetoed this bill and then talk about those.

Basically, there's a seven reasons. First the Public Act 09-148, enacts SustiNet, this plan. That's actually not accurate. No plan is implemented or enacted today when we override, if we override this veto.

All we do is move aggressively forward to lower the costs of health care, increase access and expand coverage for uninsured. The public act just requires that a board supported by four targeted committees and three focused task forces to make recommendations to

the General Assembly by January 1, 2011.

At the earliest, even assuming we go through all of that and there, the General Assembly makes -- takes those recommendations, creates bills, goes through the public process and the committees and passes bills into law and the Governor accepts those as law -- at the earliest, SustiNet will not go into effect until July 1, 2012. So there'll be another session even after the 2011 session. So it does not implement it.

Number two, that this public act commits the state to $1 billion in spending. This also is not accurate. Even assuming that the Governor's figures are correct, and there's some differing opinions on that, the public act does not require us to budget anything in this biennium. It budgets nothing. Zero.

Again, only recommendations are made, and it's up to a future Legislature or Legislatures to implement and budget as they see fit. It also -- it's important to note that by just throwing out the $1 billion of potential cost, it ignores the fact that SustiNet, as the plan is contemplated and again, if implemented in the future, would save individuals, families, businesses $1.7 billion.

Number three, that the public act doesn't include

any measures aimed at reducing the cost of health care. This also is not accurate. The Governor and some others and seem only to focus on the public option as described in this bill, but the lion's share of the bill, what really -- everybody agrees on, I'd have to say -- 60, 70, 80 percent of the bill involves health care cost containment.

There's a health IT piece, a medical home piece, health care quality piece, and preventative care piece. All of these have committees that will have experts on it to design a plan that will deal with lowering the cost. In addition, some of the main cost drivers that we know to our system, obesity, tobacco use -- there are task force that are focused on dealing with the costs of these conditions. And it also contemplates and the plan will move forward on these recommendations, if passed by future Legislatures, to increase our federal revenues to lessen the burden of health care on Connecticut taxpayers.

Number four, the act presumes the outcome of the national debate. While we do move aggressively in a direction to make sure that Connecticut is aligned with the federal government, to make sure that we make

progress on this issue of health-care reform, an issue that affects individuals, families, and we know the economic drag associated with it, it doesn't actually pick a path that's written in stone. There's flexibility within this bill, recommendations created with broad participation, boards, committees and task forces that will have an eye on federal reforms.

As a matter-of-fact, Mr. President, in the event of enactment of federal reform this public act specifically says that the board must submit recommendations within 60 days to the General Assembly to be able to deal with those reforms.

So we are not ignoring the national debate. We are aligning ourselves and making ourselves ready with the outcomes of that important debate. It's also the charge of the board to make optimum use of opportunities created by the federal government for securing new and increased funding, including increased reimbursement. So we all know how our underfunding of our health-care professionals has had a negative effect on our ability to deliver health care.

Number five, the act gives away authority to establish health-care policy which should be retained

by the Legislature and the executive branches. Nothing is given away by this bill, by this law. Only recommendations which will require future legislative and executive action. So we will be able to figure the appropriate mix in future sessions as we move this important, this crucial ball forward.

In the debate, and this is a good point that the Governor makes in her veto. It's one of her points that we missed the ball on the establishment of the board and having all parties at the table.

And, if you recall, back at the end of May, I did express disappointment at the way this went forward, and I thought that certain parties that should be involved were cut out. We need to bring all stakeholders together. I agree with the Governor; it will take the General Assembly, the Governor, the House and Senate, both sides of the aisle. It will take health-care professionals, business, labor, health care experts, our insurance companies, but it's not too late to bring people back to the table.

As a matter of fact, the reason that the Governor gives here for vetoing the bill, that the board is not complete, actually really isn't true, because if you look at the makeup of the proposed board, you have a

slot for expertise and employment, health benefits, one for plans for small business, one, an expert in health economics, another, someone with expertise in health information technology and another with particular knowledge of actuarial sciences or insurance underwriting.

So within these slots you have the ability to put all the stakeholders together. And of course, this doesn't take into account the fact that we have the four committees that are dealing with cost prevention and the task force that will also do that. Sufficient slots for everybody to be at the table.

Finally, the Governor expresses some fear about what this bill means, this law will mean to the jobs here in the state of Connecticut, our very important insurance industry. We have people out there working hard, making a living, paying taxes at these jobs. It's a good point also by the Governor. And of course, we must protect these jobs.

One thing is very important, and this law shows it, is that we have a whole other area of job creation here in the state of Connecticut, and that's in our health-care workforce and a specific task force committee is set up to deal with expanding these types

of good jobs for the people of Connecticut. And I would say, and as someone who would be overseeing this on the Public Health Committee and making sure that the board, the committees and task forces do their jobs, that we will, of course, implement only a plan that is very sensitive to our insurance jobs, to the people living as our friends, families and neighbors in the state of Connecticut.

Yes, last week it was reported by the Families USA, it was a July, of course, report that estimated the number of people that will lose coverage between January of '08 to January of 2010 would be in Connecticut alone, close to 50,000 people. 50,000 people. That's about 310 per week, 1,350 per month. Over 60,000 a year.

These figures again, show that the time is now to act, to move the ball forward, as Senator Crisco would remind us to do.

So the time is now, and this bill does it; therefore, I urge an override of the Governor's veto.

THE CHAIR:

Thank you, sir.

Will you remark further on the repass of House Bill 6600? Senator Debicella.

SENATOR DEBICELLA:

Thank you, Mr. President. Mr. President, I thank Senator Harris for his continued passion and commitment to health-care reform, but the SustiNet plan before us today fails to deliver real health care reform and instead moves us one step closer to a Canadian style government-run health-care system.

Very specifically, there are two large problems with this bill. First is it will cost 1 to 2 billion dollars a year starting in 2012. And second, and even worse, the bill will not accomplish what it claims to accomplish and misses out on an opportunity.

Let me address both of those. First, the costs. Senator Harris quite rightly says that this bill does not cost anything in the next two years. However, it presupposes the answer that will be recommended for 2012 implementation; namely, the creation of a new public health-care plan to cover the uninsured, one that will be subsidized by taxpayers.

What does that mean? That means that 94 percent of us with health insurance will pay for the health insurance of the 6 percent of folks who are uninsured, and that is clearly the intent of the core part of the SustiNet plan, what Senator Harris has called the

public option.

The problem of it -- with this is that the cost to middle-class families for a billion to $2 billion a year of increased government health care is $1,000 a family. That's on top of the $1,000 per family tax increase that this body passed for this year's budget. So congratulations. You've got a $1,000 a year tax increase. SustiNet is going to deliver another 1,000 in 2012.

What to get for that $1,000? Even proponents of SustiNet say maybe you cover 2 to 3 percent more people. It's not going to cover 100 percent of the people. So for a massive cost, does not reach the very goals it purports.

Even worse, we have an opportunity to do real health care reform right now, and Senator Harris correctly noted there are some good parts to this bill. There are parts that actually address the rapid health-care inflation that is going on right now and squeezing middle-class families.

Because the problem for 94 percent of us is that escalating cost is killing our wallets. Families USA estimates that health-care premiums, the amount that families pay in premiums have gone up 119 percent in

the last ten years, compared to 29 percent per general inflation. That's the health care crisis in America in a nutshell because the middle class is getting squeezed, and those without insurance can't afford it.

And Mr. President, the Republicans offered an alternative during the session, one that we believe would have lowered costs and would actually have allowed more of the insured to be covered. And we offer this in several parts.

Our prevention tax credit to give families who get preventative medicine in tax incentives to go and get that done and save the system cost, mandate reform to allow people to actually choose which mandates they want to be covered for rather than forcing them all on everybody in Connecticut.

The Charter Oak plan, introduced by Governor Rell to offer a low-cost alternative for folks who don't have insurance. And malpractice reform to stop the escalating cost caused by the continuing proliferation of court cases surrounding health care.

Mr. President, our choice is clear. We can either fix the current system of health care we have through cost containment or expand government health care at middle-class taxpayer expense. To me, the

choice is very clear. We need to focus on cost-containment, not implement the so-called "public option" that will cost a billion dollars a year. We need to get serious about health care reform now, not be passing the buck on to middle-class taxpayers two years from.

So, Mr. President, I opposed the attempt of override and encourage my colleagues to sustain the Governor's veto.

THE CHAIR:

Thank you, sir.

Will you remark? Senator Kane.

SENATOR KANE:

Thank you, Mr. President. I too rise in opposition of this bill. I voted against it when it came up early on, and I will vote against it today.

I don't think a move towards universal health care is the answer. We all know that health-care reform is necessary. I mean, that's obvious, and I do believe that the federal government is taking it on as we speak. I commend President Obama. That's been one of his first goals since becoming elected is to tackle this health-care issue and this health-care reform issue. And I think it will get done on the federal

level, so I think we're kind of putting the cart before the horse at this time, trying to do something on our own when we could take advantage of what the federal government does very shortly.

I do agree with Senator Debicella when he says that the costs are close to a billion dollars a year. Ladies and gentlemen, that's with a B, $1 billion a year, estimated by OPM.

Our own Office of Fiscal Analysis also said it could be as much as $530 million a year. So we are talking about big numbers. Let's not kid ourselves. We claim that, you know, this is years down the road and it's just creating a board at this point. We are talking about real numbers here. We haven't even contemplated the fact that many employers could drop their health care coverage and take advantage of this which means even greater costs. So we haven't even taken that into consideration.

There's really, in this proposal, no measures to reduce the cost of health care. All we're doing is shifting the burden just to who pays. That's all we're doing. We're not really tackling the real issue of the true problem here with health care coverage -- is the cost of health care, and we are not doing that

at all.

There's no analysis of the costs in this bill. We have not taken a look at the costs of this bill. We are underwriting something that we truly have no idea of the kind of expenditures that are going to come out of this. I do believe, as I said, the federal government is working on this, and they will take care of this.

I think the Governor herself has proposed a board that's a Connecticut Health Care Reform Advisory Board, which would kind of do what this is doing with inclusion of the health-care industry, the hospitals, the business industry, the insurance industry. You know, we forget that we are sitting in the insurance capital of the world right here in Hartford Connecticut. There are 22,000 people that work in the health-care industry in the state of Connecticut, and I think we are forgetting that and we are going to jeopardize those employees if we pass this bill today.

The executive branch is not included in this proposal. There's nothing that allows the Governor and the executive branch -- OPM, the secretary of OPM should be involved in this proposal. And there's just too many holes in this.

I think what we're doing is creating a board that has an unelected -- people on it to be in charge of billions of dollars. And in this economic climate, the way that we are -- we have an $8 billion deficit standing over our heads, hanging over our heads here. This is the wrong thing to do, and I will be voting in opposition of this. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator Kane.

Senator McLachlan.

SENATOR McLACHLAN:

Thank you, Mr. President. I rise to oppose this measure. I believe that the effort of our esteemed colleague on the Public Health Committee is laudable, and I urge you to continue the discussion about health insurance reform.

But I do believe, my fellow colleagues, that this is a race down the wrong road. And I say so because the federal government, as we speak, at the urging of President Obama is working diligently for a national health care initiative. And I don't believe that the SustiNet plan is on the same track as the federal government, and if that is the case and our plan here in Connecticut is not following the same track, we are

going to crisscross and crash, and it makes no sense for us to be committing Connecticut taxpayer dollars with an empty promise.

This is an empty promise. This is not health-care reform until 2012. You're not talking about actually covering someone for their health care until 2012, and its local Connecticut taxpayer dollars that you're committing for this big effort when the federal government is already talking about doing the same thing. So why is Connecticut's General Assembly rushing to do something that the federal government is going to trump you, apparently, in August if President Obama gets what he's asking for out of the United States Congress. So I urge you to reject this.

I say that if we're going to create a new authority by this General Assembly that is going to be responsible for billions of dollars and those individuals are supposed to be effecting health-care in Connecticut, but you're not including the health-care industry in the decision-making process, well, that doesn't make any sense. No health-care providers, no hospitals are included in the decision-making process. It -- this doesn't make sense to me. I believe the federal government

discussion is including all the players at the table. So why aren't we doing it that way in Connecticut? Why are we rushing to beat Washington to a plan that Connecticut taxpayers cannot afford?

Now, if this is a 1 billion -- or whatever the number is. There seems to be some disagreement on what the cost is, but I've heard $1.7 billion is one of the costs being discussed. One is clearly over half a billion dollars to initially add people on HUSKY A and B. May I remind all of us here that there is currently a nine -- almost $9 billion budget deficit. Well, where's the money going to come from?

So if the federal government is going to sprinkle the answer to health-care reform across the country, why are we rushing to put this together today? Bad move. This is not the right way to go.

I urge this body to reject this effort to override the Governor's veto. Her points are well taken in my book, and I will vote to sustain the Governor's veto. Thank you.

THE CHAIR:

Thank you, sir. Will you remark further? Senator Roraback.

SENATOR RORABACK:

Thank you, Mr. President. I rise reluctantly and with some reservations to oppose this bill. Mr. President, yesterday was a relaxing Sunday. I actually had a chance to sit down and read the paper, and when I got to page A13 of the Hartford Courant, I saw a full-page ad labeled urgent, and the message of this ad from 19,000 small businesses in Connecticut was that we needed to override the Governor's veto, and in so doing, the Legislature will end the delay and begin the health-care solution that small businesses and the rest of our state needs. Mr. President, I have no doubt that small businesses are struggling with the cost of health care as our individuals, the uninsured, we have a big problem on our hands.

But then Mr. President, I turned two pages later to page A16 of the Hartford Courant, and there was a full-page ad sponsored by the likes of my Chamber of Commerce in Northwest Connecticut, the Danbury Chamber, the Business Council of Fairfield County, the Metro Hartford Alliance, the CBIA -- which said if these bills pass for employers already struggling with high health care costs, these bills provide no relief. And getting costs under control is the key to

expanding access to health care.

Mr. President, I've spent a little bit of time studying health-care reform, and the message that comes from successful initiatives is it you want to do this right, you've got to get everybody on the same page. You've got to bring traditionally warring parties to the table, lock them in a room and get them to agree on steps to take together to solve this problem.

I don't think we've gotten it right, Mr. President. When there are two full-page ads from people of good conscience, people that believe strongly in the rightness of their position, each of which maintains that passage of this bill will reach an opposite result.

Mr. President, my heart goes out to any individual in the state without health insurance and to every individual that's paying 2000, 3000 dollars a month for coverage, but as Senator Harris himself acknowledged, don't worry, nobody is going to get health insurance under this bill for three years. Don't worry. Nothing will happen for three years. Well, on the one hand, I guess we don't need to worry for three years, but on the other hand, there's no

relief coming for the next three years.

Mr. President, I think we have time to get the people that sponsored this ad in the same room with the people that sponsored the other ad because there's so much they can agree on. But because they disagree -- this is the other ad -- because there's so much they disagree on, in my view it means more work needs to be done.

A couple other quick points. I think we do a disservice to the SustiNet Board of Directors by excluding representation from the members of the Chamber of Commerce, from small businesses and from large businesses, which are the people who purchase most of the health insurance in this state.

In addition, Mr. President, the SustiNet bill does nothing, nadda, zero to address the malpractice reform -- or the malpractice crisis which has such an effect on driving up health care costs. To the credit of the SustiNet initiative, the bill which first appeared before the General Assembly had a very wise initiative which said that if doctors and dentist and nurses follow evidence based medicine, they're not going to be sued for malpractice. It's that kind of thoughtful, responsible, forward thinking reform

that's going to help to bring health care costs under control.

Sadly, as the process evolved, that provision was taken out of the bill. And if anyone thinks that our country could come to grips with the high costs of health care without coming to grips with the costs that defensive medicine visits on us all, I think that we're mistaken.

So for those reasons, Mr. President, I urge rejection of this bill and urge us all to come back tomorrow to get it right and to make the steps that will actually bring every constituency in Connecticut to the table. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator Roraback.

Will you remark further? Senator Prague.

SENATOR PRAGUE:

Mr. President, the issue of a health-care policy for the state of Connecticut to adopt so that people will have access to health care is of primary importance to each and every one of us around this circle.

We have to start somewhere. I am going to vote for SustiNet because I truly believe it gives us the

basis of a good start to implement a policy of health care for everyone in this state. I'm looking at the fiscal note, trying to figure out where this outrageous amount of money that I have heard bandied around in this chamber comes from. It's going to cost us a billion dollars. It's going to cost us over a billion dollars.

The fiscal note doesn't say anything about that kind of cost at all. Maybe I'm missing something, and if I'm missing it, I'd like somebody to correct me, but I don't see those dollars mentioned anywhere in the fiscal note.

You know, I went to the Blue Cross hearing this morning. I could only stay for a short time because I had to run over here for our session, but the little bit I heard was a company, an insurance company that people in this state have depended on for years and years and years coming before the State Insurance Department with the most outrageous increase in the individual policies that I, in all my years here, have ever heard.

They were asking for an average of 32 percent in some of their policies on the individual market. People simply cannot afford the cost of health

insurance, and if we don't begin to develop a groundwork, a basis, a foundation to offering some kind of health policy in this state, then we are missing the mark.

I suggest that everybody in this chamber think how they would like it if they didn't have health insurance and couldn't afford to pay for it. We can't cover everybody under HUSKY. Not everybody fits the eligibility, and for those who do, it costs this state a lot of money.

But I urge the members of the circle to take another look at the fiscal note. There is no mention in there at all of the sum of a billion dollars that I've heard mentioned time and time again here, and I seriously ask each and every one of you to consider how important it is that we develop a basis for a state policy to offer health care to everybody. Thank you.

THE CHAIR:

Thank you, Senator.

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, I rise in support of the SustiNet bill and commend Senator

Harris and his committee and others for the leadership they have demonstrated.

Mr. President, and members of the circle, if one was to read the SustiNet bill extremely carefully, you would see an outstanding job done by Juan Figueroa and the University Health Care Foundation. It's more than dollars. It is a blueprint for a plan that needs to be done.

We could sit here and talk about doing it next year or the year after. We've been doing this for a decade. I don't think we should be Neros while Rome was burning and not take action. Look at the faces in the gallery. You have people representing some of the greatest generation of our society. You have other faces that represent the hope for our future. They're here because they believe in the plan. They're here because they are asking us to do what we should do, be responsible and take care of the people of the state of Connecticut.

And Mr. President, and members of the circle, I say this is the road, this is the journey that we have to begin. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on the motion to repass House Bill 6600? Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, speaking in support of repassage of the bill. This is a measure, Mr. President, that reflects the burning issue of health-care reform that preys on the minds of so many people in the state of Connecticut, both those who are public policymakers, those who engage in business, those who have insurance, those who do not, those who do not have adequate insurance -- everyone is worried about the future of health care coverage.

We know that the cost of health care takes up a much bigger percentage of overall gross product than was ever the case before. It is something that has a disproportionate impact in driving employment decisions and offering of hirings and people that -- choices that people make about jobs.

So it is, in many ways, become a cloud of worry over the heads of our society. And this bill, Mr. President, which passed by such substantial margins, 107 to 35 on May 20th in the House of Representatives and 23 to 12 ten days later here in the Senate -- lays out, as Senator Harris so ably said -- I wanted to

commend him for his work on this along with Senator Crisco and others in the chamber -- the nine-member SustiNet Health Partnership Board of Directors will make recommendations after a 17-month period of analysis between now and January 1, 2011, on the details and implementation of the SustiNet plan.

Reference has been made to the possibility of a federal health care reform taking place before then. And if that is the case and if it moves along the lines that are being discussed in Washington, then that will indeed be something to celebrate, and then our planning can then react to in the course of that time, but in the meantime, it is worthwhile for us to embark on that planning process, to prepare ourselves to be ready for the future in health care impacted by the federal plan or not.

So again, it is something that facilitates a process of evaluation and planning over a 17-month period when we hope that we will have a very clear-sighted view of what the blueprint should be by January 1, 2011. So I would urge repassage of this worthy bill. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further? Senator Williams.

SENATOR WILLIAMS:

Thank you, Mr. President. I rise to support the bill.

Health care is on the minds of families, individuals, businessmen and women all around the state. Some of the criticism I've heard about the SustiNet bill is that on the one hand, we should not act on it now. We should wait because of what's happening in Washington, D.C. with the efforts of the Obama administration.

On the other hand, some of the criticism has been, well, the SustiNet bill doesn't take effect fast enough and that we need something that happens now and provides reform almost instantly as opposed to waiting until 2011 and 2012.

In point of fact, we can't wait for the Obama administration. We have high hopes for what they're doing in Washington, D.C. and there's no reason why the SustiNet plan cannot dovetail with those changes and those steps forward that come from Washington, but at the same time we have to be prepared to move forward with health reform, regardless of what happens in Washington, D.C., especially if critical pieces

fall by the wayside at the national level.

And we know that some of those steps will take time. So yes, there are things that we can accomplish in the short-term, and the SustiNet plan lays the groundwork for that, gives us a roadmap and a blueprint to make that happen, but at the same time, doesn't fall into the trap of delaying endlessly those steps that will take time so that they never occur at the state level.

So, Mr. President, again, there are people all across this state, men and women who have lost their health care recently because of the economic downturn, who don't know how they're going to provide health coverage for themselves, who are looking at those premium increases that Senator Prague referred to. If you're on your own and you don't have an employer provided health care for you in the state of Connecticut, your premiums are going to go up between 23 and 32 percent. That's unacceptable, and it's so important that we move forward with this reform now.

And I want to thank Senator Harris for his efforts and second everything that he said in bringing out this bill, this important piece of legislation. Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on a motion to repass House Bill 6600? Will you remark further? If not, Mr. Clerk, please call for a roll call vote. The machine will be open.

THE CLERK:

An immediate roll call vote has been ordered in the Senate. Will all Senators please return to the chamber. An immediate roll call vote has been ordered in the Senate. Will all Senators please return to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have voted, please check the vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

The motion to repass House Bill 6600.

Total Number Voting	36
Those voting Yea	24
Those voting Nay	12
Those absent and not voting	0

THE CHAIR:

The Chamber will come to order. Thank you.

Mr. Clerk, could you please recall that tally, sir.

THE CLERK:

Total number of voting on this motion to repass House Bill 6600.

Total Number Voting	36
Those voting Yea	24
Those voting Nay	12
Those absent and not voting	0

THE CHAIR:

The motion to repass passes.

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr. President, the Clerk is in possession of Senate Agendas Numbers 6 and 7 for the reconvened session of the 2009 General Assembly.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Mr. President, the Clerk is in possession of Senate Agenda Number 6 and Senate Agenda Number 7 for the reconvened session of the General Assembly for Monday, July 20, 2009.

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REP. MERRILL (54th):

Thank you, Mr. Speaker, I would move for the immediate transmittal of this item to the Senate.

SPEAKER DONOVAN:

The motion is suspension of the rules for the immediate transmittal of the last item to the Senate. Is there any objection? Is there any objection? Hearing none, the Bill is immediately transmitted.

The Chamber will stand at ease.

(Chamber at ease.)

SPEAKER DONOVAN:

The House will come back to order.

Will the Clerk please call Calendar Number 403.

THE CLERK:

On Page 41, Calendar Number 403, Substitute for House Bill Number 6600 AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN. Favorable Report by the Committee on Insurance.

SPEAKER DONOVAN:

The Chairwoman of the Public Health Committee, Betsy Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Good evening, Mr. Speaker. Pleasure to see you still standing there this evening.

Mr. Speaker, I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill.

SPEAKER DONOVAN:

The question is acceptance of the Joint Committee's Favorable Report and passage of the Bill. Will you remark, Madam?

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, the Clerk is in possession of an Amendment, that Amendment LCO Number 7939. I would request that the Clerk please call the amendment and I be granted leave of the Chamber to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO Number 7939, which will be designated House Amendment Schedule "A".

THE CLERK:

LCO Number 7939, House "A", offered by Representative Ritter and Representative Fontana.

SPEAKER DONOVAN:

The Representative has sought leave of the Chamber to summarize the amendment. Is there

objection to summarization? If not, Representative Ritter you may proceed with summarization.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, This amendment is a strike-all Amendment and if adopted by the Chamber would then become the Bill.

I would like to offer some details on the amendment at this time.

Mr. Speaker, I will not spend a lot of time framing the particular argument around this Bill, as we have just spent quite a few hours discussing the situation regarding healthcare before the State of Connecticut at this time.

I would like to comment, however, that this Bill and the amendment that will become the Bill offers us an opportunity to expand and transform our healthcare delivery system in the state.

This amendment prepares a pathway for us to go in that direction. It should be no surprise for any of us here in the Chamber that as a nation as well as a state for some years, the urgency of the discussion around healthcare has become increasingly apparent to us. It costs too much. It's hard to get, and not

enough of us have it, and if we do, we don't get enough of it.

And this became, of course, a major topic in the most recent national election, and adding to the urgency before us today.

The Bill as amended, or I should say, I will restate that. This amendment will, in a sense, establish a framework for a healthcare delivery plan that will be directed to providing an affordable, accessible and complete coverage based on a foundation that's a little different from what we're used to today.

That would involve evidence-based practices, a medical home, electronic medical records, and an emphasis on preventive and chronic care, again, a little different than the traditional pattern that we're used to from the more traditional insurance we have today.

This plan, known as SustiNet, and I know that many people in the Chamber have heard about this, because it's been widely discussed around the state, would offer health insurance through a self insurance plan via existing channels, purchasing pools, brokers and employers.

The amendment establishes a volunteer board of directors that would be headed by the Comptroller and the Health Care Advocate. Those two people would be supplemented by seven others for a total of nine.

The board is charged with studying and then recommending to this Legislative Body, the specifics needed to implement the SustiNet plan. They are required to do that by January 1, 2011.

Those recommendations may or may not include a public authority in order to run the plan. That would be up to the board. The board and the entity that runs the plan would be charged with anticipating and capitalizing on changes and opportunities that will emerge from this ongoing discussion on national healthcare reform.

Like the partnership Bill, it does rely on the benefits of pooling to lower costs. However, it does not add more lives to the state employees pool.

Instead, it uses additional coverage pools, HUSKY A and B and SAGA, employer purchased, excuse me, employer purchase groups, and groups that would consist of state employees and possibly another of individuals. Again, this would come through the recommendations of the board, approved by this

Legislature.

Each pool would be governed by its own benefits, cost sharing and regulatory requirements. It creates a standard benefit package similar to that offered today by large sector employees.

The plan itself relies on a combination, as I've mentioned, of evidence-based practices, medical homes and electronic medical records that are designed to work together with providers and enrollees to manage costs and bring greater efficiencies to the healthcare delivery system.

The Bill requires the board to make recommendations that SustiNet be an option offered to individuals to the underinsured, and small and large group employers. It requires recommendations from the board to bring the plan to Medicaid, HUSKY A and B and SAGA recipients.

It requires recommendations to make the plan available to individuals, and it specifically requires that they look at current insurance law with regard to pre-existing condition exclusions and individual mandates in concert with guaranteed issue.

It also requires recommendations on the expansion of HUSKY, contingent on available appropriations and taking advantage of federal funding.

The Bill as amended would not do many things, and I want to mention a few of these things because they've been the subject, I know, of concern on the part of a great many people in this body.

The Bill does not create or suggest a single payer system.

It does not change the way employer-sponsored insurance is offered.

It does not prohibit competition from insurance carriers.

It does not create a fiscal burden for the state in these very difficult budget years.

It does not mandate participation by hospitals, providers, and other medical professionals.

The Bill does not conflict with the healthcare partnership we most recently spent quite a few hours discussing.

And it does not mandate changes to the way employers may choose to offer benefits to their employees.

It does not mandate what those benefits may be.

Mr. Speaker, the design of This amendment and the Bill that it will become, does in my opinion, works to best position the State of Connecticut to take advantage of what we anticipate will be increased opportunities that may emerge from federal healthcare reform.

It will also increase choices to our residents. It will, employers, providers and at the same time strengthen our, excuse me, strengthen and offer long-term stability to our healthcare system itself.

Ultimately, Mr. Speaker, this plan will have the ability not just to strengthen but to augment and I will say, sustain our healthcare system well into the future, and I urge adoption.

SPEAKER DONOVAN:

The question before the Chamber is adoption of House Amendment Schedule "A". Will you remark on the amendment? Will you remark on the amendment? Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker, very much, and good evening to you.

I want to rise to support the amendment. I'd like to thank Representative Ritter for her leadership

on this issue and the opportunity to work with her on it.

I again, support the amendment because as she has indicated, this is part of a medium to long-term effort to build on the success of the partnership and other shorter term arrangements to expand health insurance coverage, and to do it in a more comprehensive fashion that also looks at improving care, providing greater transparency and perhaps above all, controlling costs.

Essentially, Mr. Speaker, this creates a structure or framework by which we may evaluate recommendations to leverage federal legislation that may be coming down the pike this fall or next spring, as well as the potential for federal stimulus dollars to help us to expand access and coverage and so forth.

I particularly like as the Chair of the Insurance Committee, the language in the amendment, which would contemplate offering nonprofits, municipalities and small businesses additional options beyond those contemplated in the Healthcare Partnership Bill.

But in any case, I think that Representative Ritter and the advocates and the others who worked on this Bill, including our staff and the LCO attorney,

Bill O'Shea, have done a great job in laying out again, a road map if you will, to how it is that we can build over the next several years on federal reform legislation to again, expand access, improve the delivery in access to care, provide greater transparency for health, spending, control costs and again, leverage a delivery to some improvement that promotes electronic medical records, medical homes, evidence-based data, decision modeling and prevention and wellness.

So Mr. Speaker, I thank you very much for helping to shepherd this legislation through this Chamber, and I ask that when the vote is taken, it be taken by Roll, please.

SPEAKER DONOVAN:

The question before the Chamber is on a Roll Call Vote. All those in favor of a Roll Call vote please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

The requisite 20 percent has been met. When the votes are taken, it will be taken by Roll.

Will you remark further on the Bill?

Representative Gibbons.

REP. GIBBONS (150th):

Good evening, Mr. Speaker.

SPEAKER DONOVAN:

Good evening, Representative.

REP. GIBBONS: 9150tn)

Somehow I think there's this déjà vu all over again.

SPEAKER DONOVAN:

Same day.

REP. GIBBONS (150th):

But we are for it. We're going to do this. I've got a few questions for the proponent of the amendment. I don't know if it's Representative Ritter or Representative Fontana, but I'd like to speak with one of them, please.

SPEAKER DONOVAN:

Please proceed, Madam.

REP. GIBBONS (150th):

Let me start by saying we have just debated for the past seven hours, I guess a Healthcare Partnership.

How do you envision, please through you, Mr. Speaker, this SustiNet plan working in conjunction with the Healthcare Partnership?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker, and I will attempt to not review, but not at length perhaps, some of the details of the Healthcare Partnership that we just discussed recently only comparatively with the SustiNet Bill.

Through you, Mr. Speaker, we know from the previous discussion that the Partnership Bill converts the state's employee plan to self insured, opens it to municipalities, nonprofits and municipal related employers.

Groups entering the pool were then entitled to the same benefit package under the Partnership as our other state employees.

That's not quite the same with the SustiNet or evolved plan as envisioned by This amendment. That Bill sets up a standard benefit plan that is essentially equivalent to a plan as offered by large employers and subject to a periodic review and

evaluation through the Office of the Healthcare Advocate.

That plan would not be the same plan as the plan currently offered to state employees.

In addition, the plan under the SustiNet proposal could offer a variety of different combinations of benefits underneath that, as part of that program. They still must comply to the basic standard benefit plan, but there could be additional features so they could vary. There would be more choices.

I will finally mention that employers who may choose to enter the Partnership under its earlier option date may as they choose later, come to the SustiNet plan or not. It would be up to them. It would be another option.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative for her answers. I'm just trying to again, clarify how this SustiNet plan is going to work with our current method of health insurance within the state.

Is this another MCO, so to speak, so that any employer or municipality could choose this as an

insurance plan as opposed to Charter Oak, as opposed to Health Net, as opposed to any one of the other insurance plans?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, yes. It would be another option for them to choose.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you. Through you, Mr. Speaker, OFA has cited that at least $553 million in additional costs could be added to support this SustiNet plan.

Is this sort of a quasi public/private entity that we are creating? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Through you, I might direct the Representatives to the OFA analysis that I'm looking for, for this particular amendment and I don't seem to see the reference that she is speaking

of. I believe according to this fiscal analysis, there is no additional impact.

REP. GIBBONS (150th):

Through you, Mr. Speaker, I have the OFA analysis with a file number of 920, so maybe this is on the original Bill, but there has got to be some cost associated with creating this SustiNet authority.

Who is going to, who are going to pay the costs for this SustiNet authority for the directors that have the power to create the insurance plan?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the board that is created underneath this plan is a voluntary board. It consists of a total of nine members. It is cochaired by the Comptroller and the Healthcare Advocate.

I might remind the Representative that the recommendations from this board would come back to this Legislative Body, but that there is no additional cost associated with that.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative for her answers. I attended the hearing when SustiNet gave its plan, and I think that it gets high marks for what it attempts to do. It was going to increase electronic medical records, which is what I think is a goal that we all want. I think there's a lot of privacy issues associated with that, which have not been worked out, whether we do it through SustiNet or any other entity.

The other problem, the other issue that SustiNet was going to try and do was preventative care, and I think preventative care is one of the goals that we all need in whatever healthcare system we have.

However, the big caveat with SustiNet, and they admitted this in the hearing, was that in order for provider doctors and hospitals to sign on to the SustiNet plan, we were going to have to increase our reimbursements to these doctors and to these hospitals.

They estimated a $900 million fee for what this would be. They assumed that a lot of the people coming in would be Medicaid reimbursable, but I think initially you could double that figure, even if it was

Medicaid reimbursable, because we have to pay it out first.

Would the Representative please explain exactly how these reimbursements are going to work?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Before I talk a little bit about the future potential under this plan, I would like to point out that the amendment, which will become the Bill only requires that this board be set up.

Any recommendations that come to the board as the future plans or expansions of any of the programs that the Representative is talking about, would have to come before this Legislature at a future Session. Those recommendations are required to be made by January 1, 2011 designed to give us good time in a long Session in order to do that.

The Representative is correct in that the original information and very prescriptive information about the SustiNet plan ultimately looked at, among other things, an expansion of both coverage and

reimbursement under our public programs. That would be Medicaid, HUSKY A and B, and SAGA, with the intent of bringing those programs and their coverage to the point where it would essentially equal something like the standards of the coverage that would be offered by a large employer.

This amendment, however, does not provide for that to happen. What it does do, Mr. Speaker, is, I believe, well position the state to be in its best possible position to take advantage of opportunities that may come to us from the federal government either through expansion opportunities for additional reimbursement for us, or through federal healthcare reforms that indeed, may help us as we try to restructure our health care system.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative for her answers. So am I correct in understanding, through you, Mr. Speaker, that what This amendment does is just creates a partnership board of directors, and the underlying sections in the original Bill have really been eliminated, and what we are doing is creating this

board of directors to go and look at healthcare costs for the state and do nothing more at this time? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, the Representative is correct on the first part of her statement, that what This amendment does is indeed create the board of directors.

However, the amendment does go on to specifically shape and charge the types of things that the recommendations would address, and some of the things that I previously talked about, the opportunity to set up a variety of pools to allow large and small employers the opportunities to contemplate bringing the public programs under the SustiNet plan. All must be addressed through those recommendations.

So I would state that the duties that are incumbent upon the board in terms of the things that it must address are fairly clear in This amendment.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative for her answer. Again, just to be clear as to what This amendment does. Is This amendment going to charge the SustiNet authority with taking in paid customers, clients, so to speak, bring in doctors, bring in hospitals.

Is it going to really create a healthcare authority or is it just setting up the groundwork that is then going to have to come back to this Legislature for approval?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, perhaps some of my answer might be clearer if I direct the Representative to look at Lines 57 through 59 where it defines the word public authority as used in This amendment to mean a public authority or other entity recommended by the partnership, and perhaps it is that language that might be somewhat misleading.

The board of directors will recommend an entity to fully implement, or to implement and guide the future of the SustiNet plan that may or may not be a public authority.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. Again, because This amendment was just given to us as we started this discussion. I had not seen it before so I'm not totally clear what was in the underlying Bill versus what is in the amendment.

What I want to understand is, does This amendment create an authority that is going to immediately start a healthcare plan where people could subscribe on day one, and we are going to start enrolling doctors in hospitals, or is it just setting up the direction for such a plan that would be later implemented?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the answer to the first part is no.

REP. GIBBONS (150th):

Okay. Thank you. I have no further questions at this time. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Giegler of the 138th District.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. I don't think any of us would argue that the residents of Connecticut need more access to healthcare and affordable healthcare. I worked in an outpatient psychiatric clinic for 19 years where the patients came in and they were on a sliding scale.

We were associated with an outpatient health clinic that also saw patients on a sliding scale, and this was in Greenwich. People forget that Greenwich has three housing authorities there, and there are patients that needed assistance.

I also have a husband that's self-employed and know the realities of what it costs for health insurance for those that are self-employed.

But at a time when we need to focus on retaining jobs within the state to strengthen our economy and streamline our government, we're putting forth an ultimately affordable health plan, expanding the size of state government and its control over healthcare, virtually making the state an insurance company.

With this plan, we are looking at significant costs, which are deferred to out years. Millions of new funds to administer and billions in reserve for claims.

With that being said, I have a couple of questions to the Chair of the Public Health Committee.

SPEAKER DONOVAN:

Please proceed, Madam.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. Representative Ritter, in Line Number 9 of the Bill, it refers to standard benefit packages, which establishes a very rich standard of minimum benefits, and I refer to Line 12 where it describes, refers to Chapter 700(c) on the mandates.

Would that be encompassing the 60 plus mandates that we presently now have on the books?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, as I understand the Bill, those mandates are the mandates that would also apply to insurance that is generally

offered by large employers in the state, and I believe the answer to the question would be yes.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. With that being said, would that increase the premiums that would cost for those securing the plan?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

My apologies, through you, Mr. Speaker, my apologies. Would you repeat your question, Representative Giegler?

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. With this rich standard of benefit package, would that increase the premiums?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the premiums would be anticipate, well, I will answer that in a different way, Mr. Speaker.

The benefit package would, by being representative of the typical benefit package that we would see around the state from our large employer sponsored insurance would be in the same range. I cannot comment on the precise amount, and that is because it could vary across the various pools that are contemplated by the plan.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker, another question. In Line 84, it refers to the initial appointments to the board of directors, and how those board members, which are nine in number, how many years that they will be serving, and it ranges from year two, three, four and five.

In that, normally it refers in Line 92 to the board member appointed by the Governor. In all of our Committees, our nominations of boards and commissions that have been before the Executive Nominations

Committee, all appointments are usually coterminous with those of the Governor.

Would you, don't you think that we should be, continue that same practice in this appointment, and also in light of the fact that this is a board that's in its initial infant stages, that this creates an initial instability for this authority?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the Representative raises good points and indeed, those appointments would be from the mid part of July and in the case of the Governor's appointments, for two years.

I would like to direct her attention, however, to Lines 103 through 107, where there's adequate, I believe adequate provision for a re-appointment to cover any remaining period of time.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. In reference to the re-appointment, is there any cap on the length of the term that any individual could serve on this board?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, no.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. The board of directors is allowed to make recommendations, but the Bill is very descriptive of the recommendations that it has to make.

How are recommendations that the board would make differ from those of the authority?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, my apologies, Representative Giegler. Could you repeat your question?

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. The board of directors is allowed to make recommendations, but the Bill is

very descriptive of the recommendations that it must make.

How are the recommendations the board would make differ from those of the authority?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the board of directors will make recommendations as to first, the entity or authority that will be responsible for running the plan. That entity or authority will actually do the nuts and bolts of establishing and running the plan.

The board of directors' plans have to do, are more general and have to do with setting up the framework within which the plan will operate.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. I also refer to Line 149 where it makes reference to soliciting bids from individual providers, and provider organizations.

My question is, could you define who these providers are?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Those providers would encompass, could potentially encompass the entire range of healthcare providers that we have today, ranging possibly from hospitals, all the way down through individual medical providers, doctors, therapists, community healthcare organizations, as well as existing regional healthcare networks.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. So these providers then are all licensed insurers. They could be, include doctors and will they be expected to have the same protections under the current license agreements?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, through you, Mr. Speaker, yes.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. Another question. On Line 185 where it makes reference to set payment methods for licensed health providers, will this remove health plans from playing a role in the marketplace?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker, one moment. Through you, Mr. Speaker, I believe the Representative was directing me to Line 185. Am I correct?

REP. GIEGLER (138th):

Actually, it's a different number now. We just got the new one up. I'll change that. But it's in, let me tell you, I believe it's 180, no, wait a minute, Line 179 in the new LCO.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, as I understand your question, you are essentially asking if private insurers will be able to operate within the plan? The answer is yes.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. I appreciate that answer. So they think our private health plans already have the expertise in providing delivery both effectively and efficiently, so I appreciate that answer.

This Bill that's presently before us has the potential for significant costs. Although the fiscal note that's before us has no cost, it does have the ability for expansive additions, especially when it comes to HUSKY eligibility, which the previous Representative had asked would cost $530 million.

OPM projects that the annual cost of the Bill would be in excess of $1.5 as we get into the out year. The potential for the significant cost, the expansive changes to healthcare, with some of the unknown implications, causes me that I would be unable to support such a measure, even though I feel that healthcare is most important to all of us. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Camillo.

REP. CAMILLO (151st):

Thank you, Mr. Speaker. The national average for insured persons is about 80 percent, I believe. In Connecticut, I guess we're between 92 percent and 93 percent, which is very good. Of course, we always want to bet to 100 percent. It doesn't do much for those seven or eight percent that don't have some insurance.

What bothers me, and there's other ways I think of attacking that seven or eight percent. What really concerns me, and I think a lot of people in the state is the price tag or the potential price tag that comes with this.

Through you, Mr. Speaker, to the proponent, Representative Ritter, if the SustiNet members have claims that exceed the 10 percent that we already have in the contracts right now, where would that money come from, more claims coming in that we have to pay for?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, I'm having a little difficulty with that question because I believe that

question is discussing something relative to the state employees plan and it would not apply to this.

SPEAKER DONOVAN:

Representative Camillo, would you like to reframe the question?

REP. CAMILLO (151st):

No. I'll withdraw that right now and re-look at that.

But through you, Mr. Speaker, this and the earlier debate, we heard that this actually helps competition with the private insurance companies. The difference is, I believe that a private insurance company goes into the red, they go out of business.

Here, is that me?

SPEAKER DONOVAN:

Somebody may have a cell phone, so.

REP. CAMILLO (151st):

Through you, Mr. Speaker, is it not pure competition if the state is able to, if we go into the red, say if we have more claims coming in than we have the money for, and we have to dip into the general fund, is that really not competition? Is that really another competitor in the marketplace? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, this is not a state plan. The SustiNet plan would not make that requirement of the state, so I'm not precisely sure. I understand the applicability of the question to This amendment.

I would like to, however, point out for the Representative that this offers another option in the field of options for employers, large and small employers, as well as individuals to evaluate when they are looking at the best solution to their health insurance needs.

So it's another choice. The Representative spoke about competition and I certainly would agree with his concerns that competition be allowed to exist and would submit that choice is an important element in competition and so I'm not quite sure I would understand that there was a conflict there.

SPEAKER DONOVAN:

Representative Camillo.

REP. CAMILLO (151st):

Okay. Thank you very much, Mr. Speaker.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Good evening, Mr. Speaker.

SPEAKER DONOVAN:

Good evening, sir.

REP. ROWE (123rd):

Good evening, Representative Ritter. Through you, a few questions perhaps. Maybe we can back up a little bit. I mean, I know that this is going to make a change or seek to make a change from the state being fully insured to self insured for the state employees, and the other public healthcare that the state offers.

And public health, we're talking about HUSKY and Medicaid and the others of that group. Is that true?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, yes.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

And what else am I, what other insurance am I missing? I'm sure there's obvious ones, but through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, we also have the state administered general assistance is part of one of the public options that we offer now.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Are there others, or are those really the three that take up the vast majority of what we offer?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. And Mr. Speaker, that, the Medicaid, which is currently not necessarily HUSKY A or B, would also fall into that category. I would like to emphasize, however, the plan does not contemplate, obviously, anything be done to Medicare since that is a federal program.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Thank you for that clarification. It seems to me that one of the big things that this Bill does is creating the board of directors, and I'd just like to ask a couple of question about that.

Firstly, perhaps, can you tell us how the first, if at all the amendment changes the makeup of the board of directors.

And maybe I should back up even further and say, who makes up this board of directors, and so I don't have to go through you again, and how did you come to that decision as to who you're going to appoint? Through you.

SPEAKER DONOVAN:

You went through me anyway. Representative Ritter.

REP. ROWE (123rd):

Again.

REP. RITTER (38th):

Through you, Mr. Speaker, the board of directors consists of nine members. The Comptroller and the Healthcare Advocate serve as cochairs of the board of

directors, and there are seven more that are appointed by named public officials for, as Representative Giegler pointed out, is stated initial terms.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

And how much, well it seems to me that we're giving them a rather broad charge. How often do we expect or anticipate this board to meet? Is this a part-time job like the Legislature, that you know, only meets from nine to five on certain days?

But through you, I don't know what the question was, but whatever the question was, through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. I'll respond to whatever the question was. I first would like to thank the Representative for reminding me also about my part-time job. I'm enjoying it, I would say at least as much as he is, possibly more, especially the hours.

He asked the question about the board of directors, and the frequency with which it would be

meeting, and that, I believe would be contemplated by the Cochairs.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Are you talking about the Cochairs of the board of directors? What would be your, you know a lot more about this Bill than me. What was your expectation of, the duties of the board seems to be pretty broad as I indicated. What's your expectation on this board and how are they going to meet? Are they going to meet once a week. Are they going to meet as this gets going, are they going to be meeting, you know, more frequently?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, I will briefly offer my opinion, although I will tell you that the amendment does not specify a particular meeting schedule, only a required reporting date, and my expectation as someone who has served on boards myself in the past is that there may indeed be frequent initial meetings that work easily, may be parceled out, you will note, depending, to

various members, depending on their areas of expertise.

You will note in Lines 66 through 83 that there are required areas of expertise designed to cover the main elements of the plan.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Okay. Thank you. And what's the report back date from the board? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, January 1, 2011.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. And this is a volunteer board, correct? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, yes.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Now, I think you went into it a little bit when you were introducing the Bill, but can you review again what you, I know you can't say what the board recommendations will be, but we use, in other words the Bill, the amendment seems to use the word shall a lot, the board shall do such and such.

Can you give us an idea, the Bill, you know, two-sided, it's 32 pages or so, can you give us a synopsis of what you expect, what final product you would expect generally for the board to come out with in July of 2011, you said? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Yes, I can, Mr. Speaker. That report would be due to the General Assembly on January 1, 2011, and I can give you a brief synopsis of the board.

Before I do that, I would also like to remind the Representatives that there are four committees established, who will supplement the work of the board and advise them as they go through their process, and I think that may alleviate some of the

Representative's concerns about the amount of work and the wide variety of expertise that would be required.

I will remind him that those four advisory committees are first, Health IT and electronical medical records. A second one on medical homes. A third on clinical care and safety guidelines, and a fourth on preventive care.

That would also include things like chronic disease management, so there is a mechanism to support those nine people, and I appreciate the Representative's concern in that line of questioning. I think it's fully appropriate.

To his second question, an idea of the type of recommendations that the amendment contemplates on seeing from the board, and I'll try not to be too lengthy.

The first would be anticipated they would develop a set of recommendations on implementing the plan in the form of a proposed legislation, and that is appropriate, since they are reporting to this Legislative Body.

Secondly, there's a, what I refer to as a laundry list of areas that the recommendations should include. That would include a standard benefits package. I had

referred to that earlier, that would be required to implement the plan, guidelines on implementing health information technology. That would include electronic medical records and electronic health records, integrating a medical home model, developing clinical care and safety guidelines and improving preventive care programs.

And again, I'd like to emphasize that is specifically designed to be in consultation with those advisory committees.

In addition, guidelines on the offering of the SustiNet plan, and that would include the offering and the timing in some cases.

In other cases, the anticipated date is specified in the amendment, and that would include state employees, nonprofit and small employers, people without employer sponsored insurance, people with inadequate or unaffordable employer sponsored insurance, the already mentioned public recipients. That would be HUSKY, SAGA and Medicaid, and that would include HUSKY A and B individuals.

Offering this through purchasing pools agents and brokers, and in addition, offering it to other employers and there's specificity there that in so

doing, they're seeking recommendations on specific procedures to prevent adverse selection, taking in account past claims experience, changes in characteristics of covered employees and dependents, and other factors that could be improved by the board.

In addition, the board is charged with addressing methods of, in the future, expanding the HUSKY program to include more adults within available appropriations and taking advantage of federal funding.

An additional set of recommendations is expected on an expedited set, I'm sorry, expedited plans on how to best take advantage of any new federal reform legislation, possibly also involving Stimulus money and additional funding.

That would be due to the Legislature within 60 days of passage of the federal legislation, and I think in my introduction to the Bill I reviewed the desire that we be well positioned to be able to respond to anything that came our way, and we didn't leave any opportunities left on the wayside.

Additionally, I would point out to the Representative that the amendment asks that there be an establishment of an independent clearinghouse of information available to the public on insurance

policies inside and outside of the SustiNet plan so that the public would have clear and concise information to use when reviewing their health insurance needs.

Finally, recommendations are anticipated on expanding public outreach and different methods of identifying other uninsured people in the state who could benefit from a plan.

That could be it.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

That was very thorough. Thank you. To touch on a couple of the answers you gave, which I appreciated, the HUSKY. I think maybe Representative Giegler touched on this a bit, but the HUSKY element of the plan. You mentioned expansion of HUSKY, but within available appropriations.

Can you flesh that out a bit as to what the expectation or the hope is with the board of directors coming back with regard to HUSKY? I do have a concern with costs here. We've got these multi-billion dollar deficits and such, so can you assuage my concerns, or at least address them? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

I would be happy to assuage your concerns, Representative Rowe.

The contemplation around the expansion of the HUSKY program, and I should add you are correct, Representative Giegler had several question along this line as well, received considerable attention when this plan was first made public, now many months ago.

The contemplation of the expectation of additional appropriations and federal funding is, comes from several different points. The current impetus right now are from efforts that we're hearing about at the federal level contemplating federal healthcare reform, and in many of these plans there is mention of different ways to do that. One of those ways is through increased reimbursement through Medicaid.

Now, the State of Connecticut this year is receiving a Stimulus money, some increased reimbursement for its Medicaid programs, which is thankfully is something I think we'll be very happy to accept.

And it's very interesting to look at the discussion around contemplated federal reforms and envision that indeed, this could continue.

However, it might not, and consequently the timing of This amendment is designed to give us the opportunity to be able to take advantage, as I said, of anything that could come our way.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Thank you for the response. I recall or understand, and I wasn't on any Committee that this Bill went before, but there were some price tags initially associated with this and now I look on the laptop and it seems that OFA has indicated the costs are essentially going to be negligible.

Well, through you, is that the case? Is that your understanding?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, that is my understanding.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. What changed from when OFA was talking about maybe half a billion dollars that may have been with HUSKY, perhaps, but, and I think OPM was talking about a huge price tag of a billion and a half dollars or something along that range, and that may to deal with HUSKY, but I gather there might be other elements as well.

Can you address those concerns, please? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. The original, to respond to Representative Rowe and remind him that the original Bill as I had mentioned earlier, was extremely perspective and contemplated an immediate beginning of this program.

In that beginning of the program, it anticipated an almost immediate expansion of many of those programs without any discussion of the potential for availability of help through either federal reform or

additional Stimulus money, and that has been changed with This amendment.

Secondly, the original proposal called for an established, I believe quasi-public authority that would be paid and would incur various set expenses in order to operate. This Bill does not do that. I would revite you again, that it is a volunteer board that will formulate these recommendations.

That is, those are the most major changes.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. That obviously was, I think a huge concern to a lot of folks, and it may still be going, you know, I think, I hate to use the phrase the devil's in the details, but I still have a concern because we don't know where this is headed, but that being said, thanks for that answer.

Can I ask a couple questions through the Speaker, about the self insurance aspect of the amendment? Is it fair to say that the state's going to become, in some way, sort of a hybrid insurance company of sorts?

Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, I'm not quite sure what the Representative means by a hybrid insurance company.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Well, would you under Amendment "A", the state's getting, having a greater role in the involvement with health insurance. Correct? Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you. Through you, Mr. Speaker, I would correct the Representative because in, through the amendment, the administration of many of these programs could be contemplated to be moving to the SustiNet program, and away from the state.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

And then am I correct that we would be asking for competition, or are we trying to create competition

with private insurance companies, or am I going off the beaten path there?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, through this examination of This amendment and the recommendations from the board, it's my belief that this would only provide more options for individuals, employers of businesses large and small to look at when evaluating their health insurance needs, and to the extent that competition is fostered through choice, I believe it could actually strengthen that competition.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. My previous question, or maybe a question or two back had to do with the state getting involved, and you answered that it wouldn't be the state, it would be SustiNet, but are you making a distinction between the State and SustiNet.

Isn't there a, you know, relationship there that one could argue, you know, Louis IV said, l'etat je suis l'etat. The state, I am the state. So this is

SustiNet may be the state? Through you, Monsieur Speaker.

SPEAKER DONOVAN:

Thank you, Representative Rowe. Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, the state currently administers public programs. It administers Medicaid, HUSKY A and B, and SAGA, the main programs that I believe the Representative is thinking about.

To the extent that those programs are administered through the SustiNet plan, I would suggest that the SustiNet plan is perhaps doing the same job in administering those programs that is currently done, and in the Bill, the board of directors is authorized to submit recommendations asking that the entity that runs the program continue to look for ways that it can work with existing state agencies to more efficiently manage those programs.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Is there anything in the amendment, which, or your anticipation of where the board of

directors may take this, which would involve our state general fund as being involved or a guarantor of SustiNet or anything created?

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, I am not aware of any such provision in This amendment.

SPEAKER DONOVAN:

Representative Rowe.

REP. ROWE (123rd):

Okay, good, thank you. I'm just about ready to sit down, but can you tell us of other states, I mean, SustiNet, they wouldn't call SustiNet, but can you talk about what other states, if any, have trod down this path?

I know Massachusetts has something a little bit similar, but it's certainly not the same thing. So has this been done, and can you tell us any success or failure stories on how maybe you've tweaked this or changed this so that we would avoid failure and meet with success?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Some of my remarks might bring us back to the discussion that we had about the benefit of pooling under the previous Bill and I probably don't have to repeat all of that discussion.

However, as Representative Fontana pointed out to us, the pooling concept is currently used in 24 other states. However, as we know, This amendment contemplates a different use of the pooling function, and probably the closest example is in the State of Kansas.

In Kansas they have a Health Policy Authority that manages Medicaid, the state employees. It's self insured and it has a pool that it's my understanding is open to municipalities.

I can tell the Representative that in Kansas, the Kansas Inspector General has reported some success, substantial success with this. They moved into it slowly, since they actually started self insuring in Kansas back in 1997.

So these, they're a bit further down the road in some respects, but in other respects, This amendment perhaps takes us in a little bit different direction.

However, they do report that they have evidence they've negotiated better rates for coverage, declines in spending, particularly in home health in the areas of hypertension, diabetes and mental health and a reduction in what was described to me as inappropriate payments of approximately $250 million.

I would typify that as to be efficiencies in the payment system. Potentially that resulted from that.

I will add the Representative mentioned Massachusetts as well. Massachusetts has moved in this direction with their combined rating, but the structure is relatively different from this and I think not comparable.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Hi. Good evening, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Good evening, sir.

REP. ROWE (123rd):

Welcome back to the dais.

DEPUTY SPEAKER ORANGE:

Thank you very much.

REP. ROWE (123rd):

Can I just get back to the general fund connection to this, and I know your answer was no, it's not contemplated that the general fund plays any role in the pool that may be created.

But the amendment doesn't create any reserve pool. Is that correct? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I'm quickly searching through my amendment, because there is a specific direction of, if you wait one moment, I'll be able to give you the line.

I would direct the Representative to Lines 173 through 175 where the recommendations would indeed extend to the purchase of reinsurance or stop loss insurance, set aside reserves or to take other prudent steps that avoid excessive exposure to risk, and I believe that addresses the point the Representative was concerned about.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. I appreciate that. I'm just getting to look at the amendment, you know, sort of initially.

So the Bill does contemplate asking the board of directors to look into purchasing reinsurance or stop loss, et cetera, which would in theory insulate the general fund from being a guarantor.

I guess one of my concerns is that if we're looking to increase competition, the private insurance folks would be at a disadvantage if you know, the state had a huge general fund, not much left in the general fund, I suppose, but in theory if the state had a general fund to fall back on, that would put the private folks at a disadvantage.

But so, am I correct that your answer is essentially, Lines 173 through 175 takes the general fund out of the equation and says to the board, look, we want, our expectation is that you will look into the purchasing of reinsurance and stop loss coverage, and to set aside a reserve pool. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. And one thing that, or a couple things that I think this Bill does a good job of is the task forces, which seem to you know, finally treat the disease, you know, not the symptoms, and there's probably a pun in there somewhere, but really we're creating task forces for obesity, tobacco use and (inaudible) with their healthcare workforce, through Madam Speaker, is that correct?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, there are three named task forces preventing and reducing obesity, tobacco use, I think drafts, that might be the one the Representative is searching for, as well as the healthcare workforce shortages.

I would also like to add that there is nothing that does not prevent recommendations for the further use of task forces, particularly if they appear to be useful.

Those task forces, Madam Speaker, will be particularly useful in supporting the framework of the Bill that provides these mechanisms that can improve health in ways different from those that we're used to thinking about with traditional insurance plans, through the use of the medical home, the medical records and the emphasis on prevention and chronic disease, and in that respect the Representative is correct.

Those are big opportunities to be taken through this SustiNet plan.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. Can you, I'm looking through the Bill and I lost my place as to where the task forces are created. Can you one, point that out to me, and two, tell us how the membership of those task forces is going to be created and perhaps when we expect to be reported back to.

For example, do we expect their reports to be hand in glove with the board of directors when they report back to the General Assembly in January of 11? Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I would direct Representative Rowe's attention to Sections 16, 17 and 18 at the end of the Bill where the task forces are discussed.

The task forces are first charged in the beginning section of each one of those, and I'm sorry, that begins on Line 815.

REP. ROWE (123rd):

I found it. Thank you. I hadn't gotten that far.

REP. RITTER (38th):

The task forces are charged, are given their charge for their areas of investigation and are charged to then go on and develop a comprehensive plan, and that plan is to be reported out at a named date for each of them. I believe it is July 1, 2010.

In addition, there is, and actually this is something of interest to it because we love to establish task forces here and we are not always very good at determining their fate. Absence of further recommendation, the Bill in each case stipulates a

termination date for those task forces to be the following January 1st.

However, again, there is nothing that would prevent recommendations subsequent to the passage of this Bill that would change that.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Through you, I appreciate that response. No members of the task forces or the board of directors are paid, correct? I may have asked you about the board of directors, but I want to make sure on this one.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, none are paid.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. There's a couple other, I think, quite favorable aspects of the Bill. I guess if you

have a 32-page Bill, there's got to be some good stuff in it, right?

But I do think that we're hitting on some important elements. The medical home advisory committee, which I don't think has been touched on as of yet. Can you talk about what the expectations are with regard to medical home advisory committee or committees?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I would direct the Representative's attention to Section 6, beginning on Line 396 where the board of directors establishes the medical home advisory committee.

The purpose of the committee is to develop recommended procedures and regulations governing the administration of these homes. It directs them to be patient centered and that they provide healthcare services to SustiNet plan members.

Those recommendations must also be, excuse me, those formulated in the form of internal procedures and proposed regulations to the board and the board

will prescribe a schedule for reporting that. The purpose of that prescription is to ensure that it can come together in time for the required reporting date of January 1, 2011 on the part of the board. Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. And in terms of the substance of what the medical home advisory committee, or to what these are, it's my understanding that a medical home, and I think that's the right term, is a physician that is able to advise individuals on holistic or long-term big picture health issues.

Is that correct, or am I thinking of something else? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Representative Rowe, you are indeed correct. That is one way in which a medical home could be provided. In the absence of such a physician, it could be provided through, for example, a community health center, a physician group,

staff within a physician's group or a variety of other healthcare providers.

But I believe your grasp of the concept is correct.

REP. ROWE (123rd):

All right.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. And would the gentle lady agree that these medical homes, or medical homes is a concept that we need to promote and perhaps that's why it's in the Bill. Begging a question, but this is a concept that again, is looking to treat and address big picture issues and the disease as it were, not the symptoms, which we've been doing for far too long.

Is that the concept here that we're going to look to promote a long-term goal, which is served by medical homes, which is as we've been talking about, holistic, broad-based and sort of long-range thinking?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, the Representative is correct that that would be part of the function as a medical home. On a more day-to-day basis there are supporting functions, for example, appointment follow ups, testing guidelines, adherence to generally accepted and evidence-based procedures and schedules for diagnostic testing. That also would be performed by a medical home.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. And these are all things that move the state in the right direction, I think. There's another aspect, or another area that the Bill talks about and I don't have the line number, but there's a, the creation, or do we seek to create some sort of health information technology committee or advisory board, or is there a provision contained in the amendment that will help influence or guide how electronic medical records are used for the SustiNet members, presumably?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker, the answer to the question is yes, and I would direct the Representative to Line 242 at the beginning of Section 5 where that discussion begins.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, and can you fill me in, or fill us in on what the goal of this health information technology provision is. I gather that, as I indicated, has to do with medical records and how they're used for participants in SustiNet.

Can you flesh that out a bit? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Through you, I will quickly describe the structure of this. The board of directors will establish an information technology advisory committee, and that committee is directed to formulate a plan to develop, acquire, finance, lease

or purchase fully inter-operable electronic medical records, software and hardware.

The purpose for that, Representative Rowe, is to be able to offer that to subscribing providers, who have not yet been able to take advantage of say, existing Stimulus money to go ahead and automate their offices.

Those medical records provide a record of the day-to-day health and medical treatment for an individual patient. Another function of that committee is to also ensure that those records are fully inter-operable with a health record for each member.

Through that health record there are anticipated opportunities for not only efficiencies in prescribing and diagnosing, but also opportunities to cut costs through the unnecessary procedures.

A lot of that would occur through the rapid sharing of information. Once this information is available digitally, as I'm sure the Representative is familiar with, it is a lot easier to be able to access it and to share it with participating physicians or other healthcare providers.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. Thank you for the answer, and I agree with those goals, and I think they're important.

Have there been any, was there any discussion maybe at the public hearing or the many discussions you've had, about potential privacy concerns with regard to the integration of medical records and the digital world, and you know, the flip side of having instant and readily accessible records for medical providers and treaters, is that there is easily obtainable, you know, medical information out there, so there's good and bad in that.

And I would gather that there are a lot of privacy concerns, which could be implemented. Are there any, do you contemplate any safeguards, or do you anticipate the board of directors looking into that issue because I would think that when you're discussing the digital age and medical records, it's rife with privacy concerns.

So, do you share those concerns, and is any of that reflected in either the amendment or where you anticipate this going? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I would direct the Representative's attention to the discussion beginning on Lines 321 through 333, where those issues are addressed, particularly pointing out that on Line 326, it stipulates that various remedies and sanctions that apply in the result of a provider's failure to comply with privacy and security requirements, that this must indeed be consistent with federal and state law, and specifically law through the general accounting office that applies to these to privacy and sharing.

On Line 331, it's clear that remedies and sanctions that recommended by the board of directors would be in addition to those otherwise available under both state and federal law. I believe this addresses the Representative's concerns.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker, and it does. That was responsive, thank you.

Just following up a little bit more on, a bit further on, with regard to Line 341 the recommendations that permit providers to receive a proportional share (inaudible) cost savings attributable to the implementation of electronic medical records.

I hadn't seen that provision before. Do we expect, and you spoke to it a little bit before, but we expect savings in that regard?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes, we do.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

And how would that be quantified? Is there a past, is there a basis for that expectation? Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, the Bill, and I will look to find the appropriate lines in time if I can,

provides an opportunity for the entity that's running the program to negotiate purchasing contracts to acquire the specific software and expertise needed to do this. That would provide the potential for a savings.

In addition, future savings through the use in terms of efficiencies could be contemplated.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. And I appreciate those answers. I think this is a bit of an, well, unexplored for me, but I guess this is going on. Advances are being made constantly in this area, and I think it holds great promise.

But it also, it has some concerns that the privacy that we talked about but you addressed, and I think the Bill does address that with the appropriate federal and state regulations and guidelines.

I just had one other or two other lines of questions, briefly. Back to the medical home, quickly. I forgot to ask on this. This was the medical home was, I was calling it a doctor that would

sort of look at the big picture, but you had indicated that it was more than just the doctor. It might even be a network of folks, and you pointed out the lines in the Bill that referenced that, and I was able to read some of them in the break.

The recommendations in Line 480, and I think this is the medical home advisory committee, that the public authority assist in the development of community-based resources.

Can you help me out as to what an example of a community-based resource in that regard would be?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. One moment while I find the reference. Thank you, Madam Speaker for the pause.

My understanding of that is that that could be opportunities to help providers, their offices and their staff become either more accessible, enable them to extend their hours, and it provides other types of accessibilities.

The Bill contemplates 24 options for a 24-hour information line to help meet perhaps families. I know as a parent of my now grown children, that's something that would have been extremely useful to me because they only ever got sick in the middle of the night.

And it would be an opportunity that they might be able to use, or a mechanism they could use to help these providers and their offices in that type of an expansion.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. That helps. I should have asked that question when we were on the topic, so I apologize, but I appreciate your indulging me there.

And just a final line, in Section 12, we talk about the Office of Health Care Advocate developing model benefit packages, and I think I know what those are. We know what those are.

But it goes on to indicate that those are going to be based on evolving medical evidence and scientific literature to make the greatest possible contribution to member health for premium costs

typical of private employee-sponsored insurance within the northeast states.

What is meant by that? I know where the northeast is, and I know we're in the northeast, but the bigger context. Can you tell me what that area of the amendment is getting at, please? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Through you, my understanding of this is that within available appropriations, the Office of the Health Care Advocate would have the opportunity or be charged with an evaluation that must occur, I believe biennially of all of the changes and opportunities that have come to healthcare.

And with that evaluation, put together a model benefit package. The purpose of this, Representative Rowe, was to keep the standard benefit package, which the plan relies on from becoming out of date or out of step with the most current research or evidence-based practices.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Does not the Office of Healthcare Advocate already do this in some fashion, or is this a new charge we're asking of that office? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. The Office of Healthcare, the Healthcare Advocate's Office does this and lots of other research on the availability of healthcare plans as part of their regular operations.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE; (38th)

Thank you. I had the Deputy Minority Leader speaking and bothering me during the first part of that question, so can the Chair ask the Deputy Minority Leader not to bother me any more.

But secondly, can I ask through you the gentle lady to repeat her answer, please? Through you.

DEPUTY SPEAKER ORANGE:

Representative Klarides, we'll ignore what he had to say, and you may once again ask your question, and Representative Ritter, you may answer.

REP. ROWE (123rd):

Okay. Through you, can I just get, can you repeat the answer please?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, it is my understanding that the Office of the Healthcare Advocate does indeed regularly keep abreast of this information --

REP. ROWE (123rd):

Okay.

REP. RITTER (38th):

-- as part of his regular operation.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Now, the Office of Healthcare Advocate, I believe, was targeted for elimination under the Governor's budget. Through you, Madam Speaker, is that correct?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I believe that is the case, was the case.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. So, but the amendment has the Office, the Healthcare Advocate being the chairman of the board? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Well, that could be a problem. Is that a problem, Madam Speaker, through you?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, this Chamber voted to reappoint the Healthcare Advocate to a new four-year term, I believe about a month ago. I do not believe that will be a problem.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Okay. Thank you. With regard to the board, the Governor has, well, can you give me the lines again. I've got my 32 pages all over the place. But we talked before about the makeup of the board.

The board is created early on in this package. Where is that again, please? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, that discussion begins on Line 66,

REP. ROWE (123rd):

Thank you.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Now, am I correct that the nine members are being appointed by various appointing authorities? You told me that already. Does the Governor only have one of those nine appointments? Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Okay. It would seem to me that, and I'm looking here at the Comptroller and the Health Care Advocate, if the Health Care Advocate exists, and the Governor and the President of the Senate, it seems that everyone except me gets to appoint someone to the board of directors, which is okay.

But what was the thinking of giving the Governor you know, the chief executive of our state, only one of the nine? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I will refresh the Representative's memory that in the original Bill, there were 14 members. I believe it was 14 members of this board, a much larger board, and I believe the Governor had one appointment at that time as well.

If, I'll leave it at there. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

And when we had the 14 appointees, I didn't have an appointee in the 14? Correct? Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. ROWE (123rd):

Because I'd like to go back to that if I did.

DEPUTY SPEAKER ORANGE:

Representative Ritter, do you care to answer that?

REP. RITTER (38th):

Through you, Madam Speaker, that is correct.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. Was there a thought of having the board determine a recommendation, was there a thought of having the board make more determinations than the Bill? I know you probably tread a delicate line between the charge you wanted to give and the end result you wanted to have, but also giving discretion to the board.

Are there concerns that the board does, I don't know the answer to this, that the board might not have enough discretion to implement what we're asking them to do?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I am not aware of any such concerns, and I believe if the Representative takes a look at the areas of expertise that are represented by the board, and also the four advisory committees that are required to supplement the work and recommendations of the board, that there is a quite a breadth of expertise and diversity of opinion that would be provided.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. So the answer is, we are giving them sufficient discretion. This will be a group of experts, we anticipate, and we have high expectations. Fair to say? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative Rowe.

REP. ROWE (123rd):

Thank you. And I promise I'm wrapping up. But in Line 84 where we talk about the initial appointment to the board, if an appointing authority, one of the nine, I guess, fails to make an appointment, the President of the Senate and the Speaker of the House jointly appoint a board member that satisfies the required specs, the expertise as you indicated.

Was there, I've been doing this a little while, but why was not the Governor, what was the thought process behind not giving the Governor that appointing

authority or even a chair at the table with the President of the Senate and the Speaker of the House?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I do not believe I know the answer to that question.

DEPUTY SPEAKER ORANGE:

Thank you, Ma'am. Representative Rowe.

REP. ROWE (123rd):

Thank you, Madam Speaker. You've known the answer to all my questions so far, though, so that was, and I appreciate the gentle lady's responses. It was very informative, at least for me, and I appreciate you walking me through it and indulging me in some of the questions.

It's an expansive Bill. I think we touched on some of the very favorable elements that Representative Ritter and others have been able to include in the Bill, and the ones that I think we ought to care about most are, you know, the medical homes and the task forces, the obesity task force, and the tobacco use task force.

These are things that are going to bear long-term fruit, I believe. I'm not, and I appreciated the answers with regard to the cost, and how we started months ago with costs that were unsustainable and I guess would have made this you know, dead on arrival, to a point where it might even be affordable, if the answers, if it turns out as you expect.

I think there probably are concerns, given the charges we have given the board and all the unknowns and such. I appreciate your answers also with regard to the general fund and how the general fund is insulated because we're asking the board to create that reserve pool, which I think in a way will not put the private insurance providers at a disadvantage.

So I thank the gentle lady very much for her responses, and I'm going to sit down now.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Well, thank you very much, Representative Rowe. Care to remark further on the Bill before us? Care to remark further? Representative O'Neill of the 69th District, you have the floor, sir.

REP. O'NEILL (69th):

Madame L'Orateur, bon soir. If the Representative from Trumbull can speak French on the floor, then I suppose any of us can speak French on the floor.

I was going to pose my questions to the proponent of the amendment in French, just to move things along here in a new and different direction.

DEPUTY SPEAKER ORANGE:

Nice ambiance.

REP. O'NEILL (69th):

But, I'll stick to English this evening. Looking at Lines 112 through 116, if I could pose a few questions to the proponent of the amendment, through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

You may proceed, sir.

REP. O'NEILL (69th):

Thank you. Looking at Lines 112 through 116, which is Section 2(3), if I could ask, what is the purpose of that language? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter, do you care to answer, Ma'am?

REP. RITTER (38th):

Thank you, Madam Speaker. That sounds much better. The purpose of that Section was first to make it clear that that board of directors is not to be considered to be a department, institution or agency of the state.

And the second is to assign administrative support to the board.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. By not having the board be considered to be an administrative agency, department or institution of the state, does that mean that the board is not going to be subject to such things as the Freedom of Information Act? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, it is my understanding that it is fully subject to the Freedom of Information Act.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Well, then if I could, Madam Speaker, because my understanding is that the definition of a state agency, which is subject to the Freedom of Information Act in fact pretty closely parallels the language that we're talking about in the Section.

I mean, there's a little bit of over, or language that's not there, but that if one were to look at the Section, I think it's 1-200, and the definition of a state agency, it seems to cover all of those entities.

There are a few other things that are covered in that Section that render something to be a state agency or a local agency and therefore, subject to the Freedom of Information Act, but this looks like it's, by exempting it from, or saying that it is not to be construed as a department, institution or agency of the state, it appears as though that language does try to say that this is not going to fit the definition of agency, and therefore if they're not an agency, you're not going to be considered subject to the Freedom of Information Act.

So I just want to be sure that that language is not intended, there's no purpose there to exempt this

board from the requirements of the Freedom of Information Act.

Is that correct? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker, and I thank Representative O'Neill for his concern, and the opportunity to clearly establish the legislative intent of this Section.

There is no intent that this in any way be free from any of the provisions of the Freedom of Information Act, and again, I want to thank Representative O'Neill for allowing me to be perfectly clear.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. And then if I could ask, because this is in both the amendment and the underlying Bill, what is the goal of that language being there? What is intended to be accomplished?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker, and through you, it's my understanding that the goal is to make it clear that it is not an agency in the way that we might think of, for example, of the Department of Social Services or the Department of Public Health.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

And if I could ask, through you, Madam Speaker, why is that important?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. That's important because this is a voluntary board of directors. It serves without compensation and it has no other powers other than what it is given in This amendment.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. It's my understanding that there are many voluntary boards, which are state

agencies, various boards and commissions and there are dozens of them that are listed in the register and manual for which people are not compensated at all.

I'm trying to understand why it is, it's considered to be important that this board of directors is not considered to be a state agency, institution or department. What's the drawback if they were? What would be bad bout them being considered such a thing?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. It's my understanding that this also makes it very clear that the general fund of the state is protected, and I would bring the Representative's thoughts back to some of the previous conversation that I had, I believe with Representative Rowe to that point.

But again, I would like to establish that this is absolutely within the provisions of the Freedom of Information Act. I have been since reminded that that has been verified through the Attorney General's office when we first looked to drafting this. And I

want to again thank the Representative for allowing us to make that clear.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker, and I thank the Representative for the answer. But, and I was trying to pay attention to the various colloquies that have occurred, but I'm not sure I understand why, and in what manner does the fact that this is defined as not being a state agency, department or institution protect the general fund?

Through you, Madam Speaker, if she could explain how it protects the general fund?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. This is a voluntary board. It does not have any, have the ability to hire and it does not have staff, and that is my understanding of that section.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. So that in the event that this language were not here, then this board would have the power to hire staff and incur debts that would be obligations of the state. Is that what this is aimed at preventing? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I think I would, rather than simply repeat my previous statement, which is my understanding of how this board would act, point out that we are familiar with other instances in which we have done this type of thing, and most immediately and pertinent to this would be the Health First Authority. A similar, voluntary board.

It did significant work, but it did not hire staff or in any way use any other state resources with the single addition of the mention of support, administrative support that is provided.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker, and moving on then to the second sentence there. It talks about the, what I assume is the Public Health Committee is going to provide administrative support to the board of directors, and if I could inquire as to what does that mean in terms of actual activities that the Committee is going to, or the staff of the Committee is going to have to undertake if that could be explained? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. A large number of those activities would include the making and filing of agendas, posting meetings, taking minutes, copying information and disseminating it to Members of the Committee. Those are the tasks that most immediately come to mind.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. So then the tasks that we're talking about would not include, for example,

doing research or interviewing people, that sort of thing?

Is that correct? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, it would be my understanding that that would not be involved, and I would point out to the Representative the ability of the four advisory committees to be able to support the work of the board and perhaps some of those functions would be chosen to be delegated to those committees.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker, and that does take me now to the four advisory committees. I did not see language, and perhaps I missed it, that exempts them from the designation of being considered a state department, institution or agency, and the question that I would have first off, is there language in the amendment that exempts those four committees from such a designation?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I don't believe I am aware of any such language. Those are appointed by the board of directors.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker, because I do believe that in the Freedom of Information Act, again Section 1-200, it does reference committees, although it would perhaps be strange to have something that's specifically identified as not being a state agency, institution or department, somehow being able to create a committee that would be considered subject to the part of the state government, but perhaps I want to make it clear or to find out.

Is it the intention that these committees themselves are not going to be considered in any way parts of the state government as departments, institutions or agencies?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

And would the activities of these committees that are going to be doing the actual work, would they be subject to the Freedom of Information Act?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, yes.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. And so I then have to wonder, how are they going to be able to do the research and gather the information? Are they going to be, who are they going to be supported by? Who is going to, in effect, staff those committees? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, two points. First, I would like to point out that these committees are subordinate to and appointed by the board of directors, and they're consequently, if there were such a need, it would be the responsibility of the board of directors to either know that or to make accommodations for that through any supports available to them.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. I guess I'm, if the, my understanding of the prior answers is that the board itself is not a state agency, or institution or department. It's going to get what sounds like the, what word is administrative support. It sounds pretty much like it's going to be clerical support, agendas, minutes, perhaps being prepared, information, documents being copied and disseminated to the members.

So, but that's a fairly limited role that the Public Health Committee's staff is going to be providing. The board itself doesn't have any resources with which to hire staff, or does it? Perhaps I should ask that question.

Does the board have somewhere else in the Bill, resources made available for having its own staff to do things like research? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I am not aware of any.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. And then, the, so the board doesn't have any of its own staff to do any research or gather information, and then there are these four committees that are appointed by the board.

Are they going to be given somewhere in the Bill, resources with which to gather information or do things?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, the committees themselves have no specifications around either their membership or their size, Madam Speaker, and I am not aware of any dedicated resources in This amendment.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. Well then is it the anticipation that the committees are going to be able to do, get volunteers to donate time and effort to the committees instead of having paid staff to do the research and analysis, and that sort of thing, to do the work of the committees? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, I would like to bring to the mind of Representative O'Neill the work of the Health First Authority, which actually is something of a model for this type of committee work. They

produced a very extensive report after 18 months of work. That Authority is now disbanded.

It was supported administratively in the same manner as this will be supported by the staff of the Public Health Committee. That report, I think, the participants certainly, and people who managed several subcommittees, found that work to be both highly detailed and well done, and that, as I said, was the model for this.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. I have to confess. I'm not intimately familiar with the work of the Health First organization, and so since this is the model upon which the amendment before us is based in terms of the organization of the board and then it's four subcommittees, if the Representative could indicate, give us some information about the Health First group as to what it's membership, I'll start with that, what it's membership was.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I can remind Representative O'Neill that this body established the Health First Authority two years ago. It gave it, I believe, an 18-month charge that consisted of, I believe, of 10 members and had two subcommittees. Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker, and was it then the case that the subcommittees were similar in terms of being of unlimited membership? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I do not have the list of the subcommittee members of the Health First Authority with me at this time, and so I'm unable to share it with Representative O'Neill.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. And so the appointing authority for these new four committees is going to rest with the board of directors and then they're going to appoint people to be on these committees.

Does the amendment indicate, I didn't, I don't recollect seeing it, a list of criteria of the folks that are to be appointed to the four committees?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, the amendment does not.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Okay. Thank you, Madam Speaker. The other area that I wanted to get into is that I notice that there's a difference in the amendment, or a distinction in the amendment between it and the Bill in that the Bill talked about the Comptroller or her designee, or the, and I forget who the other person is

that's going to be cochair or the chair of it, Health Care Advocate, or his designee.

The amendment does not provide for a designee to serve, so it seems as though the Comptroller is required by the terms of the amendment, to actually go to all the meetings and act as chair of all the meetings.

Is that in fact the intent of the amendment?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, the amendment designates the Comptroller and the Healthcare Advocate as the cochairs, that is correct.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Yes, Madam Speaker, but in the underlying Bill, and the amendment would replace the Bill, in this particular is a distinct, a significant distinction. The underlying Bill allows for the Comptroller to designate someone else to go in her stead to the various meetings of the board.

And my question is, is the Comptroller going to be required to personally appear at all of the board meetings? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. The Comptroller and the Healthcare Advocate have been participants in this particular part of the amendment, and I think it is fair to say have been enthusiastic about doing this work.

And while the amendment does not stipulate they are required to attend every minute, I think their participation makes it clear that they are looking forward to doing this. Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Madam Speaker. Well, I'm glad for that answer, and I hope that the Comptroller retains her enthusiasm for going to these meetings.

I know that usually when we create an organization like this, and it says that a particular person is designated, a particular commissioner or

other person is required by virtue of their office to be a participant, almost always we provide for the designee to be a substitute, given the fact that someone like the Comptroller has a great many duties to attend to, and the job requirements that are built into the statutes, the core requirements for the job of Comptroller are pretty substantial.

And one would think that at this particular time with our financial difficulties being what they are, that the Comptroller is especially burdened with day-to-day responsibilities.

It is my hope that she is going to be able to accommodate attending to these board meetings. Presumably, hopefully they will not be particularly numerous, but on the other hand, since we are by statute ordering her to attend these meetings and not send anyone else in her place, and she has to not only attend them, but she has to chair the meetings, that it may be a particularly burdensome responsibility.

So I'm sort of surprised that at least the option of having a designee was not retained in the amendment, and I hope that the Comptroller does not come to regret having signed off on this. Thank you, Madam Speaker.

REP. O'NEILL (69th):

Thank you, sir. Care to remark further on the Bill before us? Care to remark further on the Bill before us? The distinguished Deputy Minority Leader, Representative Klarides. No? Okay. Representative Pam Sawyer of the 55th District, you have the floor, Ma'am.

REP. SAWYER (55th):

Thank you, Madam Speaker. I'll allow Representative Ritter to sit for just a few moments, because I have comments to make on Section 12.

Section 12, Madam Speaker, refers to the Office of Healthcare Advocate, and mandating that they develop an update model benefit packages, based on evolving medical evidence and scientific literature.

And what's interesting in that particular paragraph and they're describing what they want them to do, it also says within available appropriations. And in every effort I can see that it was made to have no cost, (inaudible) fiscal note.

What I can tell you is, we're talking about a very small agency of seven people plus the Advocate, and what they're supposed to do, Madam Speaker, in Connecticut according to their mandate is, they're

supposed to assist Connecticut residents who belong to managed care HMO health plans.

If you have questions about your managed care, you need to understand the referral or pre-authorization process or need to, or need assistance in the appeal or grievance procedures, they're there to help.

So really what they're there for is to do some consumer protection for people who need to find a way to wiggle their way through the healthcare system because it is very complicated and oftentimes a family in distress. They do not know how to get the help that they need.

So we have seven people, and I can tell you, Madam Speaker, as far as I know, each of those people work very hard every day tending to the residents of the State of Connecticut and helping them with the healthcare. They don't have an excessive of staff and we didn't give them an excessive staff. It's not in the budget to give them more staff, ladies and gentlemen.

As a matter of fact, in the Governor's budget, she no longer included this in trying to find ways to save every penny.

Madam Speaker, what we're asking this agency, this health agency to do is to do very, very high level, specialized, model creation for healthcare based on evolving medical evidence and scientific literature.

Madam Speaker, there are people who do this around the world. They are very few in number, and they're highly specialized, and I would propose to you, Madam Speaker, and to others in this Assembly that the Office of Healthcare Advocate would need to have outside assistance to be able to do this.

Currently, this office has a $1 million budget, and about 85 percent of that budget goes to salaries and fringe benefits and those type of things, so we're really only talking about $150,000 that they have to run the whole office.

They do not have the depth of bench. They do not have the financial depth to be able to do what we're asking here. I think people were trying to be fiscally careful, perhaps, but they ask an agency that is not equipped to be able to do this, and they have about 16 to 18 months to do this, because they're expected to report back by December 1, 2010 and biennially thereafter.

It goes on to say that the same Office of Healthcare Advocate shall recommend guidelines for establishing an incentive program that recognizes employers who provide employees for health insurance benefits that are equal to or more comprehensive than the model packages.

Incentives may include, I say this with a straight face, public recognition of employers who offer such comprehensive benefits. Well, I certainly think they could do that. They could send out a press release to say atta boy, there you go. You did it. Very nice. It doesn't cost them anything.

But I go back to the beginning of that Section, and it says, develop and update model benefit packages, which is really outside of the realm of what we've given them to do in the past.

So Madam Speaker. I'd like to just point out to this particular august body that they're well-intentioned. I would be very concerned that we would not have everything we need coming back in those model packages for the other groups, the other directors to be able to make decisions from, and there's not a backup.

So I'd like to thank the Chamber for the indulgence on this, and I do not have any questions at this time, but I will not be voting for the package.

Thank you very much.

DEPUTY SPEAKER ORANGE:

Thank you, Representative Sawyer. Will you care to remark further on the amendment before us?

Representative Candelora of the 86th, you have the floor, sir.

REP. CANDELORA (86th):

Thank you, Madam Speaker. I don't have any questions on this Bill, and I don't want to carry this too much further into the night, but I am concerned when I read this Bill, the amount of authority that we are giving this board of directors. They're going to be responsible for creating this healthcare plan, for administering a software program, which I've just seen with the, you know, Core CT.

It could be millions of dollars that they are going to be stewards of, and as a result of that, I think it would be important that the board of directors be required to submit financial disclosure statements, similar to what we're subjected to.

So I think that it's important that we do address that issue and I do have an amendment that addresses this concern, but because we have this underlying amendment before us, I will call it after.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark on House Amendment Schedule "A"? Will you care to remark on House Amendment Schedule "A".

If not, staff and guests please come to the Well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting House Amendment Schedule "A" by Roll Call. Members to the Chamber.

DEPUTY SPEAKER ORANGE:

Have all Members voted? Have all Members voted? If all Members have voted, please check the board to determine whether your vote has been properly cast.

If all Members have voted, please check the board to be sure that your vote has been properly cast.

If so, the machine will be locked and the Clerk will take a tally.

The machine is still open. The machine will now be locked and the Clerk will take a tally.

And the Clerk will announce the tally, please.

THE CLERK:

On House Amendment Schedule "A" for House Bill Number

6600.

Total Number Voting	140
Necessary for Adoption	71
Those voting Yea	105
Those voting Nay	35
Those absent and not voting	11

DEPUTY SPEAKER ORANGE:

Representative Green.

REP. GREEN (1st):

Thank you, Madam Speaker, I'd like to vote in the affirmative.

DEPUTY SPEAKER ORANGE:

The Transcript will now record that you would vote in the affirmative, and with that, the amendment.

Representative McCrory, hello.

REP. McCRORY (7th):

Thank you, Madam Speaker. I'd like to have my vote recorded in the affirmative.

DEPUTY SPEAKER ORANGE:

The Transcript will so note, sir, Representative McCrory in the affirmative.

The amendment passes.

Will you remark further on the Bill as amended? Will you remark further on the Bill as amended? Representative Candelora, good evening, sir, you have the floor.

REP. CANDELORA (86th):

Good evening, Madam Speaker. Madam Speaker, the Clerk is in possession of an Amendment, LCO 7856. I ask that he call and I be allowed to summarize.

DEPUTY SPEAKER ORANGE:

Will the Clerk please call LCO Number 7856 designated as House Amendment Schedule "B".

THE CLERK:

LCO Number 7856, House "B", offered by Representative Candelora.

DEPUTY SPEAKER ORANGE:

Representative Candelora.

REP. CANDELORA (86th):

Thank you, Madam Speaker. Madam Speaker, This amendment attempts to have individuals who serve on the board of directors, that they be subject to the financial disclosure requirements under Section 1-83 of our General Statutes.

This board will be administering possibly multi-million dollar contracts and I think it is imperative that the board members be subject to our financial disclosure requirements. Thank you, Madam Speaker.

REP. CANDELORA (86th):

Thank you for summarization. Would you care to move for adoption?

REP. CANDELORA (86th):

And I move for adoption.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on adoption of House Amendment Schedule "B". Will you remark on the amendment? Representative Ritter, you have the floor, Ma'am.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, I would like to urge the Chamber to think favorably upon This amendment.

I'd like to thank Representative Candelora for it. I urge, I would regard it as a friendly amendment, and once again, I would urge the Chamber to adopt it.

DEPUTY SPEAKER ORANGE:

Will you remark further on the amendment that is before us? Will you remark further? If not, I will try your minds. All those in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

All those opposed, Nay. The Ayes have it. The amendment is adopted.

Do you care to remark further on the Bill as amended by House Amendment Schedules "A" and "B"? Do you care to remark further? Representative Giegler, you have the floor, Ma'am.

REP. GIEGLER (138th):

Thank you, Madam Speaker. The Clerk is in possession of Amendment, LCO Number 7835. I ask he call it and I be allowed to summarize.

DEPUTY SPEAKER ORANGE:

The Clerk will please call LCO Number 7835 designated as House Amendment Schedule "C".

CLREK:

LCO Number 7835, House "C", offered by Representatives Cafero, Hamzy and Klarides.

DEPUTY SPEAKER ORANGE:

The Representative seeks leave of the Chamber to summarize the amendment. Is there objection? Is there objection? Hearing none, Representative Giegler, you have the floor, Ma'am.

REP. GIEGLER (138th):

Thank you, Madam Speaker. This amendment will address the issue that we really want to debate, the cost of healthcare. LCO Number 7835 is similar to Senate Bill Number 678 and Senate Bill Number 782.

Its Sections 1 through 4 it requires the Governor in consultation with the Legislative Leaders, the Lieutenant Governor and the Public Health Commissioner by June 1, 2009 to designate an entity to serve as the state's lead health information exchange organization beginning on July 1, 2009.

It also requires this entity to seek funds for developing a statewide health information exchange,

implement the statewide health information technology plan.

The Bill requires the Public Health Department to submit to the Legislature on July 1, 2009 and it develops standards of protocol for privacy in sharing electronic health information.

This Bill also requires DPH to develop conflict of interest policies to govern the designated entity actions.

Sections 5 through 7 establish a process for healthcare providers and patients to engage and share decision making concerning treatment options for the patient.

This Bill creates the Connecticut Healthcare Cost Containment Authority to develop community-based health authority. These actions have the ability to make real reductions to the cost of healthcare in our state.

House Republicans want to make important steps to reduce healthcare costs, but not support the creation of costly legislation in the underlying Bill the way to cut costs without creating a government program, and I move adoption.

And I ask when the vote be taken that it be taken by Roll Call.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on adoption of House Amendment Schedule "C". Will you remark further?

And the motion is on, I believe, a Roll Call Vote, Representative Giegler. All those in favor of a Roll Call Vote please signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

The 20 percent has been met. When the vote is taken, it will be taken by Roll Call. Will you care to remark further on the Bill as amended by House Amendments "A", "B" and "C". On "C". Only "C". Thank you.

Representative Ritter, you have the floor Ma'am.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, I'll make it clear that I am speaking to the amendment, LCO Number 7835 and not to the Bill.

Madam Speaker, This amendment, while I see that it has taken some thought to put the amendment

together, I will tell you that I cannot regard This amendment as friendly to the Bill.

While the amendment supports many parts of the Bill related to the surrounding delivery system contemplated in the SustiNet plan, it does not contemplate the coverage of healthcare, and that being a major purpose of the Bill, I would ask the Chamber please to reject the amendment.

Thank you.

DEPUTY SPEAKER ORANGE:

Thank you, Madam Chairman. Would you care to remark further on House Amendment Schedule "C"? Do you care to remark further on House Amendment Schedule "C"?

If not, staff and guests to the Well of the House. The machine will be opened. Members take your seats.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting House Amendment Schedule "C" by Roll Call. Members to the Chamber.

DEPUTY SPEAKER ORANGE:

Have all the Members voted? Have all the Members voted? If all the Member have voted, please check the board to make sure your vote is properly cast.

If all the Members have voted, the machine will be locked and the Clerk will take a tally.

And the Clerk will announce the tally, please.

THE CLERK:

On House Amendment Schedule "C".

Total Number Voting	142	
Necessary for Adoption		72
Those voting Yea	34	
Those voting Nay	108	
Those absent and not voting	9	

DEPUTY SPEAKER ORANGE:

The amendment fails.

Do you care to remark further on the Bill as amended by House Amendment Schedules "A", "B". and, no, just "A" and "B". Do you care to remark further on the Bill as amended?

If not, staff and guests please come to the Well of the House. The machine will be opened. Members take your seats.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber.

DEPUTY SPEAKER ORANGE:

Have all the Members voted? Have all the Members voted? Please check the board to be sure that your vote has been properly cast.

The machine will be locked and the Clerk will take a tally. And the Clerk will announce the tally, please.

THE CLERK:

House Bill Number 6600 as amended by House "A" and

"B".

Total Number Voting	142
Necessary for Passage	72
Those voting Yea	107
Those voting Nay	35
Those absent and not voting	9

DEPUTY SPEAKER ORANGE:

And the Bill passes as amended.

SPEAKER DONOVAN:

Representative Merrill.

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CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2009

VETO
SESSION

VOL.52
PART 34
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Those voting Nay 35

Those absent and not voting 10

SPEAKER DONOVAN:

The bill is repassed.

Will the Clerk -- members of the Chamber.

Will the Clerk please call House Bill 6600.

THE CLERK:

On page 2, Calendar 403, Substitute for House Bill Number 6600, AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN AS AMENDED BY HOUSE AMENDMENT SCHEDULES "A" AND "B", favorable report of the Committee on Insurance and Real Estate.

SPEAKER DONOVAN:

Representative Merrill.

REP. MERRILL (54th):

Yes, Mr. Speaker. I would make a motion for a reconsideration of this matter, and the record will show that I was on the prevailing side.

SPEAKER DONOVAN:

The question before the Chamber is a reconsideration of House Bill 6600. For the benefit of the Chamber, I will note that Representative Merrill was on the prevailing side of this issue when the Chamber passed this measure on May 20, 2009, and

is therefore an appropriate member to make the motion for reconsideration.

Is there objection to the motion to reconsider? Is there a motion to reconsider?

Without objection, the bill will be reconsidered.

Will you remark further on the motion to reconsider -- oh, never mind. The bill is reconsidered.

There we go. Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, I move for repassage of the bill.

SPEAKER DONOVAN:

The question before the Chamber is on repassage of the bill.

Representative Fontana, you have the floor.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, this bill establishes a nine-member SustiNet Health Partnership Board of Directors that must make legislative recommendations by January 1, 2011, on the details and implementation of the SustiNet plan, a self-insured health care delivery plan.

Specifically, the bill creates a flexible

framework for designing and implementing sustainable health care reform that fulfills the Institute of Medicine's central principles regarding cost, quality and access. It charges the board of directors with forming four committees and three task forces to develop specific legislative recommendations in several policy areas.

Mr. Speaker, this bill is the summation of years of work on the part of many organizations, entities, advocates and stakeholders. Over the past several years, there's been a growing demand in this state for health care reform. We've conducted numerous studies as have independent organizations, culminating in the work of our HealthFirst Authority over the past two years and it's majority report.

While there's been a vacuum in leadership on health care reform until recently, the Universal Health Care Foundation and other stakeholders have moved to fill that vacuum and to provide that leadership. Their plan, the product of lengthy, comprehensive and open processes to develop goals and structure for a SustiNet plan has earned the support of many various stakeholders, small businesses intent on health care reform, realtors, senior citizens,

doctors, groups of faith and others.

Mr. Speaker, the cost of doing nothing at this point is far greater than passing this worthwhile bill. We don't need to study the issue any further, and we don't need further inaction. What we're asking for is leadership.

As the New London Day put it so well in this opinion editorial on June -- July, 10, 2009, no more blue ribbon panels are necessary to sort out the various problems with the health care system in the state. We simply need to charge the SustiNet Board of Directors with doing the job and bringing back to us in two years' time, recommendations for implementing improved health care access, coverage, affordability, and quality.

Mr. Speaker, I urge passage.

SPEAKER DONOVAN:

Thank you, Representative.

Will you remark further on the bill? Remark further on the bill?

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you, Mr. Speaker. If I may, through you to the proponent.

SPEAKER DONOVAN:

Proceed, sir.

REP. HETHERINGTON (125th):

Thank you. This bill, in effect, we really won't know the details of for possibly two years. Is that correct? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the bill charges the SustiNet Board of Directors with coming up with recommendations to implement health care reform. It may or may not have results in two years time -- we certainly will have results in two years time. As I recall, there's a section in the bill which directs the board of directors to formulate recommendations within 60 days based on national health care reform registration which is a possibility.

So in fact, we may see some recommendations from the board of directors prior to two years from now, but certainly within two years, Mr. Speaker. Through you.

SPEAKER DONOVAN:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you. The proponent anticipates the next area that I wanted to inquire about and that is with respect to the possibility of a federal health care plan.

Now, this would presumably take into consideration a federal health care plan if one is in place? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, as I recall, the bill charges the board of directors to take cognizance of federal legislation if any is passed this year and to report back to us within 60 days on its recommendations for action on our part. Through you.

REP. HETHERINGTON (125th):

So -- thank you. And through you, Mr. Speaker, does that contemplate that the state would then supplement to some degree whatever national health insurance plan is in effect? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I expect that the SustiNet Board of Directors would not only provide us with recommendations based on how we in Connecticut could work with federal legislation, but in addition, any other recommendations it might have to perhaps augment or expand upon the base provided by that federal legislation. Through you.

SPEAKER DONOVAN:

Representative Hetherington.

REP. HETHERINGTON (125th):

Well, then this summary question, through you, Mr. Speaker. Well, what is the immediate effect of this, other than charging the panel to come up with a plan? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the purpose of the bill is to create the board of directors, create the committees and task forces and charge the committee with coming up with specific recommendations for us and a plan over the next year and a half to two years. Through you.

SPEAKER DONOVAN:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you. I thank the proponent.

Mr. Speaker, I fail to see the reason for this bill at this time. There are, pending in Congress now, at least five proposals for national health care. The president has made health care a priority and urged the Congress to act before the August recess on the 8th of August.

I fail to see the reason for acting precipitously since there is, I conclude from the proponent's response, nothing to be accomplished in the short run. In fact, we wouldn't know what is to be accomplished until the panel reports back, which may be as far away as two years.

So it seems to me that the efficient, obvious way to approach this is to not act at this time and wait to see what the federal government comes through with in terms of a plan. I think this is premature. I think that it involves the state in a direction that may lead to significant costs that may be unnecessary because of the actions of the federal government.

And for that reason, Mr. Speaker, I -- I'm going

to oppose the measure on reconsideration, and I urge my colleagues to do the same. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative.

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. Through you, if I may please, a couple of questions to the proponent of the bill for reconsideration.

SPEAKER DONOVAN:

Please proceed, madam.

REP. GIBBONS (150th):

If I said that correctly. Thank you.

Through you, Mr. Speaker, it's my understanding that this bill before us, it does not actually set into motion a new insurance plan that provides the framework to set up a commission to study an insurance plan that -- and they would report back to us within 18 months or two years, whatever it is. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the lady is partially

correct. It does create a board of directors which is charged with coming up with a plan and recommendations to implement that plan. Through you.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the gentleman for his answer. Again, through you, Mr. Speaker, is this proposal going to ultimately lend or move us towards, one, the state being a self-insured company of itself and, two, towards universal health insurance for all residents of Connecticut. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the structure or framework of the guidelines contained in legislation contemplates health insurance, so that is certainly true. As to whether or not we can actually achieve universal health coverage or not, that -- well, that is a goal of the legislation in the sense that it is a purpose to which we would strive to achieve. There is no guarantee. There is no specific requirement. Through you.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. Again, through you, if we are going to be self-insured as a state, what do the guidelines say or what you think will happen to our current self -- our insurers that provide for our state health insurance? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, just to clarify things first, we would deal with self-insurance as a state, which would mean that a state entity such as state employees, as well as those who would receive or procure insurance through the state, would therefore participate in a self-insurance program. We would not be converting every employer in the state to self-insurance much less converting them to the state plan.

So just to clarify, this is about creating, as a basis, a self-insurance program for the state, its employees, those who receive health care benefits through the state and those who might procure it

themselves. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. Again, to clarify, currently the state employees -- we receive, those of us who are -- have opted to take the state insurance plan, we can receive our insurance through three or four different insurance companies under the state plan. If the SustiNet plan were enacted, anybody on the state insurance plan would be receiving insurance and health benefits through one entity, through a state plan. Isn't that correct? And if so, what would happen to the current plan such as -- or current companies such as Health Net when this plan is enacted? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the gentlelady, I think conflates the word "plan" in two different contexts. The SustiNet plan is intended to be the framework by which we provide health insurance, cost controls, access, transparency and so forth in a variety of

health care contexts.

The plans to which she's referring would be the Anthem plan or the ConnectiCare plan or the Oxford plan or Health Net plan, and those are specific benefit packages that are provided underneath the current state employee plan. So then, in essence, plans within a plan. Plans, plural, within plan, singular. The SustiNet plan would, in essence, build off of and expand upon the plan, singular, not replace any of the individual plans, plural. Through you.

REP. GIBBONS (150th):

I thank the Representative for his answer. Again, through you, Mr. Speaker, that's one of the things I'm trying to understand as to whether this is creating a whole other insurance entity or commission, or whether it's going to operate within the framework of what we currently have under our state insurance program.

I gathered from your last response it is the latter. Is that correct? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, just to clarify again,

the goal of the SustiNet plan, singular, is to offer plan participants a variety of choices, a chance to offer them more choices than they have currently because we're aware that there are those who would like to choose from the options besides those plans currently provided to state employees through the state employee plan.

So the goal of SustiNet is to explore a variety of plan designs to augment the plans that we currently offer through the state employee plan. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. Again, just to make sure that I understand, when I attended the health forum where the SustiNet providers or proponents were explaining the program, one of the issues was to get doctors and hospitals to be providers under this new SustiNet program. If they are already providers under Health Net, Anthem, or what have you, how are they going to also -- would they just include this as another form of an insurance plan that they are willing to be a provider for, or is there going to be

an either/or? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the simple answer is not the either/or, the other approach. Clearly, providers that are already signed up through one or more of our existing insurance companies, HMOs, provide through those companies, and then to us, for instance as state employees they would, ostensibly be providers, have the opportunity then to participate in additional plans that the state might sponsor or coordinate, not replacing the current arrangement, but simply building off of it and perhaps offering other types of arrangements to people who might want them. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative for his answer. Again, through you, Mr. Speaker, I think the 800-pound gorilla in the room is if the SustiNet plan is going to include many people who are currently uninsured or provide universal health insurance for residents of

Connecticut, who is going to pick up the cost for insuring those additional participants? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, that would be dependent upon the recommendations contained within the SustiNet plan sent to us in 2011, as well as what we might choose to do or not do with that plan. Through you.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

I thank the Representative. Through you, Mr. Speaker, do you have any inkling as to whether you can provide us with an idea of how these costs are going to be obtained? I think that's the scary part with all these health -- proposed health plans. Everybody wants increased health insurance or increased health access for anybody who wants to make it available. The problem is, is who's going to pay for it? Do you have any idea how these costs will be sustained? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I don't because that's the nature of the process. That's what the SustiNet Board of Directors and their committees and task forces will be working on for the next 18 months. So I do not know, and I cannot provide the gentlelady with an answer. Through you.

SPEAKER DONOVAN:

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker. I think those are all the questions I have now, but in 2011, God willing, if we are all still here, believe me, I'll have plenty more. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative.

Representative Hamzy.

REP. HAMZY (78th):

Thank you, Mr. Speaker. I rise to pose just a couple -- or a few questions to the proponent.

SPEAKER DONOVAN:

Representative Fontana.

REP. HAMZY (78th):

Thank you, Mr. Speaker. With regard to the plan that is developed by this board of directors, I understand that by January 1, 2011, it's supposed to be -- I believe the plan is supposed to be referred to committees of the General Assembly.

At that point in time, how do those recommendations take effect? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, we will have to conduct public hearings, vote on them and, in essence, enact them into law for them to take effect. Through you.

SPEAKER DONOVAN:

Representative Hamzy.

REP. HAMZY (78th):

Thank you, Mr. Speaker. And with regard to the recommendations that are developed by this board of directors, I understand that there's pretty specific guidelines that are given to the board of directors with regard to what the plans, with the ultimate recommendation -- I'll stop using the word "plan" because it does get confusing -- with regard to the

ultimate recommendation that is issued by this board of directors, are consumer directed health care plans, are those viable options under the provisions of this bill? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, it -- they may or may not. The guidance and the legislation contemplates the development of a model benefits package which consumer-driven health care might or might not be able to accommodate by virtue of its particular design. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Hamzy.

REP. HAMZY (78th):

Through you, Mr. Speaker, would health savings accounts as they are currently offered, would those be an option to be considered under this legislation? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I believe the

legislation is silent as to whether or not the board of directors, its committees and task forces, may or may not consider health savings accounts. Through you.

SPEAKER DONOVAN:

Representative Hamzy.

REP. HAMZY (78th):

Through you, Mr. Speaker, and with regard to the fiscal impact of this legislation, is there an estimated -- I know that there have been several versions of this bill, and I was trying to look for the final fiscal note on the public act, which I had trouble locating, but with regard to the bill as passed, can -- is there a fiscal note that can be shared with the Chamber?

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the fiscal note that I found, I believe -- goes along with File Number 996. And the fiscal note that I have states, the bill establishes the SustiNet Health Partnership Board of Directors as a voluntary organization that is not a state agency and receives no appropriated funds.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Hamzy.

REP. HAMZY (78th):

I apologize, Mr. Speaker. I was interrupted. I did not hear the response.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, just to repeat, the fiscal note that I found follows File Number 996, which I believe was the final version of the bill prior to passage in the Senate and enactment and passage to the Governor, and the fiscal note states, that the bill establishes the SustiNet Health Partnership Board of Directors as a voluntary organization that is not a state agency and receives no appropriated funds. Through you.

SPEAKER DONOVAN:

Representative Hamzy.

REP. HAMZY (78th):

Thank you, Mr. Speaker, and I thank the Chairman for his responses.

Mr. Speaker, in rising to sustain the Governor's

veto, I do so for a couple of different reasons.

First of all, as laid out in the bill as passed, there is a set of guidelines that precludes, I believe, consumer-directed plans from ever being fairly considered as one of the options that could be available for people to choose from. And my most significant objections to this plan is that it establishes the format for government to be increasingly involved in providing health insurance, which I think -- I happen to disagree with.

Judging from the experience that has been taking place in Massachusetts and Maine, we have seen costs that have been totally underestimated when these plans were created, fiscal pressures that have been created on those two states, in particular with regard to how their universe -- their plans for universal health coverage are paid for.

And people will say that there is no fiscal impact in this biennium under the bill that was passed, and that may be entirely true. But what we are looking at in the years 2012, 2013 and every year going forward are significant increases in costs whenever government gets more involved in providing health insurance for people. And I think the way that

government responds to those increases in costs is that either there's a restriction in care or there's a reduction in payments made to providers.

One of the things that you can take a look at with regard to the debate going on in Washington D.C. is one of the plans that's being considered was analyzed by the Congressional Budget Office, and its estimated costs over the next ten years is $1.3 trillion with the costs underestimated for the first couple of years and then accelerated in every year thereafter.

One of the things that we need to keep in mind is that in the state of Connecticut the rate of uninsured, people who are uninsured or the percentage, is approximately 7 percent. Now, I happen to believe that everyone deserves to be insured. Everyone needs to be insured. There's no question about it. There is no debating that principle. The only debate that exists is in how do we achieve that objective?

I personally believe that allowing people to become more involved in their health care related decisions is the proper way to go, not the other way. And there's been a whole bunch of studies that are done. There's been a great deal of analysis and

statistics that have been generated that shows that people who are allowed to choose consumer directed plans are more involved in their health care, the costs are significantly decreased, and people's outcomes, the outcomes of treatment are significantly better. And I think to preclude that choice is wrong.

Mr. Speaker, I don't believe that this path will do anything to reduce costs in the system. I think what it will do is increase costs based on firsthand experiences that we have seen in other states, and I don't believe that this is the right path to take or the right decision to make with regard to solving this problem that I think we all acknowledge exists. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative.

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. I don't think anyone here denies the fact that health insurance is on all of our minds and is a concern for all of our constituents. However, if we're going to change the policies within the state of Connecticut, I think we need to get it right and we can't be quick on making

decisions.

And I have a question to the Chair of the Insurance Committee.

SPEAKER DONOVAN:

Please proceed, madam.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. Is it not true that we all know that this implements a board or an authority to oversee the plan, but is it not true that it fails to include many of the stakeholders that are currently within the health care community.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the SustiNet Board of Directors is designed to bring together the work of technical experts rather than represent constituencies. Essentially the bill reflects and embodies a consensus of opinion based on our years of work and study and analysis that we want to move forward in that particular direction. Therefore, the board does provide for insurance underwriting and actual expertise.

It provides for expertise in employee benefits

administration and it doesn't preclude the involvement of hospitals, insurance companies, and others in the work of the committees and task forces. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker.

It is my understanding that there's no one from the health insurance industry, the hospital industry, or the business community included on this board. And due to the potential cost of the plan, shouldn't the secretary of off -- of Policy and Management be included as it is a self-insured plan for state employees?

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, there is no requirement that we include the entity she describes. Certainly they are welcome to participate, and we do expect that their expertise will come to bear, but again, the emphasis here, Mr. Speaker, is on bringing together technical experts rather than constituency groups.

Essentially, that's what the HealthFirst Authority did over the last two years, was to bring together various constituency groups to hash out the various ideas that we could contemplate pursuing.

The bill we have before us essentially is a product of those discussions among others and essentially moves forward in a particular direction. Through you.

SPEAKER DONOVAN:

Representative Giegler.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. You make reference to constituency groups; however, those that have been instrumental in the health care within the state and is actually a big business in the state of Connecticut, is the insurance industry.

And also, a large person that's involved in a lot of our health is our Commissioner of DPH who also is not included in this plan. My concern is that this plan is going to have a tremendous impact on health insurance and the health care consumers and providers in the state. And at this time I think we're premature in moving forward in light of the fact that the President of the United States has a national plan

that he's putting forth, and I think we have to see where that's going before the state starts implementing such a plan.

So I ask my fellow Legislators to hold the Governor's veto on this bill. Thank you.

SPEAKER DONOVAN:

Thank you, Representative.

Representative Williams.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker, and good afternoon. Mr. Speaker, I too rise with some hesitation on this issue, and obviously, all of us in this Chamber and all of us throughout state government want to be able to provide adequate and reasonable access to health care to all Connecticut's citizens. And Mr. Speaker, my concern obviously, as is the Governor's and many of my colleagues throughout this Chamber and in the Senate is obviously the cost.

Mr. Speaker, through you, just a couple of quick questions to Representative Fontana.

SPEAKER DONOVAN:

Please proceed, sir.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker. Through you to

Representative Fontana, just following up on the line of questioning from Representative Hamzy regarding the issue of consumer driven plans, is Representative Fontana in agreement with Representative Hamzy that, in fact, this does have the potential to squeeze out the advent of consumer-driven plans such as health savings accounts? Through you.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, again, the legislation, in line 7, File 996, et se., talks about the formation of a standard benefits package. If consumer-driven health care can meet the requirements of a standard benefits package which provides quality affordable health care to everyone, I don't see why they can't compete. The unfortunate fact is the consumer-driven health care does not focus on comprehensive quality affordable health care, so it makes it kind of difficult. But if they can do it, then I would imagine that they'll be part of the solution. Through you.

SPEAKER DONOVAN:

Representative Williams.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker. And through you, now was there any testimony offered in the committee as to whether or not health savings accounts -- from companies that provide health savings accounts as to whether or not they could achieve the standard that is laid out in the public act? Through you.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, to the extent that the bill actually received a public hearing in the Public Health Committee, a committee which I'm not a member, I was actually not privy to the public hearing myself, and we did not have a public hearing on this bill in the Insurance Committee so I cannot testify as to whether they did or did not speak. Through you.

SPEAKER DONOVAN:

Representative Williams.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker, and through you to Representative Fontana, the Governor's veto message talks about how, specifically, with respect to the cost, that the practical effect of this legislation

could be that the cost is double what the Office of Fiscal Analysis had projected with respect to employers being encouraged to drop their plans.

Through you to Representative Fontana, did he agree with this assessment that potentially the costs could be double what we think it is? Through you.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I have no basis for agreeing or disagreeing. The focus of the bill, again, is to have the board of directors, the committees and task forces evaluate the potential costs of any recommendations they will seek to make, so I have no basis for making that conclusion. Through you.

SPEAKER DONOVAN:

Representative Williams.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker. And is it Representative Fontana's impression, through you, Mr. Speaker, that the -- whatever plans are developed out of this task force, that those plans would have to honor the 60-some-odd health insurance mandates that we

currently have on our books requiring insurance companies to provide certain medical procedures to their patients and their members of their plans? Through you, to Representative Fontana.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I would expect that they would; however, they certainly will be free to make recommendations adjusting such a set of benefits if they choose. So I would expect them to, but they may not. Through you.

SPEAKER DONOVAN:

Representative Williams.

REP. WILLIAMS (68th): Thank you, Mr. Speaker, and in order for the plan to get out from under those mandates, would it be then incumbent upon the Legislature to then repeal those mandates, or would that power be vested to the organization in question? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, that would require

legislation.

SPEAKER DONOVAN:

Representative Williams.

REP. WILLIAMS (68th):

Thank you, Mr. Speaker. And I thank the gentleman for his answers.

I have to agree with what Representative Hamzy said earlier, Mr. Speaker, and that is, generally speaking, health insurance is expensive today because health care is expensive. The cost of health care is very expensive. And there's nothing in this legislation, as well-intentioned as it is, in my opinion, Mr. Speaker, that does anything to reduce the cost of health care. And that's essentially what Representative Hamzy was talking about earlier about consumer-driven plans. What I've talked about and my colleagues have talked about throughout many of our careers on the Insurance Committee, that reducing health insurance mandates would ultimately help us reduce the cost of health insurance and, therefore, theoretically, more people could become insured.

Mr. Speaker, I remember Senator Cook talking in the past, when she served in the General Assembly, about the issue of the Town of Stonington being

covered under -- I think it was the town of Stonington. It may have been the teachers of Stonington, being covered under Anthem Rhode Island because they were so close to Rhode Island, and the Attorney General of Rhode Island said you know, you guys can't be in our plan anymore. You should be in Anthem Connecticut.

So when they moved over to Anthem Connecticut, their costs grew exponentially, and that's because they had far fewer health-insurance mandates on the books in Connecticut -- in Rhode Island than we do in Connecticut. So Mr. Speaker, you know, reducing the cost of health care is certainly, in my opinion, what we should be doing. That's the way to provide easier access and more affordable access to health care to all of our citizens and accomplish the goals that we all hold so near and dear to our hearts.

So, Mr. Speaker, I would urge members of the Chamber to uphold the Governor's veto. Thank you.

Deputy Speaker McCluskey in the Chair.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks.

Will you remark further on the bill?

The distinguished gentleman from Norwich, Representative Coutu, you have the floor, sir.

REP. COUTU (47th):

Thank you, Mr. Speaker. I just briefly want to speak out on this plan for the future with our health system. And for me, it's ironic that in many ways universal health care has been, I guess, part of my life. Being a member of the United States military, you get in the VA system sooner or later, certain people before others.

And I know, as I've had multiple experiences, you know, as a patient and also as an employee for the federal government who visited these health centers across the eastern part of America, I have some concerns, primarily, in multiple areas knowing when the government, for the most part is owning a health care system, we'll call it.

In my situation, for dental, I would -- I have one doctor within a 40-mile radius that I could actually get my dental service through. And in other cases, if you had emergency -- other times when you had to go to the nearest VA hospital which is about 65 miles away.

What this really comes down to me is, is the government going to own health care, or are we going to organize health care? Now, the idea that the ownership, something like the military, where you have one, you tell them what to do, where to go, how many are going to go and how much you're going to spend to fund that one entity or organize something like food where we control the safety, we control the amount of food, and we monitor exactly what's going on, but we don't own everything to do with food.

Now, when you go to the grocery store, there's 60,000 products. They get to the grocery store, but the government doesn't specifically tell exactly how it's going to get there, who's going to make it and everything else under the sun relating to that. We actually go out of our way, as a government -- well, the federal government, when they organize food, if you don't have enough, they'll get you some means with some food stamps. If you can't get it, we'll do Meals on Wheels.

So I think at the end of the day we have to say, do we want to own health care and have a limited liability to provide health care for the masses, which does include a situation something like Massachusetts,

which the cost has doubled? Or do we want to organize and make health care access availability and everything else to do with health care better? I personally believe we should organize. Owning it is a dangerous path because the government doesn't have a proven track record of managing things under cost, specifically.

And once again, as we are looking at a $9 billion deficit, a billion dollars last year -- this is an interesting road to take. Additionally, HSAs -- I think there should be more stress on HSAs. I've had that HSA account and many of my fellow federal employees, when I was a federal employee, had HSA accounts. And we appreciated the option to manage our own health care.

It just seems the government doesn't want -- the State of Connecticut doesn't want to allow their employees and the people of our great state to have that option where you have your own bank account that you put money into and use your credit card, and every penny you use is tax deductible -- it's tax deferred actually. You don't even pay out of your income any money that goes into your HSA. Any money you pay towards the plan is actually a deduction. It's

deferred.

So once again, that would result in important things that the State of Connecticut has to focus on, which is maintenance and prevention. So I hope that this group, this board of directors for this future plan, really looks into HSAs, and I hope that they think and really analyze the idea that we don't want to own health care; we want to organize it.

And with that being said, once again, I do have some concerns. From what I've seen in the plan -- and all I can really base my opinion on is the numbers of a billion dollars annually. And I do have one question for the Chairman of the Insurance Committee. Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Please proceed, sir.

REP. COUTU (47th):

I've heard quite a bit -- and this might not be true, but basically will this plan -- in the future, the idea is it's supposed save us money, I believe. Is there some basis to that position?

DEPUTY SPEAKER McCLUSKEY:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I believe that one of the five Institute of Medicine principles involves the addressing of cost and health care costs. And I think it's safe to say that we will not get a handle on our health care system and truly fix it until and unless we can control costs effectively. Through you.

DEPUTY SPEAKER McCLUSKEY:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker. And on that, I will say I agree with you 100 percent. Costs for our health care system seem to be going up year after year. And unfortunately, this year, on one particular day we tried to pass 21 percent increase in new mandates. In the state that has the most mandates in the country on our insurance providers, there is some concern there that this also contributes to the cost of insurance going up and up and up.

I will say, I know there's been a lot of effort and a lot of people have thought about a way to implement, a way to own insurance. And Massachusetts is one example that has done this, and as we all know, the costs doubled over a period of time. So I wish that board of directors and the people that are going

to be working on this in the future -- "hope", because I think that's an appropriate word when it comes to SustiNet in the future. So thank you. Thank you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks.

Will you remark further?

The distinguished gentlemen from Manchester, Representative Thompson, you have the floor, sir.

REP. THOMPSON (13TH):

Thank you, Mr. Speaker. And Mr. Speaker, I rise to speak in support of the motion to overthrow the Governor's veto. And I beg to differ with much of the subject matter I -- or discussion I heard here this afternoon.

I think it was in 1991, when Derek Bok was retiring as president of Harvard and he was addressing the last class he would address, and he reminded that graduating class of how much they had learned there and how lucky they were and how fortunate they were to receive the type of education that Harvard had to offer.

And he said -- but not only the books and library and research and so on, but here you've been very

active in the community here, in the Boston area. You've gone into different neighborhoods and worked with the people. You worked in clinics. You worked in food centers, shelters, and so on and so forth. These are things you should take back to your communities and be as active in your own communities as you've been up here in the Boston area.

And he said, as an example, he said, today, 16 million Americans are without health insurance, 16 million. And he called that an absolute disgrace. Ladies and gentlemen, it's now 20 years -- almost 20 years later, and there are about 50 million Americans without health insurance. We're going the wrong way.

And thank heavens that there is now some focus on this issue from both the federal and the state level. And I think this legislation that the Governor vetoed is really part of the grand scheme that's happening, almost accidentally.

When you consider the United States of America, with all its wealth, the richest country in the world has the most expensive health care system in the world and also ranks 37th in the world in its effectiveness, its efficiency and so forth.

France is number one and it has been number one

for a number of years. And I think some of the features of the French system are already here. It's a community-based health care system.

You can have a youngster going across Europe this summer, and if that youngster breaks a toe in one country, and breaks an ankle -- sprains an ankle in the next right across Europe, it's every country across -- and that student will receive adequate and superior health care, not necessarily superior to ours or any other place, but they will receive health care, no questions asked.

And they'll take your insurance if you have insurance in America. And if you don't, they'll work out something, and probably, you won't have anything to pay. That's how widespread health care, effective health care is across Europe. All their industrial countries, I believe, rank ahead of us, well ahead of us in the effectiveness. And they look at things like longevity and infant mortality rates, and so on.

So I'm saying that what we've done here with this legislation has continued to open the door wider so that we're really going to sit down and get serious about health care reform.

Dr. Galvin came before our Appropriations

Committee to discuss a deficiency in his department. And in the exchange we had begun on the subject of health care and community-based health care, and he said, well, we have a seamless system in Connecticut. We have hospitals, we have federally qualified health centers, we have school-based health centers, and we have a host of other clinics and community centers, and when they work together, they have, in effect, a seamless system. And we've seen this happen in my community.

In 2006, the federally-qualified health center in East Hartford, Connecticut, which included Manchester, Vernon, Rockville, South Windsor, Glastonbury and so forth, had approximately 8,600 patients.

Right now, as of two weeks ago, it had over 14,600 patients. They opened up a dental clinic in our community, went from two operatories to six. Went from a couple thousand people to several -- over 4 or 5,000 patients now, unduplicated. They opened up a clinic about a year and a half ago, and the first months -- health clinic in our community, they saw 900 unduplicated patients.

This past year, the -- right now this General Assembly provided a $50,000 funding to the Eastern

Connecticut Health Network which administers the Manchester Community Hospital, Manchester Memorial and the general hospital in Rockville, Rockville Hospital, administers those two hospitals. They came together with our health center and said, we'll form a working agreement, and the centers, the clinics in these towns will provide primary care, for the patient. It will relieve us of some of the emergency room department overcrowding. And we in turn will provide the hospitals -- will provide the surgeons, will provide 500 visits for $50,000, $100 a visit. So that the primary care provider, the clinic in our communities, will be the -- the referral -- will make the referral of the patient from their center to the surgeon's office, which will be provided by the Eastern Connecticut Health Network through these two hospitals.

The first question, of course, is what happens when that visit turns up something that's wrong and needs further treatment and surgery? And they said, we'll take care of that. The patient will either qualify for some kind of insurance that they are able to pay for it, or if they have their own, we'll take that. If they don't have their own, we will -- and

they don't qualify for either the federally qualified federal program or state program, we'll pick it up. We'll manage.

In other words, we want you, the primary care provider at the center to make sure the patient is referred to us. And under their charter from the federal government they have access to transportation money. We'll get the patient to you, so you won't be wasting an hour or so, and you'll see the patient and we'll provide whatever treatment or surgery that patient might need.

Now, that's a pilot program and it's started, and I believe it's going to work. So I'm very excited about the -- what Dr. Galvin has called, a seamless system. And I think the Governor has invested some money in that system as well, bonding money to create more clinic space. There's also been money allocated for different programs. For example, the clinics now go into our schools with portable equipment, or here in Hartford with the equipment right in the schools, and provide a dental hygiene program, and it will also take care of the child's teeth if they do not have their own dentist, and so on and so forth.

So there are exciting things going on out there

and this, what this legislation does, it opens up to the possibility of doing something. And with President Obama on the national level also doing something, we will be moving forward, and this legislation gives us the opportunity to look at a seamless system now in place, but more important, it gives us the opportunity to look at community-based health care. So that instead of worrying about not having access to doctors -- and doctors in my community have already told patients, we are not accepting Medicaid; we're not accepting Medicare, and they can do that.

So they turn -- and now they have an alternative and it's the best kept secret, I think, in our health system in Connecticut that we have -- and I'm getting the timeout signal from one of my colleagues. Cut it short, Jack.

Well, I could go on for another hour and I will not. All I'm saying is, we've got an opportunity to do something and do it right and there are -- that opportunity exists out there now. I see everyday in my community. And it doesn't rule out private insurance or anything else, but what it does say is everybody will have the opportunity to have health

insurance and if we work together on the local level and doctors and dentists and so on.

You had a dental days where thousands of people showed up at and dentists volunteered. But Dr. Galvin tells us we could do this every day using the system we have by working together. But we've got to work it out in such a way that I think this Legislature will permit that.

I'm going to be raising my voice on federally-qualified centers and community based and so on and that's what this legislation will help us to do. So I think we ought to get on with business and override this veto and get on with planning and talk to the people who really know something about health and health care and health provisions and so on and so forth.

And I'll stop right then and there and say, let's get on with it and support the override. Thank you.

Speaker Donovan in the Chair.

SPEAKER DONOVAN:

Thank you, Representative.

Representative Miller.

REP. MILLER (122nd):

Thank you, Mr. Speaker. A couple of questions to the proponent.

SPEAKER DONOVAN:

Please proceed, sir.

REP. MILLER (122nd):

Under purposes and powers, I think you had said earlier that under the OLR report, there's no funding. Is that true?

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, I was referring to the fiscal note which accompanies -- which is the word I was looking for -- File 996. And the fiscal note states that there are no appropriated funds going to the SustiNet Board of Directors. Through you.

SPEAKER DONOVAN:

Representative Miller.

REP. MILLER (122nd):

Under powers, through you, Mr. Speaker, it says that this agency can adopt a seal and provide itself with offices and staff. Is that correct? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the SustiNet Board of Directors is not a state agency. Through you.

SPEAKER DONOVAN:

Representative Miller.

REP. MILLER (122nd):

Yeah. Again, let me try that again. Through you, Mr. Speaker, they will be allowed to have a seal and provide themselves with offices and staff. Although they're not a state agency, they will be spending monies, and where will those monies becoming from? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the gentleman will have to point out to me specific language in the bill in order to get an answer.

In lines 110 through 114 it says, it shall not be construed as a department, institute, or agency of the state. The staff of the joint standing committee of the General Assembly having cognizance of matters

relating to public health shall provide administrative support to the board of directors.

So I don't see an office. I don't see staff. I don't see money, so if he has something he'd like me to respond to, he'll have to give me more direction. Through you, Mr. Speaker.

REP. MILLER (122nd):

Thank you, Mr. Speaker. I'm looking at the OLR bill analysis, HB 6600, AN ACT CONCERNING ESTABLISHMENT OF THE SUSTINET PLAN. And I'm looking under "Powers and Purposes." I don't have a line on any of those two areas. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, it's conceivable the gentleman is looking at an older version of the OLR analysis. There were several done based on the file copy that was created at different occasions. I'm looking at the OLR analysis that I culled from the most recent file copy and I'm not seeing that.

So I hate to say it, but the gentleman is going to have to point out specific language in File 996, or the public act for me to respond. Through you.

REP. MILLER (122nd):

Thank you, Mr. Speaker. I may be looking at an older file here.

Let me go into another area. We're going to provide insurance for people who do not have insurance. If a homeless person living in -- under the viaduct in Hartford, the railroad viaduct -- has no insurance. Under this plan, would he be provided insurance? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Through you, Mr. Speaker, the board of directors is charged with -- to come up with plans. Whatever plans they come up with, will be up to them, through you.

REP. MILLER (122nd):

Thank you, Mr. Speaker. I think I'll --

SPEAKER DONOVAN:

Thank you, Representative.

REP. MILLER (122nd):

-- I'm getting the signal to shut up.

SPEAKER DONOVAN:

Okay. Must be there's a lot of that going

ground. Thank you, Representative.

Would you care to remark further on the bill? Would you care to remark further on the bill?

If not, staff and guests come -- please come to the well of the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call, members to the Chamber. The House is taking a roll call vote, members to the Chamber, please.

SPEAKER DONOVAN:

Have all the members voted? Have all the members voted? Please check the roll call board to make sure your votes were properly cast.

If all the members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

House Bill Number 6600.

Total Number Voting	142
Necessary for Passage	101
Those voting Yea	102
Those voting Nay	40
Those absent and not voting	9

SPEAKER DONOVAN:

The bill is repassed.

Will the Clerk please call House Bill 6582.

THE CLERK:

On page 2, Calendar 225, Substitute for House Bill Number 6582, AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP. It's amended by House Amendment Schedule "A". Favorable report of the Committee on Public Health.

SPEAKER DONOVAN:

Representative Merrill.

REP. MERRILL (54th):

Yes, Mr. Speaker, I would move for reconsideration of this item and I would note for the record that I was on the prevailing side.

SPEAKER DONOVAN:

The question before the Chamber is on reconsideration of House Bill 6582. For the benefit of the Chamber I will note that Representative Merrill was on the prevailing side of this issue when the Chamber passed this measure on May 20, 2009, and is therefore an appropriate member to make a motion for reconsideration.

Is there an objection to motion to reconsider?

JOINT
STANDING
COMMITTEE
HEARINGS

APPROPRIATIONS
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Appropriations Committee
SB 246
March 20, 2009

Good Afternoon distinguished Chairs and Committee Members.

I come before you today to testify about SB 246. I ask that you please not cut our benefits, and reconsider requiring pre-authorizations for the procurement of psychopharmacological medications. Pre-authorizations would cause an unnecessary gridlock around patient access, as already overbooked doctor's offices have less and less time to process paperwork, and those responsible for granting access are often overwhelmed by the efficiency of the Monster they helped to create.

This budget balancing tool has been tried before over the last TEN (10) years. Advocates like me have been appearing before you to plead against this very action. It seems that all concerned should be well aware of the dangers of limited access. I also implore you to consider that the often recommended "Fail First" Policy places an even greater burden on those already dealing with Mental Illness. The often physically debilitating side effects of medications is often bad enough, but coupled with the frustration found as consumers are forced to revisit meds they already know do not provide the cessation of symptoms they are looking for can be traumatic and in some cases relapse inducing.

The last point I'd like to make is that when provider consultations along with patient history have already shown that pills are the only pharmaceutical therapy that has shown promise for the patient, care should be taken by those of us who are not Certified Medical Personnel. It is time to put MEDICINE back in the hands of the DOCTORS, ACCOUNTING back in the hands of the ACCOUNTANTS, INSURANCE (and nothing else!) back in the hands of the INSURERS. Patients deserve better care than this, especially when there are alternatives to cutting care. If you cut other programs not tied to the basic needs of living, you will have the funds needed to keep these measures from even being presented for consideration in the first place. The Universal Health Care Foundation's "Sustinet" Bill (SB # 6600) is one alternative to the budget cuts we have heard discussed in hearings just like this over the last few months. Although this plan is not complete with regard to the scope of its coverage, I believe this plan is a better answer to our existing fiscal woes if only for its ability to keep OUR HEALTH AND OUR CARE IN OUR HANDS WHERE IT BELONGS. I believe no one knows my body and my mind better than I do, after all, I have lived with them all my life.

Thank you for your time and effort regarding this issue.

Maureen Kelly
85 Norman Rd., APT. 107
Norwich, CT 06360

JOINT
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SENATOR HARRIS: Thank you, Jeff.

Any questions by the Committees?

Thank you. We're breezing through on to House Bill 6417. Barbara Albert, and then Jeff Walter is up again. We just had (inaudible) I guess, (inaudible).

BARBARA ALBERT: Oops. (Inaudible).

SENATOR HARRIS: Good morning, Barbara, or Afternoon -- excuse me.

BARBARA ALBERT: Good evening. Good night.

SENATOR: (Inaudible) yeah, something. It's like a Casino in here. I can't tell the time of day.

BARBARA ALBERT: With all due respect, everyone, Hello. I am a human being named Barbara Albert.

I'm a registered voter, resident of Hartford, Connecticut, human rights advocate and activist, and multiply, medically challenged. I've had jobs and -- and still a taxpayer. However, due to many medical illnesses, I've been receiving assistance from Medicare and Medicaid since the late '80s. I do volunteer work when able. I've been homeless before, and still, I'm barely surviving.

HB6417
HB6600

It's my opinion that Medicaid and HUSKY programs are not successful federal-state health care partnership -- partnerships -- slow down, breathe -- designed to meet the complex medical and mental health needs of low-income people they serve.

According to Medicare patient rights, I have the right, quote, if I have a complex or

serious medical condition, to receive a treatment plan that includes direct access to a specialist. I do not have an -- I do not have access to qualified specialists for my medical needs -- been therapist-less -- it's a good thing I don't lisp -- for two and a half years, which is, unfortunately, negatively affecting all of my medical challenges, including what's left of my sanity. I receive nothing in writing about why any health care service is denied, also in violation of my rights. I'm unable to appeal decisions made by whoever has the "denied" stamps.

Physicians are reluctant to accept the Charter Oak Health Plan, and the SustiNet Proposal, a/k/a Healthcare 4every1, refuses to acknowledge aged, blind and disabled. I am hoping that this proposal is part of the journey, not the destination. Health care is critical for all people, no matter what medical condition, what age, or financial situation.

Every human being is eligible to become ill. And I just -- well, I wanted to also read this universal declaration of human rights. It's from the United Nations, Article 25: Everyone has the right to a standard of living adequate for health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood and circumstances beyond his control. Thank you all for listening.

SENATOR HARRIS: Thank you, Barbara. And thank you For your persistence coming back here.

Jeff Walter, back up. I'm sorry. Barbara --

I cut out the Committee.

Representative Schofield. That's okay.

REP. SCHOFIELD: Thank you for your testimony, and For braving the weather in getting here today.

I just wanted to go back -- you said had not gotten any denials. Do you know -- are you enrolled in a managed care plan or are you in -- in the Medicaid fee-for-service plan?

BARBARA ALBERT: Fee-for-service.

REP. SCHOFIELD: Fee-for-service. Okay. And -- and you said you had difficulty finding a network of providers in the fee-for-service plans?

BARBARA ALBERT: Oh, no. I get lists, but --

REP. SCHOFIELD: But none of them accept --

BARBARA ALBERT: -- the ones I got from DSS included

A therapist that I was seeing for fifteen-plus years, who has retired. So I -- I didn't even bother. And then I received something from DMHAS in the Capital Region, some application for case-management services at (inaudible). And I'd already been there, done that -- told them all that they were about as useful as mammary glands on a steer, because that's what they are there. They're unqualified, in my opinion, and they just -- they don't know what to do with me. Nobody knows what to do with me.

I have one -- I have one of these rare mental illnesses or disorders, and nobody knows what to do with me. And it's not for lack of trying. I have been to in -- intake

appointments and seen various different people. I've been to -- the last place I went, I was told that I was only -- until I had Medicare or Medicaid, I was only supposed to be able to go to see a licensed clinical social worker. And they are not qualified to handle somebody who dissociates left and right --

REP. SCHOFIELD: Okay. So --

BARBARA ALBERT: -- because I can sit here and do it Right in front of you, and everybody else here in this room, and won't even know it myself.

REP. SCHOFIELD: Okay. So under the fee-for-service plan that you're -- you're on under Medicaid, you're -- you're feeling you're not getting any sort of help finding providers or accessing services.

BARBARA ALBERT: For two and a half years, Violations of federal law -- and now we can -- some statute of limitations probably blown by a long time ago, I can't do jack about it. So I'm basically screwed. So I'm going to go get a shovel and start -- I have already -- you know, the suicidal stuff has already been cranking, thinking about, you know, digging a hole and jumping in, except I'm allergic to mold, so I better not, because I don't want to be laying there and not being able to breathe. But what do I care, because -- I wanted to be dead before I was 20 years old. And now, I'm a little more than twice that. I'm not quite so sure I want to be still be here --

REP. SCHOFIELD: Well, we want you to be here. And I really appreciate you coming in and -- and sharing your situation with us today. And I wish you well. Hang in there. And we'll see what we can do to help you out. Okay?

BARBARA ALBERT: Okay. Thank you.

REP. SCHOFIELD: Thank you.

SENATOR HARRIS: Thank you, Barbara. And thank you Again for coming in.

Why don't you -- hit on something in your testimony which is -- I think, we can't overlook, because we talk about a journey versus destination? Well, we know it's a journey and this is a complex issue. But the problem is, I think, that you raised directly, and very vividly for everybody, is while we're on this journey, there are people that are not getting the care they need. And that's something that we all have to be cognizant of.

BARBARA ALBERT: I don't think I can hold on much Longer until like, 2011, 2014 -- when these things are supposed to be -- what's the word --

SENATOR HARRIS: In place.

BARBARA ALBERT: -- to be put into effect.

SENATOR HARRIS: Well, they're things that could be Done. And we've talked before, so you should come and talk--

BARBARA ALBERT: Because I feel like I'm hanging on By a chicken's lips. And we all know that chickens don't have lips.

SENATOR HARRIS: You should come in, as you do, come and talk to us individually, so we can help you with the current system. Okay?

BARBARA ALBERT: We tried that. That's where I got The list.

National Alliance on Mental Illness

Testimony before the Joint Hearing of the Human Services, Insurance and Real Estate, and Public Health Committees
March 2, 2009
SB 998, SB 990, HB 6600, HB 5172 SB988

Good afternoon, Chairs and members of the Human Services, Insurance and Real Estate, and Public Health Committees. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here to testify on several bills before you today.

NAMI-CT has **strong concerns about SB 988**, An Act Concerning Medicaid Funding for SAGA and Charter Oak, which would permit CT to utilize the "Health Insurance Flexibility and Accountability" (HIFA) waiver to get federal reimbursement for some SAGA and Charter Oak Health Plan services. HIFA was developed by the Bush Administration to allow individual states the flexibility to expand health insurance coverage to new groups but also to reduce benefits - including mental health benefits - increase cost sharing, and set limits on the number of lower-income people served. SB 988 could significantly harm people with mental illnesses and others currently on Medicaid by reducing access to health care and eliminating optional benefits. What this means is that optional beneficiaries, especially those with special health needs such as people with mental illnesses, may lose critical Medicaid benefits such as EPSDT and long-term care.

To ensure that beneficiaries have a comprehensive health services package, federal law requires that individual states provide certain benefits to all Medicaid beneficiaries, such as EPSDT services for children and home health care for those with long term care needs. EPSDT is a comprehensive prevention and treatment benefit that ensures that children receive necessary medical services. Under the HIFA waiver policy, states may roll back Medicaid benefits for optional beneficiaries (even so-called "mandatory benefits"). Therefore, some "optional" individuals may find they have less access to essential needed benefits than they did previously.

States may also require cost-sharing for all benefits provided to optional Medicaid populations - this cost-sharing may exceed "nominal" limits. Even optional children who are currently exempt from any Medicaid cost-sharing, may be charged fees not exceed a total of 5% of family income. For all other Medicaid groups, including those who are elderly or have disabilities, HIFA allows states to impose unlimited cost-sharing.

Currently, if a state chooses to provide an optional service, it generally must provide that service to the same extent to all beneficiaries. Under HIFA, states would no longer have to give currently eligible optional parent and child beneficiaries, people with disabilities and seniors the same

NAMI-CT 241 Main Street, 5th Floor, Hartford, CT 06106
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benefits they provide to mandatory beneficiaries. Instead, optional beneficiaries could be given a package of benefits that is less comprehensive. Services such as EPSDT could be eliminated.[1]

In addition, this bill would increase the income eligibility for people on SAGA to 100% of the federal poverty level (FPL) when "aged, blind, and disabled" persons currently receiving Medicaid coverage are only eligible at 60-80% of the FPL. A federal waiver for SAGA makes sense for the state and would protect and enhance a critical health care program serving some of the state's poorest citizens. Instead of a HIFA Waiver, the state should seek to negotiate a general federal waiver to include SAGA medical as a Medicaid covered service, **without requiring reductions in existing Medicaid coverage or services.** Currently, the state receives federal reimbursement for hospital but not other medical services under SAGA.

NAMI-CT strongly opposes SB 990, An Act Concerning Expanding the HUSKY Formulary, would remove the exemption that mental health related drugs currently have on HUSKY's preferred drug list (PDL). This means that mental health related drugs would be placed on the state's PDL and be subject to prior authorization, which would greatly restrict access to desperately needed psychiatric medications for children and adults. **People that avoid getting their mental health related medications filled will experience medical and psychiatric emergencies resulting in greater costs to the very systems this bill is trying to save money on.** Every study shows that barriers to medication access for low-income people with behavioral health needs most often lead to an interruption in their treatment and can have serious life-threatening consequences (please see attached).

Lastly, while there are many positive components in HB 5172, An Act Establishing the Connecticut Healthy Steps Program, it would allow for "aged, blind and disabled" persons on Medicaid to voluntarily enroll in managed care health insurance plans and exempt the plans from the state's insurance mandates. The state had to carve out behavioral health services from the Husky HMO's because of their failure to provide "timely, appropriate, and effective care to children with special behavioral health needs" (May 2005, Commissioner Wilson-Coker, Memo to Appropriations and Human Services Committees). Furthermore, the Commissioner noted that there were "gaps in essential services, care decisions driven by dollars, and a system of services that is confusing and difficult to navigate" and that **"the design of the Medicaid Managed Care program may undervalue behavioral health".** HB 5172 would put an even more vulnerable population with significant mental health needs in managed care plans that cannot meet their mental health service needs. Medicare managed care plans should be a lesson to us all about the ineffectiveness of using this model for people who are elderly or have disabilities, "a decade of research has found that enrolled beneficiaries would have cost the program less if they had stayed in the fee-for-service (FFS) sector."[2] Every federal study shows that the beneficiaries have a more difficult time accessing services and the plans cost 14% more on average than fee for service.

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[1] Miller, Joe E , NAMI POLICY RESEARCH INSTITUTE (December 2003), "WHAT LIES BENEATH THE MEDICAID WAIVERS: A GUIDE FOR CONSUMERS AND FAMILIES"

[2] Center for Medicare Advocacy, Inc , 2008. "Medicare Overpayments to Private Plans."

The bill also provides an exemption from the state's insurance mandates, including mental health parity, which flies in the face of Connecticut's strong insurance law and the federal parity law – both designed to protect all insured residents from discrimination in mental health care.

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Testimony before the Insurance & Real Estate, Human Services, and Public Health Committees
March 2, 2009
HB 5172, SB 990, SB 998 & HB 6600

SB988

Good afternoon distinguished chairs and members of the Insurance and Real Estate, Human Services, and Public Health Committees. My name is Cheri Bragg, Coordinator of the statewide Keep the Promise Coalition. Keep the Promise was founded 10 years ago to ensure that the promise to create and maintain a comprehensive community mental health system was kept.

The Coalition is opposed to SB 990 and we have some concerns about HB 5172. HB 5172 would allow people who are elderly, blind or disabled to enroll in managed care health insurance plans. The State of CT has already wisely chosen to carve out behavioral and mental health care from the child and adult HUSKY plans because managed care plans were inadequate in serving these populations. People who are termed "aged, blind or disabled" are currently subjected to severe income limits, 60-80% of the Federal Poverty level as opposed to 185% for parents in the HUSKY program, just to qualify for Medicaid. To add the burden of a managed care plan that is often difficult to navigate combined with restrictive access to care would be disastrous. These plans are paid per member per month, resulting in a direct incentive to deny care. HB 5172 would put an even more vulnerable population with significant mental and physical health care needs in plans that cannot meet their critical service needs. This bill would also exempt the plan from CT's health care mandates, including mental health parity, which is unacceptable, particularly after Federal lawmakers implemented mental health parity.

SB 990, an act concerning the expansion of the HUSKY formulary, would remove the current exemption that mental health related drugs currently have on HUSKY's preferred drug list (PDL). This means that these drugs would be placed on the PDL, making them subject to prior authorization, which would greatly restrict access to critically needed psychiatric medications for children and adults. This could mean the difference between wellness and severe illness for many, a move that is penny-wise and pound foolish as the overflow costs of failing to provide individually responsive psychiatric medications spillover into

-HB No. 6417 - Medicaid Services
-HB No. 6600 - Concerning Sustinet Proposal

T6

Good afternoon everyone, 3/2/09

I am a human being named Barbara Albert, I'm a registered voter, resident of Hfd, CT, Human Rights Advocate and Activist, and multiply medically challenged. I have had jobs and still am a taxpayer, however, due to many medical illnesses, I've been receiving assistance from Medicare and Medicaid since the late '80s. I do volunteer work when able. I've been homeless before, and still, I'm just barely surviving.

It's my opinion that Medicaid and Husky programs are NOT successful Federal-State health care partnerships, designed "to meet the complex medical and mental health needs of low income people they serve". According to Medicare Patients Rights, I have the right "if I have a complex or serious medical condition, to receive a treatment plan that includes direct access to a specialist." I do not have access to qualified specialists for my medical needs, been therapistless for 2½ years, which is unfortunately negatively affecting all of my medical challenges, including whats left of my sanity. I receive nothing in writing about why any healthcare service is denied - also in violation of my rights. I'm unable to appeal decisions made by who ever has those "denied" stamps.

Physicians are reluctant to accept the Charter Oak Health 'Plan', And the Sustinet 'Proposal', aka - healthcare 4 every1, refuses to acknowlege "aged, blind and disabled". Am hoping that this proposal is part of the journey - not the destination. Healthcare is critical for all people, no matter what medical condition, what age, or financial situation. Every human being is eligible to become ill. Thank you all for listening, and your patience.

001252

Universal Declaration of Human Rights

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality

Article 23

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment

(2) Everyone, without any discrimination, has the right to equal pay for equal work

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection

(4) Everyone has the right to form and to join trade unions for the protection of his interests

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay

Article 25

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection

Article 26

(1) Everyone has the right to education Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental

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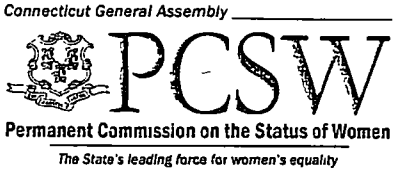

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Testimony of
Teresa C. Younger
Executive Director
The Permanent Commission on the Status of Women
Before the
Human Services, Insurance and Real Estate, Public Health Committees
Monday, March 2, 2009

Re:
H.B. 6582, AA Establishing the Connecticut Healthcare Partnership
H.B. 5172, AA Establishing the Connecticut Healthy Steps Program
S.B. 988, AAC Medicaid Funding for SAGA and Charter Oak
H.B. 6600, AAC the Establishment of the Susinet Plan

Senators Doyle, Crisco and Harris and Representatives Walker, Fontana and Ritter and members of the committee, thank you for this opportunity to provide testimony in support of on several healthcare reform bills before you today. I am also testifying on behalf of the Connecticut Women's Health Campaign (CWHC), a broad coalition of organizations committed to and working for the health and well-being of Connecticut women over their lifespan; and the Young Women's Leadership Program (YWLP), which highlights the concerns of women ages 18 to 35.

While the specifics of each bill – House bills 5172, 6582 and 6600, and Senate bill 988 – are all different, they all attempt to expand availability and affordability of health insurance benefits to all Connecticut residents. We support this intent because the increasing numbers of uninsured persons affect all genders, races, and ages.

In 2006, 11% of Connecticut's population aged 25 to 64,[1] and one-third of young adults, ages 19 to 29 were uninsured.[2] As of December 2007, the Kaiser Family Foundation estimated that there

[1] Families USA *Dying for Coverage*, April 2008
[2] <http://www ct.gov/ohca/lib/ohca/common_elements/household06_summary_single_pages_for_pdf pdf>

were over 130,000 uninsured women ages 18-64 in Connecticut.[3]

Lack of health insurance increase the risk of undiagnosed conditions resulting in health disparities and deaths. Uninsured adults are more likely to be diagnosed with a disease in an advanced stage. For example, uninsured women are substantially more likely to be diagnosed with advanced stage breast cancer than women with private insurance.[4]

Lack of health insurance also leads to financial ruin for many families. Almost 8% of working adults in Connecticut spend 20% or more of their income on out-of-pocket medical expenses.[5] Connecticut women have higher out-of-pocket medical expenses than men, and are more vulnerable to medical debt. Fifty-six percent (56%) of medical bankruptcy filers are women.[6]

We request that any plan that is developed address women's special needs and concerns to ensure that we have equal access to health care, which means ensuring that it is:

- Gender appropriate
- Culturally competent
- Comprehensive and preventive; and
- Confidential.

This means that coverage must be both **comprehensive and preventative**. Coverage must include specialty care, mental health and substance abuse treatment, access to prescription medication, vision and oral health care, preventive care, acute and long-term care, rehabilitative care, and reproductive health services, including coverage of family planning, contraceptives, abortion, cancer detection and treatment, prenatal care, and inpatient overnight stays for child-birth and mastectomy when needed.

Consumers must be able to access an array of practitioners, including midwives and nurse-practitioners. Settings should include community and school-based health centers, family planning clinics, and others that provide a safety net to underserved populations, including women and girls. Women must be able to identify a gynecologist or other specialist as their primary care provider if reform builds on a managed care system.

Health care should be responsive to and inclusive of diverse populations and differences among clients. Proposals should strive to eliminate racial and ethnic disparities by design. This would include proactive recruitment of bilingual and multicultural health professionals and improved health data by collecting information gender, race and ethnicity. In particular, this

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[3] <http://www kff.org/womenshealth/upload/1613_07 pdf>
[4] Families USA, *Dying for Coverage*, April 2008
[5] State Health Access Data Assistance Center, December 2007
[6] D U. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* February 2005.

means that medical interpreters must be provided and paid for as a covered service in order to ensure that those with limited English proficiency are able to communicate effectively with their providers.

Protect the confidentiality of women and girls. Current state statutes protecting the confidentiality of services for all minors, including reproductive and behavioral health care, must be integral to any universal plan. For example, patients with HIV infection, survivors of sexual violence and domestic abuse, and those who seek behavioral health care must be confident that seeking care will not result in disclosure of their health condition.

Health care and insurance must be affordable so that true universality is accomplished. This means that low-income households should be exempt from cost-sharing while higher income households should pay no more than 5% of family income on total health care costs.

We urge you to include these elements in any plan for health care reform. Thank you for your consideration.

CONNECTICUT WOMEN'S HEALTH CAMPAIGN E-News
January 2009

PCSW
Permanent Commission on the Status of Women

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Planned Parenthood of Connecticut, Inc.
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clarify that?

GIAN-CARL CASA: Yeah. It's not -- I don't think we think it's necessary, but there is some murkiness, so it would certainly help clear things up.

REP. FONTANA: Very good. Thank you. Thank you, Chairman.

SENATOR CRISCO: Thank you, Chairman. Any other questions? Thank you, Gian-Carl.

GIAN-CARL CASA: Thank you.

SENATOR CRISCO: Mary Glassman. Is Mary Glassman here, Simsbury? Suzanne Havilland? Suzanne Havilland here? Okay. Thank you. And how about the tag team of Julie Rose and Gabriela, small business owners, are they here? Okay. Ron Cretaro?

HB 6582
HB 6600

RON CRETARO: Double Chairs and Members of the Committees, I'm Ron Cretaro, the executive director of the Connecticut Association of Nonprofits. We represent 530 nonprofit organizations, 300 of which are state-funded Health and Human Service organizations. Connecticut nonprofits applaud Speaker Donovan and others for once again taking the steps to ensure that there is more comprehensive healthcare coverage in Connecticut. We support the Connecticut Healthcare Partnership which will open the state employee health insurance pool to nonprofits, municipalities and small businesses, and we thank you for your support of small businesses and nonprofits.

Nonprofit employers, like many others, have been facing years of skyrocketing healthcare

prices, annual percentage rate increases in the double digits, leave nonprofit directors struggling to keep costs down for their employees. But when healthcare costs rise, they're forced to pass these increases onto employees in the forms of higher cost-sharing and co-pays. Nonprofit employees who make significantly less than their public sector counterparts simply cannot afford these constant increases. It's a matter of sustainability for nonprofits, as well as our ability to stay competitive as operating costs increase and income revenues become more difficult to attain. Opening the state employee health insurance plan will allow small and nonprofits to take advantage of a much larger pool with significantly increased purchasing power. The lower premiums and co-pays associated with the healthcare plan are welcome option for the state's nonprofit providers. As we indicated last year, the cost of joining the state employee health insurance plan will not be affordable for all nonprofits, but it will certainly be a viable option for some.

Connecticut nonprofits also support House Bill 6600, the Universal Healthcare's Foundation the SustiNet proposal. The foundation has been a leading force in advocating for quality affordable healthcare coverage for all Connecticut residents, and we commend them for their efforts. The high cost of healthcare puts all businesses, including nonprofits, at a severe disadvantage. Worse off yet are the thousands of individuals without access to employer- sponsored insurance. These -- both programs are comprehensive approach to healthcare coverage. It is critical that we take these steps now, and we believe that quality adequate healthcare coverage is a

right for all citizens and we urge the legislature to make these proposals a reality and ensure that Connecticut residents no longer go without healthcare coverage.

SENATOR CRISCO: Thank you, Ron. Any questions? Yes, Chairman Fontana.

REP. FONTANA: Thank you, Chairman. Good morning, Ron. Thank you for testifying. Just a quick question: What do nonprofits do now for healthcare for their employees?

RON CRETARO: They do many things. Some of them partially self-fund, but they usually -- they belong to the CBIA program. If they are under fifty employees, they're able to go into the market. If they exceed fifty employees, they belong to the MEHIP program in some cases; a few nonprofits are able to do that. So having more options right now is, I think, nonprofits feel is their best advantage in the marketplace until we do have a larger pool that we can belong to.

REP. FONTANA: So these nonprofit entities employ hundreds, if not thousands, or tens of thousands of people in the state doing work paid for in part, or in whole, by state government or local governments and yet they cannot provide guaranteed health insurance to their employees.

RON CRETARO: That's right. They face the vagaries of the marketplace, just like small businesses and everyone else.

REP. FONTANA: Great. Thank you for clearing that up for me. Thank you. Thank you, Chairman.

SENATOR CRISCO: Any other questions? Thank you

might have to raise taxes. People can't afford to raise the taxes. We have to lay off school teachers and take money from other areas where at this time it's not really a good time to cut. We also believe that the state employees pool will be a better deal for some employers, especially since annual insurance costs are much less, allowing companies to budget better. Best of all, if people look at the plan and the cost and decide it's not for them, they do not have to use it.

SENATOR CRISCO: Thank you, Tony. Mark Nati.

MARK NATI: Yes. My name is Mark Nati. And I'm also with Pratt and Whitney and Local 1746. Basically, I'm here to say that, on behalf of our union, we believe that the goal should be that everybody gets covered. And our problem is, we nearly go on strike every three years over healthcare, and that has got to stop. (HB6582) (HB6600)

The SustiNet plan, which has been proposed, seems to be a very good plan. I was reading about it on the Tim Foley article, and the big thing for that plan seems to be marketing it to the small businesses. It's a huge step that has never been proposed before on any public/private insurance plan to keep -- to compete with the private plans. The pay-for-play part of it would -- seems to be a good incentive for businesses to try to provide health insurance through this plan. Also, we need to get the greed out of the private insurance. The William McGuires of the world that get $1.78 billion in stock options and now receive over 5 million a year in pension need to stop in this country. We need a good health plan that does not discriminate against previous conditions, that

everybody can be insured so that we can have good health at a good affordable cost, and that the doctors get paid correctly for their services, unlike what's happening today with some of the HUSKY plans. Thank you very much.

SENATOR CRISCO: Thank you very much, Mark. We appreciate that. Any questions for Mark? Thank you very much. Fred Manfredonia. Fred Manfredonia here? Fred Manfredonia? If not, Secretary of State Bysiewicz.

SUSAN BYSIEWICZ: Good morning, ladies and gentlemen of the committee. I am delighted to be here to offer testimony in support of House Bill 6582, and also House Bill 6600. As you might know, last year, our office joined with Speaker Donovan to travel around the state to speak to small business owners about the possibility of small businesses joining in the state health insurance pool. I will tell you that there was overwhelming and enthusiastic support for that idea. Once people learned about the bill, they wanted to sign up for that insurance yesterday. So I am here on behalf of business owners all over the State of Connecticut who very much appreciate the work that you are doing on this important bill.

As Secretary of the State of Connecticut, I'm the chief business registrar for the state, and when I speak to small businesses about what challenges they face to grow their business, affording health insurance is one of the first things that they will cite. So your work on this issue is very much appreciated. I will tell you, as you probably know from your own constituents, that small businesses are stressed right now in this difficult economy and this is one very smart and simple

thing that you can do to help the small business community in Connecticut. We just had, in 2008, more than 13,500 businesses close their doors, which is a record number of business failures. And I do think that the high cost of health insurance was one of the things that drove many of these businesses to close their doors, and I can't stress enough how important this bill is to our business community and Connecticut.

I also want to strongly support the SustiNet healthcare plan. I think that this is a more long range plan because it involves a much bigger investment of state resources. I think the pooling bill is something that we can accomplish much sooner, and I hope that that happens. I do support the concepts that are embodied in House Bill 6600, and I know some of those concepts have also been raised by President Obama, and they may be things that are covered in the federal government proposals that go forward. So with that, I want to thank the committee for the very good work that you are doing and offer my assistance and let you know that I will be again traveling around the state, encouraging small businesses to support these important proposals.

SENATOR CRISCO: Thank you, Madam Secretary. Questions? Chairman Fontana.

REP. FONTANA: Thank you, Chairman. Good morning, Madam Secretary.

SUSAN BYSIEWICZ: Good morning.

REP. FONTANA: Thank you for your work on behalf of small businesses. And let me just ask you, when you go around the state and you hear from

small businesses, do they tell you that they have no insurance or that they have very expensive insurance, or what do they tell you about what kinds of insurance they have or don't have?

SUSAN BYSIEWICZ: I have heard the gamut from small business owners who have gone for more than eighteen months or several years without any health insurance at all, and they have shared their fear that, you know, that they could become ill and soon be bankrupt. I have also heard from small businesses who have very expensive insurance, and were looking forward to seeing this proposal pass because they believe that it could cut their rates literally in half.

I will also share with you the experience of two business partners, a man and woman who owned an advertising firm in Stamford, Connecticut. The gentleman, who was the business partner, has a family of four and it cost him $25,000 a year for insurance for his family. His former business partner, a woman, paid half that much, about $12,000 a year for her insurance. She was offered a position as an advertising executive in New York City, and because she would not have to pay for health insurance, she actually left that business that she had helped found in Stamford that employed six people and went to work for this New York advertising firm just so she didn't have to shell out that $11,000. So, literally, we are losing entrepreneurs in Connecticut because of the lack of affordable health insurance.

REP. FONTANA: So, in essence, health insurance is one of those things that allows small businesses to be competitive with large

businesses, and if we are trying to help small businesses, that could be, in fact, the single biggest thing we could do to help them; is that right?

SUSAN BYSIEWICZ: Absolutely. And small business owners also shared the fact that they were unable to offer a competitive salary package without health insurance, and that was a deciding factor in them being able to get qualified people to work with them. I also think it's very important to share with the committee that half the people in the state, 52 percent of the people in the state who are uninsured work for small businesses. 75 percent of the businesses that operate in Connecticut are between three and nine employees. So what you are considering here today is absolutely critical to the economic health of our state.

REP. FONTANA: So the overwhelming number of businesses and the majority of employees or lives covered by those businesses are uninsured currently?

SUSAN BYSIEWICZ: That's right. And those people are working for very small businesses of between three and nine people. So this would be critical to their survival.

REP. FONTANA: Very good. Thank you. Thank you, Mr. Chairman.

SENATOR CRISCO: You are welcome. Any other questions? Thank you, Madam Secretary.

SUSAN BYSIEWICZ: Thank you so much.

SENATOR CRISCO: Is it Barry Simmon or Barry Simon?

but on a deferral in payments. When you move -- Self-insurance plan, you pay your premiums in advance -- I'm sorry -- fully insured plans, you pay your premiums in advance; self-insurance plan, you pay the claims in arrears. So the, quote, savings is the result of a delay in that period of time, maybe six weeks, where you would not be paying your premiums in advance and the six-week period before the claims under the self-insured plan would come in.

If you look at those -- if you dig deep and look under the hood, if you will, of the analysis of those who suggest that there would be savings from this plan, that's primarily the basis for the savings. It's not a savings. It's a deferral. At the end of the day, all of those claims need to be paid, and as I indicated, the actuaries indicate that our current claims experience would result in an increased cost on a monthly basis. So I hope you will take that into consideration.

I did want to -- you have many bills before you, and I won't comment on all of them. I did want to just mention the bill that is the final bill on your agenda. While we have not done 6600, An Act Concerning the Establishment of the SustiNet Plan, I don't believe any state has adopted anything similar to that at the present time.

And while we have not done a thorough analysis, my understanding is that the current estimates are about $950 million in 2014 when the plan would roll out. I would caution you about being less cautious about expenditures because they occur in the out years. Just because we don't have to put them in the budget this year, doesn't mean we won't have

REP. FONTANA: Great. Thank you. Thank you chairman.

SENATOR CRISCO: You are welcome. Any other questions? Thank you very much. Tom Sullivan? Tom Sullivan here? Mark Masselli. Masselli. Mark Masselli. Paul. Paul Filson.

PAUL FILSON: Good afternoon, Chairs of Insurance and Human Services, and all the distinguished intrepid members of the various committees that made it in in the snow. My name is Paul Filson. I'm the director of the Service Employees International Union, which is the largest union in Connecticut, with over 55,000 members. We represent over 20,000 state workers and 18,000 healthcare workers. SCIU supports Speaker Donovan's Healthcare Partnership, 6582, and the SustiNet Plan 6600.

As you all know, Connecticut is facing a budget crisis with an over $8 billion deficit, and we also know that a huge driver of the crisis in the state and in its municipalities is the rising cost of healthcare. Insurance costs have been rising at double and triple, even quadruple the rate of inflation. This forces municipalities to cut school programs, raise property taxes and, of course, now the state is facing huge deficits. SEIU cannot understand why it is taking so long to make changes that will lower costs, increase quality and move towards universality.

Now is the time to, one, self-insure the state employee plan and create a larger pool to leverage buying power and increase competition, and, two, create more opportunities for the uninsured to get insurance. By insuring more people, healthcare costs will decline in the long-run.

It's unfortunate that hundreds of our members, including school bus drivers and some other municipal workers, have no insurance at all.

Finally, if, in fact, self-insurance and opening up the state employee pool would raise costs, then I would suggest that you look to see who is opposing pooling in the SustiNet. It's the private profit-making insurance industry. So if adverse selection punishes the state, then one would think that the beneficiaries would be the insurance companies who would have the healthier people to insure at the rates they want to insure them at. SEIU strongly supports moving the ball forward with 6582 and moving towards universality with SustiNet in 6600. Thank you very much.

SENATOR CRISCO: Thank you very much, Paul.

Chairman Fontana.

REP. FONTANA: Thank you, Chairman. Good afternoon, Paul. We received testimony earlier from the secretary of OPM, and it seems some of his comments dealt with the speculative nature of healthcare reform pro and con. It seems to me that you and your members deal with the reality of healthcare reform, and I just wanted to give you an opportunity to sort of express to us, if you could, any empirical or anecdotal data that you can so that we are not dealing so much with speculative concerns about what might or might not happen to the state plan or going self-insured, but what this actually means to people who work full-time, because, as I understand it, a large share of the people who are uninsured in the state work full-time currently, something like 70 or 80 percent of the people who are uninsured work full-time.

So it's not a matter of them not working. It's a matter of them not getting health insurance, or getting health insurance they can afford. So perhaps you could just enlighten us a bit with some actual experience that you've observed from your members.

PAUL FILSON: Well, I would like to point out a couple of things. One is the benefits of having a large pool. We represent janitors in Connecticut who are immigrants, who are some of the -- doing some of the work that -- here in the building here cleaning up in office buildings. We represent about 4,000 -- 5,000 in Connecticut.

But the interesting thing is that we represent about 75,000 of them in New York and Connecticut and New Jersey, and they've created what's called the Taft Hartley Fund, which is a joint employer/union healthcare plan, which is self-insured, which provides absolutely topnotch health insurance for our members, and the costs for that are significantly less than you can find out in the private insurance world, and it's, in fact, even less than the state employee plan, and, in fact, when our state -- when our janitors who were covered by our health insurance lost their health insurance and they were forced to have their kids go on HUSKY, it ended up costing the state more to have the kids on HUSKY.

So, the benefits of pooling are clear. When you have a large pool with hundreds of thousands of lives, you can leverage lower costs, and you can have insurance. And when you don't have it, our members end up having to use emergency rooms. This is absolutely

true. They have to go without, and they end up having worse health. And if you compare unionized janitors with health insurance with the nonunion janitors without, you'll see that their families are much healthier, they get the preventative care that they need, and it just makes absolute sense. And for our healthcare workers, it's absolutely obscene that they go to work in some nursing homes and they can't afford family coverage. Almost all our members have individual coverage, but their kids can't get health coverage, and they make too much money for Medicaid, for HUSKY, and their kids end up in emergency rooms.

So I would say that we need to move the ball forward; we need to create options; and we need to move towards universality. I don't know if that answered your question.

REP. FONTANA: It did. Thank you very much. Thank you, Chairman.

SENATOR CRISCO: Thank you, Mr. Chairman. Any other questions? Thank you so much, Paul.

PAUL FILSON: Thanks a lot.

SENATOR CRISCO: That concludes our public hearing part for 6582. We move on to 5172. Eric George.

ERIC GEORGE: Senator Crisco, Representative Fontana, Representative Ritter, members of the Insurance Public Health and Human Services Committee, my name is Eric George. I'm the associate counsel for the Connecticut Business and Industry Association, and I would just like to add our voice along with those who are looking for significant comprehensive healthcare reform. Representative Ritter, you

State of Connecticut

NANCY WYMAN
COMPTROLLER

MARK E OJAKIAN
DEPUTY COMPTROLLER

Hartford

Testimony Before the Insurance and Real Estate Committee
Public Health Committee
Human Services Committee
State Comptroller Nancy Wyman
March 2, 2009

HB 6600
SB 1048

Good morning Chairman Crisco, Chairman Fontana, Senator Caligiuri, Representative D'Amelio and distinguished members of the Insurance and Real Estate Committee, Chairman Doyle, Chairman Walker, Senator Kane, Representative Gibbons and distinguished members of the Human Services Committee and Chairman Harris, Chairman Ritter, Senator Debicella, Representative Giegler and distinguished members of the Public Health Committee. I am State Comptroller Nancy Wyman and I would like to thank you for the opportunity to testify before the Joint Committees on several initiatives.

As you our legislative leaders continue the necessary debate on healthcare reform, I am encouraged by the wealth of innovative ideas and practical solutions being generated around this complex issue. The thoughtful dialogue that is now occurring, both here in Connecticut and in the halls of Congress, demonstrates the pressing need to transform our healthcare system at a time when so many are facing economic uncertainty.

Each of us is aware of the enormity of this mounting problem. There are 46 million citizens uninsured in America. More than 8.6 million of those that go without are children, mostly from working, low-income families. The enormous expense of this broken system is a staggering $2.3 trillion per year and threatens to have serious long term negative impacts on our economy.

The costs are already measured in more than dollars and cents –a study out earlier this year reported that the lack of health insurance results in a loss of three lives each week in Connecticut alone. The serious, life threatening nature of this issue has led a new survey to conclude that 82% of Americans want sweeping and fundamental reform.

Elected officials grasp the significance of the problem and have offered numerous legislative initiatives to secure coverage for individuals unable to afford care.

I would like to take the opportunity to comment on **House Bill 6582, "An Act Establishing the Connecticut Healthcare Partnership."** As many of you know, I have been a support of purchasing health insurance through pools that allow smaller employers to achieve the advantages that large employers have of spreading their health care

experience over a larger pool and thereby lowering the cost of providing coverage for their employees.

I have been a proponent of the Municipal Employees Health Insurance Plan which was originally enacted to leverage the purchasing power of the State to negotiate more favorable rates for municipalities. Over the years the MEHIP program has been expanded to include not for profit organizations and small employers. Most recently we have worked on an initiative to allow our municipalities to join together and purchase insurance through a self-funded pool that we call Enhanced MEHIP. The Enhanced MEHIP program offers a standard set of benefit plans for a municipality to offer and would permit municipalities to pool their risk within a larger pool in order to achieve savings.

In addition, in 2006 and 2007 I worked with the Chairman of the Finance and Appropriations Committee on proposed legislation that would have created a self-funded municipal health insurance purchasing pool in order to provide property tax relief to our cities and towns.

I am in agreement with the concept of the Healthcare Partnership, but I have a number of concerns as it is currently written, however, I have been working with the Speaker of the House to craft substitute language that could make this a viable workable program for the State and for our cities and towns. I am in favor of a self-funded pool that brings together the state employee plan and municipal employees. I will note that the state employee plan is currently a fully insured plan as a result of a collective bargaining agreement with SEBAC (State Employee Bargaining Coalition) and that aspect needs to be addressed in order for this program to move forward.

In discussions with the Speaker, the substitute language will no longer include small businesses and not for profit organizations, but pools together employers and employees with a similar risk profile in terms of employee populations and work environment. It makes the partnership a permissive subject of bargaining for the municipality and provides a mechanism through an actuarial review to assess the risk of accepting a portion of a town's employees as bargaining units merge into the plan and permits the Comptroller to deny participation if such a group results in a shift of disproportionate risk to the plan. Lastly, the language would permit us to adequately provide for a reserve fund that will protect cities and towns from claims fluctuations that could result in mid-year assessment of additional premiums.

I look forward to continuing to work with the Speaker and the Chairmen of the Insurance Committee to make this legislation and this program a viable alternative to help our cities and towns lower the cost of providing health care to their employees and therefore protect their budgets from skyrocketing health insurance premiums they have and are experiencing.

I would also like to comment on **House Bill 6600, "An Act Concerning the Establishment of the Sustinet Plan."** This legislation brings forth some very good ideas regarding moving our healthcare system forward on a path toward better outcomes.

The Sustinent Plan provides for the creation of a model for the use of medical homes for coordinating patient care and developing a system for electronic medical records. These are two concepts that my office is working on with our state employee and retiree health plans.

I do want to note a number of concerns that I have with this proposal. The bill provides for the creation of a separate, non-lapsing account within the general fund and provides that any investment income from those funds would remain within the restricted account and not be credited to the general funds. I note this because during this current fiscal climate, the Legislature needs to be cognizant of the impact to the State in terms of lost revenue to the general fund. In addition, it would appear that the Office of the State Comptroller would be subordinate to a quasi-public entity with respect to matters that are within the scope of the office.

I would also ask that as you consider this legislation that you assess the full impact on the State and our municipalities, such as the collective bargaining rights of municipalities that have not been addressed. Lastly, the economic downturn has forced businesses and government alike to look at how we do business and whether or not we are operating in the most effective and efficient manner. We need to be mindful that we do not create redundant layers government when we could be focusing on better coordinating the resources that we currently have.

I would also like to comment on **House Bill 1048, "An Act Concerning Bulk Purchasing of Prescription Drugs."** I applaud the Chairs of the Public Health Committee for attempting to tackle an issue that faces so many Connecticut families. This legislation requires the Commissioners of Public Health and Social Services and the Comptroller to develop a plan to combine the purchasing powers of certain state-sponsored prescription drug programs to lower the ever increasing cost of medication to those populations.

Unfortunately, there are a number of barriers that prevent the merging of Medicaid and Non-Medicaid populations. I welcome the opportunity to work with the Chairs to study the impact of combining the Non-Medicaid groups, such as inmates in our correctional facilities, ConnPACE and Charter Oak, with the state employee plan to find savings in greater purchasing power.

As we embrace a new administration and new Congress I am hopeful that our government's willingness to make health care a top priority will result in reform that addresses the pressing needs of our population. All of us understand that our nation's healthcare dilemma will most certainly be costlier if we do not act with bold ideas now.

Thank you for the opportunity to comment on these proposals.

February 28, 2009

Dear Senator Joseph Crisco and Representative Steve Fontana, Co-Chairmen of the Insurance and Real Estate Committee,

I am writing in support of both HB 6582, an act establishing the Connecticut Health Care Partnership, and HB 6600, the Sustinet health insurance plan.

Connecticut's health care system is in crisis. We truly need quality affordable health care in Connecticut. The people most affected by our broken health care system are the middle class citizens; hard working people and families like yours and mine. Working in the field with children, I see first hand how poor quality health care service or no health care service affects children's ability to learn.

Implementing universal health care can help lessen the gaps in achievement between those that can afford it and those that cannot. Please work to provide this fundamental right for all Connecticut residents.

Thank you.

Miguel A. Cardona
Principal
Hanover Elementary School
208 Main Street
Meriden, CT 06451
(203) 235-6359
Fax (203) 630-4099

Connecticut Insurance and Financial Services Cluster

Aetna
AXA-Equitable
ConnectiCare
Department of Economic & Community Development
GlobeOp Financial
The Hartford Financial Services Group
Hartford Steam Boiler Inspection & Insurance Company/AIG
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Sun Life Financial
TD Banknorth
Travelers Companies
UBS Wealth Management
UnitedHealth Group
United Illuminating
Webster Bank
XL Insurance

Statement on Behalf of

Connecticut's Insurance and Financial Services Cluster

Regarding the Opposition of

House Bill 6600: AAC The Establishment of the SustiNet Plan
House Bill 6582: AA Establishing the Connecticut Health Partnership

Public Health; Insurance & Real Estate and Human Services Committees

Joint Hearing: March 2, 2009

A healthy Connecticut population is smart business. No one will argue that Connecticut's economic health is tied to the wellness of its citizens. Our vitality is our ability to sustain business, to grow current and future workforce, and to compete in the global marketplace.

Like many other states; however, we grapple with an outdated health care delivery system. We recognize the need to provide health coverage choices for all residents We know that preventive and wellness care are paramount to sustainable health. We need to keep coverage affordable.

Connecticut has a strong foundation in healthcare. Connecticut's health plans are second highest ranked in the U.S. for quality, access and customer satisfaction (US News/NCQA). We also have the 3rd highest percentage of employer provided insurance in America (Kaiser Foundation). There have been multiple healthcare reform proposals developed for Connecticut within the last two and a half years These proposals are generally sound in their intent, but have fundamental weaknesses. To adopt *any* in their *entirety* would be detrimental to the health of our state.

For example, one component to the SustiNet Plan [HB 6600] is a type of pay or pay system requiring employers and employees to either pay into the system or suffer fiscal and public penalties. An effective, enforceable individual mandate may be a better solution. The Plan also calls for the creation of the 'SustiNet Authority'. As we stand amidst a fiscal budget crisis, is this really the time to create another state bureaucracy? Additionally this bureaucracy would not have to comply with Connecticut protective health insurance laws. Consistent regulation is an effective means of protecting the consumer.

Similarly, a recommendation of The Connecticut Health Partnership [HB 6582] suggests expansion of the state's insurance health plan to non-state public employers, municipal-related employers, and small employers. The state's plan is already too rich and expensive. If we really want to increase access to affordable healthcare, than this is the wrong strategy

In comparison, The HealthFirst Connecticut Authority recently voted out its own report last week. While there was a lack of financial data to accompany the

31 Pratt Street
Hartford, Connecticut 06103
860-728-2271

report, an ambiguous reference to "pooling" and lack of clarity around a few key concepts, the report did include several meaningful recommendations for your consideration:

- Increased use of electronic medical records
- Promoting greater transparency in health care data collection and dissemination
- Promoting wellness, prevention and chronic disease management, and
- Incorporating value-based designs into both public and private plans

Elements of the Connecticut Healthy Steps Program also make sense:

- A focus on building healthy lifestyles
- Formalizing the utilization of tax credits as employer incentives
- A study on the impact of mandates on private employer's premiums
- A study to define eligibility for individual mandates

The Connecticut IFS Cluster understands that *today* we need to make a decision on Connecticut's healthcare reform. We agree to focus on a solution that meets the demands and needs of both our state residents and employers. We recognize that economic wealth and resident health go hand in hand. Given these facts, HB 6600 and HB 6582 cannot be supported. We urge you to reject the bills as written.

Thank you.

Susan C.Winkler
Executive Director
Connecticut Insurance & Financial Services Cluster

STATEMENT REGARDING
House Bill 6582: *AA Establishing the Connecticut Healthcare Partnership*
House Bill 6600: *AAC the Establishment of the SustiNet Plan*

Public Health, Insurance & Real Estate and Human Services Committees
March 2nd, 2009

The MetroHartford Alliance is Hartford's Chamber of Commerce and the region's economic development leader. Our investors include businesses of all sizes, health care providers, institutions of higher education, and 34 municipalities. The Alliance's mission is to ensure that the Hartford Region competes aggressively and successfully for jobs, talent and capital so that it thrives as one of the nation's premier places for all people to live, work, play, and raise a family.

We write today in strong opposition to House Bill 6582 and House Bill 6600. Our investors believe it is important to focus on market-based solutions and engage in public-private partnerships to reach our goal of improving the current health care system, which covers over 90% of Connecticut's residents, among the highest percentages in the country. To this point, we supported and participated on the Connecticut Health Insurance Policy Council (CHIP) in 2007, a non-profit entity which focused on controlling health care costs and expanding access to quality health care—recommendations that the Alliance endorses.

The CHIP recommendations focused on encouraging individuals to take personal responsibility for their wellness, make appropriate use of the state's robust health care system, and participate in one of Connecticut's existing health insurance plans. The CHIP report specifically emphasized the need to:

- reduce the number of existing mandates and allow greater efficiencies in product development and approvals at the department level to create flexible benefit options, and improve access to affordable care;
- promote healthy lifestyles with employer-sponsored wellness programs and greater emphasis on prevention overall;
- increase Medicaid reimbursement rates to hospitals, which are receiving only 73 cents on every dollar of care to Medicaid patients, forcing overall health care costs to rise;

- use e-medical records, electronic information exchanges and telemedicine more efficiently to improve patient safety, expedite treatments and reduce redundant care, ultimately reducing costs; and
- provide more quality data to consumers to help them make more informed health care choices.

This past year, health care reform was once again the subject of considerable deliberation by the members of a new entity, the HealthFirst Connecticut Authority. The Authority voted out their report last week, and, while we have concerns with the lack of fiscal impact and clarity around a few key concepts, the report included several meaningful recommendations that were consistent with the CHIP report such as:

- increased use of e-medical records;
- promoting greater transparency in health care data collection and dissemination;
- promoting wellness, prevention and chronic disease management; and
- incorporating value-based designs into both public and private plans.

Given the constructive and comprehensive set of recommendations set forth in the CHIP and Authority reports, it is not necessary to create yet another bureaucracy to sell insurance, as House Bill 6600 suggests, nor does it make sense to expand the state's very expensive and rich health plan, as suggested in House Bill 6582. Expanding an already too expensive plan or creating an entirely new government entity when we can't afford the government we have would actually increase the cost of health care, which is the opposite goal we are intending in the quest for affordable, quality care. Additionally, the SustiNet proposal establishes a bureaucracy that would sell self-insurance plans without being required to comply with many of Connecticut's protective health insurance laws. It is critical to retain the integrity of consistent regulatory oversight in order to protect the consumer.

More importantly, we have before us the opportunity to implement some of the CHIP and Authority recommendations, a step that should be pursued deliberately and aggressively before we create another layer of bureaucracy or expand the state employee plan that is proven to be too expensive. Each of the recommendations mentioned above has the potential to actually improve quality by avoiding errors and helping people make more informed decisions about their care based on real data, and to reduce the overall cost of health care, which would enable more people to have affordable access to health insurance coverage.

Additionally, the President and Congress are very much committed to pursuing federal health care reform. In fact, included in the stimulus package was $19 billion in funding to convert medical records to electronic forms, and $1.1 billion for research comparing which treatments work best for specific diseases. Given our state's current fiscal climate, these recommendations might have been

otherwise unattainable at this time. It is important that we seize the momentum coming from Washington and take advantage of any and all federal assistance to make health care more affordable. It is equally important that we continue to have an active voice at the federal level with regards to reform, without recreating the wheel or preempting any possible federal reform with expensive state legislation.

It is vital to the state's fiscal health and the health of all of our residents that the public and private sector work together to strengthen our current system by identifying and pursuing practical and economically feasible market-based solutions to expand access, improve quality and increase affordability. The blueprints already exist, and it is time to begin implementing these recommendations. If we are to foster long-term prosperity for all of Connecticut's citizens, we must ensure that our insurance and health care economic engines remain resilient and strong in the competitive climate of a global marketplace.

Thank you for your support.

Secretary of the State Susan Bysiewicz
Testimony
Joint Public Hearing on Health Care ReformLegislation, March 2, 2009

Good Morning distinguished Co-chairs and members of the Public Health, Insurance and Real Estate, and Human Services Committees. I am happy to see both familiar and new faces at this public hearing.

For the record, my name is Susan Bysiewicz, and I am the Secretary of the State.

Thank you for giving me the opportunity to testify before you today regarding access to affordable and quality health care for all Connecticut citizens; containment of health care costs; and allowing small businesses, municipalities and nonprofits to achieve savings in their health care costs through health care coverage pooling.

Given the current economic crisis and the escalating costs of health care, I applaud the Legislature for addressing these challenging but important issues.

I am here today to offer testimony in support of H.B. 6582 - *An Act Concerning Expanded Access to the State Employees' Health Insurance Plan* and H.B. 6600 – *An Act Concerning the Establishment of the SustiNet Plan.*

H.B. 6582 would authorize the Comptroller to begin converting insurance plans under subsection (a) of section 5-259 of the general statutes to self-insured plans, to allow non-state public employers, municipal-related employers, small business employers, and nonprofit employers to join such self-insured plans and to make conforming changes.

As most of you know, last year I joined State House Speaker Donovan in promoting the Connecticut Health Care Partnership Initiative throughout the state.

That initiative would have allowed municipalities, small businesses and nonprofit organizations to utilize the state employees' health insurance plan in order to empower them to bargain for lower premiums and copayments for their insured.

This legislation could have saved municipalities alone millions of dollars in reduced health care costs:

New Haven – over $8.6 million
Danbury – over $2.8 million
Meriden – over $1.9 million
Towns like East Hartford and Groton – over $1.1 million
Towns like New Britain and Windham – over $800,000

We traveled across Connecticut conducting roundtables for small business owners, elected officials, and not-for-profit organizations. We received enthusiastic support and positive reactions from various groups including, municipal representatives, union members, small business owners, doctors, and elected officials.

That measure was passed by the legislature only to be vetoed by Governor Rell.

I want to bring to the Committee's attention the need to address the lack of affordable health insurance coverage for small businesses and their employees.

As many of you may already know, as Secretary of the State of Connecticut, I also serve as the state's Chief Business Registrar.

Since 1999, I have worked to protect and enhance the state's small and minority business population, recognizing the fact that for the past 10 years, 96 percent of new job growth in Connecticut has been spurred by businesses of 50 or fewer employees.

Indeed, small businesses are responsible for creating more than 90% of all new jobs in Connecticut, yet with skyrocketing health costs, more than half of the state's uninsured population – about 180,000 people – are employees of small businesses.

Both the Universal Health Care Foundation of Connecticut and the Health Insurance Policy Council agree that the lack of affordable health insurance for small business owners is a priority that needs to be addressed.

The Health Insurance Policy Council in its 2007 report "A Framework for Health Care Reform for Connecticut" cites that **52.2% of uninsured workers and dependents are in firms with less than 50 employees**.

In a survey entitled "Small Business Health Care Network Survey 2006" released by the Universal Health Care Foundation of Connecticut, 95% of Connecticut small business leaders stated that providing health care coverage is an important issue. More than half (52%) named it one of their top business challenges.

More importantly, the survey found that the lack of affordability prevented firms from offering Employer Sponsored Health Insurance (ESI) and that the cost will need to decrease for them to offer ESI in the future. The survey also found that:

Most firms (78.0 percent) that did not offer ESI cited the inability of the business to afford the cost of coverage and more than one-third (39.0 percent) cited the inability of the employees to afford coverage.

The majority of firms (61.5 percent) that did not offer ESI indicated they wanted to provide coverage in the future.

Most small business owners (80.4 percent) believe that all persons in the United States should have access to health care, regardless of their ability to pay.

I have also consistently heard from small business owners through my Small Business Roundtables and Small and Minority Business Showcases that they can no longer afford to provide health insurance coverage to their employees, and that the various programs to assist small business owners with affordable health insurance are too costly and out of their reach.

It is no secret that, in this time of economic crisis and uncertainty, small businesses are struggling with higher energy and other costs and a constrained credit market.

Because of this and high health care costs, many small business employers have been forced to cut back on coverage, eliminate coverage all together, or simply go out of business.

Indeed, in 2008, some 13,456 businesses filed paperwork to dissolve their company, the highest such annual figure since these numbers were first recorded in 2000. This represents an 18% increase in business stops over the 2007 figure, which is the highest year-to-year increase in business closings on record.

The numbers also reveal that Connecticut saw 27,483 new business starts in 2008, which is the 2nd lowest annual figure on record. Only 2003, a post-recession year, saw fewer new business starts. The 2008 figure represents an 11% decrease in new business start-ups as compared with 2007, which is the highest year-to-year decline in business starts ever recorded.

The consequences to our state—lost jobs, loss of income, home foreclosures, loss in tax revenue, and increased unemployment and other expenses to the state—are quite dramatic and evident.

State employee health pool expansion is not a new concept. As many as 24 other states allow local government employees to participate in their State employee plan, including Massachusetts, which opened its State employee plan last year.

By allowing municipalities, small businesses, and non-profits to voluntarily join the state employees' health insurance plan, H.B. 6582 would create a large pool of more than 200,000 people that would put Connecticut in a strong bargaining position when negotiating rates with the major health insurance providers.
Some have expressed concerns about the potential for the insurance providers to increase costs. That is why establishing a Non-state Public Health Care Advisory Committee is so essential.

Municipal employee representatives and others in that committee would be able to advise the Costs Containment Committee on changes in benefit coverage and other bargaining issues pertaining to non-state public employees.

The Cost Containment Committee has been successful in keeping health care cost increases to a minimum in the past.

Making quality health care affordable and accessible is good for Connecticut's economy and is good for taxpayers. I therefore strongly support this legislation.

Lastly, I want to express my support of H.B. 6600 – *An Act Concerning the Establishment of the SustiNet Plan.*

The SustiNet Health Care Plan being proposed by the Universal Health Care Foundation of Connecticut offers Connecticut an innovative vision and plan to accomplish five major goals for our state:

(1) providing access to high quality health care coverage to most Connecticut residents;

(2) establishing cost-control practices and mechanisms so that health care is affordable and sustainable for individuals, families, and businesses;

(3) promoting preventive approaches to reduce illness complications and minimize expensive medical intervention;

(4) addressing racial and ethnic disparities in health care and health outcomes; and

(5) positioning Connecticut strategically to tap into future federal funding for health care reform such as the proposed $634 billion Health Care Reserve Fund.

The Foundation's presentation at last Thursday's forum on health care reform provided great insight into ways in which our state can accomplish both: health care for the vast majority of its citizens and cost containment through measures such as electronic medical records and preventive health practices.

Two of the highlights of this plan are the creation of a "medical home" for Connecticut patients and a medical team approach that includes facilitating access to electronic medical records of patients. This plan offers an incentive for adopting electronic medical records as an integral part of health care reform.

An attractive aspect of this legislation is that it seeks to establish SustiNet in a competitive environment that may, in the end, encourage all insurers and medical providers to follow best practices for effective and more efficient health care management and service delivery.

Like all major initiatives, this one would entail a significant investment by state government—over $900 million dollars.

But long-term savings achieved through the creation of a more cost-efficient health insurance infrastructure and system in our state would make this investment worthwhile. In addition, such investment would allow us to attract federal funding for these health care reform initiatives.

Thank you again for the opportunity to testify before your Committee, and I'll be glad to answer any questions that you may have.

February 28, 2009

Sen. Joseph Crisco
Co-chair, Insurance and Real Estate Committee

Rep. Steve Fontana
Co-Chair, Insurance and Real Estate Committee

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

I am writing to ask you to support two critically important health care bills HB 6582, an act establishing the Connecticut Health Care Partnership, and HB 6600, the Sustinet health insurance plan.

I have been an optimist all my life, believing that I'll come out on the other side of a difficult time in a better place. I have seen a lot of ups and downs in the economy and for the first time, I am really scared, and here's why.

Health care and the economy are intricately intertwined with each other. Over the past year, the small company my husband works for has been cutting back: no pay raises, dropped dental insurance, cut pay and layed off staff, increased health insurance premiums 17%, then ran out of cash and had layoffs again while trying frantically to raise capital to keep the business going. This time my husband lost his job.

My husband is the bread winner and I have been the primary care giver for our two young boys. I have gone from working one, to three part time jobs, with no benefits, to bring income in. I have no idea how we will afford our regular bills plus the huge increase in health insurance. We have worked hard, saved money, he had a good job and good health insurance. Everything can change so fast.

These times are nothing like we have ever seen. We need courageous leaders who are willing to take bold steps to boost the economy, provide more affordable quality health care that saves money in the end for everyone, and helps the residents of Connecticut build themselves up again.

I urge you to support HB6582 as the first step in health care reform and support HB6600 for the comprehensive reform needed to help families and small businesses get back on their feet.

Respectfully,

Joan F. Goodman
8 Windy Way
Meriden CT 06450
203.630.3541

Marissa Cardona
85 Walt Drive
Meriden, CT 06450
203-815-5680

February 27, 2009

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

I strongly support both **HB 6582**, an act establishing the Connecticut Health Care Partnership and **HB 6600**, the Sustinet health plan that would be comprehensive health care reform. This plan would be universal, covering everyone in Connecticut and it would provide high quality health care coverage which is a human right.

Having worked closely with people who are underinsured and uninsured, I have witnessed firsthand how challenging it is for families to receive quality care. I constantly advocate for people and families who did not receive high quality care based on the type of health insurance card they are holding. There are many challenges that families face when in that situation. They are not able to receive timely preventative care and due to the overwhelming amount of patients, visits are rushed not giving much time to focus on prevention and education which is important. This also results in many inconsistencies with medical records which results in poor quality care and patients being misdiagnosed.

Working as a Community Organizer for the healthcare4every1 Campaign has truly made me realize that our health care system is broken and time and time again, people are faced with the decision of having to choose between their health and providing the basic needs to their families such as food, shelter. In many cases, choosing the basic needs to provide for the family over health has resulted in death.

While other countries have declared health care to be a basic right, the United States treats health care as a privilege, only available to those that can afford it. Healthcare in America is treated like an economic good; not as a social or public good.

It's time for a change and Connecticut needs to be an exemplar.
HB 6582 would allow non-state public employers, municipal-related employers, small employers and nonprofit employers to join self-insured plans. This would result in significant savings for a number of these stakeholders.
HB 6600 - the Sustinet health care plan would allow thousands of families to have the right to quality health. Sustinet is a new proposal to make sure everyone in Connecticut has high quality, affordable health care regardless of pre-existing conditions, job changes, self-employment, divorce and other life changes. It offers a comprehensive benefits

package that includes dental and mental health coverage. People can choose their own doctors, and have the option of keeping their existing health plans.

Although we are facing challenging times in the United States, we need to prioritize health care because the price of not having health care would far exceed the price of having it. We all deserve quality health care, right?

We truly hope that you can focus on this important issue.

Sincerely,
Marissa Cardona

Marissa Cardona
Community Organizer
Universal Healthcare Foundation
Meriden Children First Initiative

February 28, 2009

Sen. Joseph Crisco
Co-chair, Insurance and Real Estate Committee

Rep. Steve Fontana
Co-Chair, Insurance and Real Estate Committee

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

We are writing in support of purposed bills **HB 6582** (an act establishing the CT Health Care Partnership and **HB 6600** (the Sustinet Health Insurance Plan).

Our support is *necessary*, in our view, because healthcare is one of the most important issues before every person especially at this time. No matter what a person's status, class, race, ethnicity, gender, etc.; good health is not a guarantee during your lifespan. We are bombarded with all types of health issues and they continue to grow. (I can attest to this situation because my husband is living this nightmare each day). We are all at the mercy of the medical community for a cure of whatever our illness may be. The problem is that everyone cannot afford the plans that are available now. Not only is affordability an issue, *mediocre healthcare* is not good enough! Everyone should receive the very best health care available!

It is apparent to us that if any proposal is put forth to become law and it assures us that its goal is ***affordable healthcare for everyone***, we will then support it. Although we are lay persons trying to understand and interpret the language (law) of the proposed bills, it seems that these bills – HB 6582 and HB 6600- are bringing forth the issue of affordable healthcare for everyone at a lesser cost and better quality; in PARTNERSHIP. That seems to be a great idea.

Sincerely,

Earl and Velma Estes

55 Brooklawn Dr., Meriden, CT 06450
203.639.8134
Emails – velmae@cox.net
-earle426@cox.net

Natalia Perez
113 Willis Avenue
Meriden, CT 06450
203-237-3199
February 28, 2009

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

We need you to stand for your constituents that would benefit from the following bills: **HB 6582**, and **HB 6600**, the Sustinet health plan, a comprehensive health care reform. I had a great health care plan for over 30 years where I was fortunate enough to have a full time job with benefits. Three years ago I was diagnosed with spinal stenois, thyroid disease and severe arthritis. My Doctor was shocked to know that I was working under these conditions and immediately told me that I could not go back to work because my condition will continue to worsen.

My Doctor was right, I am feeling worse and most of the time struggle getting out of bed due to the severe pain I am feeling. I have 4 lovely grandchildren and can't enjoy them as much as I would like because I can't pick them up due to the strong back pains I constantly have. I have applied for Social Security 4 yimes and have been denied and at times regret having seen my Doctor because now I am uninsured for the first time in my life and cannot afford the necessary prescriptions to take away the constant pain I feel. I reschedule Doctor's appointments because I cannot afford to pay my copays and also struggle to pay my bills and buy groceries.

It's very challenging for me to see that I worked hard to provide for my family and to give my children a college education . I worked hard to live the American Dream and at the age of 58 where I should be thinking about how to plan my golden years, I have to make difficult decisions such as; should I pay my bills first or buy my needed prescriptions?
I urge you to think of the hard working families who are most affected in our state. Please think of our state motto "He who transplants, sustains." We need to implement a plan in Connecticut to cover everyone.

Sincerely,
Natalia Perez

Natalie Gill
245 East Woodland Street
Meriden, CT 06450
203-440-9544

February 28, 2009

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

Please support HB 6582, an act establishing the Connecticut Health Care Partnership and HB 6600, the Sustinet health plan that would provide quality, affordable health care to everyone in Connecticut.

HB 6582 would open up opportunites to the underinsured. The Sustinet health care plan HB 6600 is one that I truly support. I work with the underinsured and uninsured through the WIC program and see the many challenges that families and children face when in this situation.

I talk to many of my clients whom are families who express their frustration with our health care system and have to wait months for their babies, toddlers, and or children to be seen by a Doctor due to the overwhelming waiting lists. There are cases where due to not being able to be seen by a physician, these families have to go to the Emergency Rooms and of course it is very expensive to pay their bills when put in that situation. Most of these children are not receiving timely preventative care and cannot receive quality dental care because there are only a few Dentists that will accept Husky. These patients can not receive the timely, preventative care they deserve.

The medical home component of Sustinet would be beneficial and a crucial component in fixing Connecticut's broken health care system. Please put yourselves in the shoes of these children and families and always remember that anyone can lose their health care plan at any given moment. Please support these bills and make sure that everyone is treated equally and not solely on the type of health care plan they currently have.

Sincerely,

Natalie Gill

February 27, 2009

Sen. Joseph Crisco
Co-chair, Insurance and Real Estate Committee

Rep. Steve Fontana
Co-Chair, Insurance and Real Estate Committee

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

I am writing in support of two important bills that you will soon consider. One is HB 6582, an act establishing the Connecticut Health Care Partnership. The other is HB 6600, the Sustinet health insurance plan.

Even though the economy has hit all of us hard, Connecticut remains one of the richest states in the country. And as home to the insurance industry, it stands to reason that we should have one of the best health-care systems in the America. But we don't. With your leadership, we can do better.

HB 6582 would allow non-state public employers, municipal-related employers, small employers and nonprofit employers to join self-insured plans. This would result in important savings for these groups and increase overall transparency.

I also hope you will support **HB 6600**, the Sustinet health insurance plan. Your support of both HB 6582 and HB 6600 would put Connecticut at the top of the heap as a national leader in quality and affordable health care coverage.

Thank you for your consideration and support of these two vitally important pieces of legislation.

Sincerely,

Chaucey Perreault

96 Curtis Street
Meriden, CT 06450

203-639-8491

February 27, 2009

Sen. Joseph Crisco
Co-chair, Insurance and Real Estate Committee

Rep. Steve Fontana
Co-Chair, Insurance and Real Estate Committee

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

I am writing in enthusiastic support of both HB 6582, an act establishing the Connecticut Health Care Partnership, and HB 6600, the Sustinet health insurance plan.

Health insurance costs are skyrocketing. And with each passing day, more and more people in Connecticut are losing health insurance coverage for themselves and their families. Our current system of health care is broken, and we urge you to act now, and to act boldly

HB 6582 would allow non-state public employers, municipal-related employers, small employers and nonprofit employers to join self-insured plans. This would result in significant savings for a number of these stakeholders.

Passage of 6582 is an important and necessary first-step as part of the comprehensive health system reforms as proposed by **HB 6600**, the Sustinet health insurance plan. This plan is one of the most thoughtfully and thoroughly developed in the country. Your support would put Connecticut as a national leader in health care coverage that is quality, affordable and accessible.

These are difficult times. We look to you for strong leadership on fixing our health care system once and for all. *Your support of both HB 6582 and 6600 will help ensure your legislative legacy and importantly – provide the quality, affordable health care system that we all deserve.*

Sincerely,

David Radcliffe

David Radcliffe
Director
Taxpayer, Husband and Father of Three Young Boys

Meriden Children First
203-630-3566 / 203-630-2423 (fax)
105 Miller Street
Meriden, CT 06450

February 27, 2009

Sen. Joseph Crisco
Co-chair, Insurance and Real Estate Committee

Rep. Steve Fontana
Co-Chair, Insurance and Real Estate Committee

Dear Sen. Crisco, Rep. Fontana and Members of the Insurance and Real Estate Committee:

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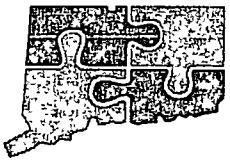
These are difficult times. We look to you for strong leadership on fixing our health care system once and for all. *Your support of both HB 6582 and 6600 will help ensure your legislative legacy and importantly – provide the quality, affordable health care system that we all deserve.*

Sincerely,

Andrew P. Reynolds

Andrew P. Reynolds
Owner/Publisher
Taxpayer, Husband and Father of Three Young Children



CONNECTICUT ASSOCIATION of NONPROFITS | ...to serve, strengthen and support Connecticut's nonprofit community.

Testimony before the Public Health, Human Services, Insurance & Real Estate Committees
3.2.09

In support of HB 6582, AA Establishing the Connecticut Healthcare Partnership
and
HB 6600, AAC the Establishment of the SustiNet Plan

BY RON CRETARO, EXECUTIVE DIRECTOR

Senator Harris, Representative Ritter, Senator Doyle, Rep. Walker, Senator Crisco, Rep.Fontana, members of the committees, my name is Ron Cretaro and I am the Executive Director of Connecticut Association of Nonprofits (CT Nonprofits). We represent 530 nonprofit organizations, 300 of which receive state funding to provide health and human services on its behalf.

HB 6582

CT Nonprofits applauds Speaker Donovan and others for once again taking steps to ensure more comprehensive healthcare coverage in Connecticut. We support the Connecticut Healthcare Partnership, which will open the state employee health insurance pool to nonprofits, municipalities and small businesses. We thank Speaker Donovan for offering this option to nonprofits across the state that continue to struggle with increased healthcare costs.

Nonprofit employers, like many other employers, have been facing years of skyrocketing healthcare prices. Annual percentage rate increases in the double digits leave nonprofit directors struggling to keep costs down for their employees. No funding increases for nonprofits mean that not only can they not give their wage increases to their employees, but when healthcare costs rise, they are forced to pass that increase onto employees in the form of higher cost-sharing and co-pays. Nonprofit employees, who make significantly less than their public-sector counterparts, simply cannot afford these constant increases. It is a matter of sustainability for nonprofits as well as our ability to stay competitive as operating costs increase and income and revenue become more difficult to obtain.

Opening the state employee health insurance plan will allow smaller nonprofits to take advantage of a much larger pool with significantly increased purchasing power. The lower premiums and co-pays associated with this healthcare plan are a welcome option for our state's nonprofit providers. As we indicated last year, the cost of joining the state employee health insurance plan will not be affordable for all nonprofits, but it will certainly be a viable option for some. Again, we thank the Speaker and welcome this additional choice for nonprofit providers.

HB 6600

CT Nonprofits supports the Universal Healthcare Foundation's SustiNet proposal. The Foundation has been the leading force in advocating for quality, affordable healthcare coverage for all Connecticut residents and we commend them for their continued efforts.

With over 300,000 Connecticut residents currently uninsured, our state clearly needs of SustiNet. Overhauling our healthcare system to ensure that it covers everyone and costs are reduced is an economic imperative for our state. As I said before, nonprofit employers, like many other employers, have been facing years of skyrocketing healthcare costs that are growing more and more difficult to sustain. The high cost of healthcare puts all

90 Brainard Road ♦ Hartford, CT 06114 ♦ Tel: 860.525.5080 ♦ Fax: 860.525.5088 ♦ www.ctnonprofits org

businesses, including nonprofits at a severe disadvantage and leads to lower wages and fewer jobs. Worse off yet are the thousands of individuals without access to employer sponsored insurance. Many of these people are low- to middle-income individuals and families who are served by our state's nonprofit providers. It is a daily concern for our members that their clients do not have adequate, preventative healthcare coverage.

SustiNet merges state employees and retirees with HUSKY and SAGA participants into a self-insured pool. Others also eligible include: individuals without access to employer sponsored insurances; individuals with employer sponsored insurance that does not provide affordable access to essential care; and employers, including nonprofits, small businesses, and municipalities. SustiNet is a broad health benefits plan that will include essential services such as medical home services, mental health and dental coverage. It will accept all applicants, regardless of pre-existing conditions, as well as subsidize premiums and co-pays based on income. This is comprehensive plan that will bring much needed quality, affordable and sustainable healthcare coverage to Connecticut residents. Although, ideally we would like to see adults enrolled in the Medicaid program for the elderly, blind and disabled, some of our state's most vulnerable residents, be included in coverage under SustiNet.

Both the Connecticut Healthcare Partnership and SustiNet are important steps towards comprehensive healthcare coverage for all Connecticut residents. It is critical for our state to take these steps now; we cannot afford to wait any longer. CT Nonprofits believes that quality, adequate healthcare coverage is a right for all citizens, not just those that can afford it. We urge the Legislature to make these proposals a reality and ensure that Connecticut residents no longer have to go without healthcare coverage.

Thank you for the opportunity to submit testimony. Please do not hesitate to contact me with any questions.

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EXECUTIVE DIRECTOR
Teresa C. Younger

Testimony of
Teresa C. Younger
Executive Director
The Permanent Commission on the Status of Women
Before the
Human Services, Insurance and Real Estate, Public Health Committees
Monday, March 2, 2009

Re:
H.B. 6582, AA Establishing the Connecticut Healthcare Partnership
H.B. 5172, AA Establishing the Connecticut Healthy Steps Program
S.B. 988, AAC Medicaid Funding for SAGA and Charter Oak
H.B. 6600, AAC the Establishment of the Susinet Plan

Senators Doyle, Crisco and Harris and Representatives Walker, Fontana and Ritter and members of the committee, thank you for this opportunity to provide testimony in support of on several healthcare reform bills before you today. I am also testifying on behalf of the Connecticut Women's Health Campaign (CWHC), a broad coalition of organizations committed to and working for the health and well-being of Connecticut women over their lifespan; and the Young Women's Leadership Program (YWLP), which highlights the concerns of women ages 18 to 35.

While the specifics of each bill – House bills 5172, 6582 and 6600, and Senate bill 988 – are all different, they all attempt to expand availability and affordability of health insurance benefits to all Connecticut residents. We support this intent because the increasing numbers of uninsured persons affect all genders, races, and ages.

In 2006, 11% of Connecticut's population aged 25 to 64,[1] and one-third of young adults, ages 19 to 29 were uninsured.[2] As of December 2007, the Kaiser Family Foundation estimated that there

[1] Families USA. *Dying for Coverage*, April 2008
[2] <http //www ct gov/ohca/lib/ohca/common_elements/household06_summary_single_pages_for_pdf pdf>

were over 130,000 uninsured women ages 18-64 in Connecticut.[3]

Lack of health insurance increase the risk of undiagnosed conditions resulting in health disparities and deaths. Uninsured adults are more likely to be diagnosed with a disease in an advanced stage. For example, uninsured women are substantially more likely to be diagnosed with advanced stage breast cancer than women with private insurance.[4]

Lack of health insurance also leads to financial ruin for many families. Almost 8% of working adults in Connecticut spend 20% or more of their income on out-of-pocket medical expenses.[5] Connecticut women have higher out-of-pocket medical expenses than men, and are more vulnerable to medical debt. Fifty-six percent (56%) of medical bankruptcy filers are women.[6]

We request that any plan that is developed address women's special needs and concerns to ensure that we have equal access to health care, which means ensuring that it is:

- Gender appropriate
- Culturally competent
- Comprehensive and preventive; and
- Confidential.

This means that coverage must be both **comprehensive and preventative**. Coverage must include specialty care, mental health and substance abuse treatment, access to prescription medication, vision and oral health care, preventive care, acute and long-term care, rehabilitative care, and reproductive health services, including coverage of family planning, contraceptives, abortion, cancer detection and treatment, prenatal care, and inpatient overnight stays for child-birth and mastectomy when needed.

Consumers must be able to access an array of practitioners, including midwives and nurse-practitioners. Settings should include community and school-based health centers, family planning clinics, and others that provide a safety net to underserved populations, including women and girls. Women must be able to identify a gynecologist or other specialist as their primary care provider if reform builds on a managed care system.

Health care should be responsive to and inclusive of diverse populations and differences among clients. Proposals should strive to eliminate racial and ethnic disparities by design. This would include proactive recruitment of bilingual and multicultural health professionals and improved health data by collecting information gender, race and ethnicity. In particular, this

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[3] <http://www kff org/womenshealth/upload/1613_07 pdf>
[4] Families USA, *Dying for Coverage*, April 2008
[5] State Health Access Data Assistance Center, December 2007
[6] D.U Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*. February 2005.

means that medical interpreters must be provided and paid for as a covered service in order to ensure that those with limited English proficiency are able to communicate effectively with their providers.

Protect the confidentiality of women and girls. Current state statutes protecting the confidentiality of services for all minors, including reproductive and behavioral health care, must be integral to any universal plan. For example, patients with HIV infection, survivors of sexual violence and domestic abuse, and those who seek behavioral health care must be confident that seeking care will not result in disclosure of their health condition.

Health care and insurance must be affordable so that true universality is accomplished. This means that low-income households should be exempt from cost-sharing while higher income households should pay no more than 5% of family income on total health care costs.

We urge you to include these elements in any plan for health care reform. Thank you for your consideration.

CONNECTICUT WOMEN'S HEALTH CAMPAIGN E-News
January 2009

Members 2009

Advocacy for Patients with Chronic Illness, Inc.
African American Affairs Commission
American Heart Association
Coalition for Choice
Connecticut Association for Human Services
Connecticut Commission on Aging
Connecticut AIDS Resource Coalition
Connecticut Association for Nonprofits
Connecticut Breast Cancer Coalition Foundation
Connecticut Coalition Against Domestic Violence
Connecticut Community Care, Inc.
Connecticut Primary Care Association
Connecticut Sexual Assault Crisis Services, Inc.
Connecticut Voices for Children
Connecticut Women's Consortium
Connecticut Women's Problem Gambling Project
Hartford Gay & Lesbian Health Collective
Health Care for All Coalition
Latino and Puerto Rican Affairs Commission
Legal Assistance Resource Center of CT
MATCH Coalition, Inc.
NARAL Pro-Choice Connecticut
National Council of Jewish Women
National Alliance on Mental Illness, CT (NAMI-CT)
Permanent Commission on the Status of Women
Planned Parenthood of Connecticut, Inc.
The Paul and Lisa Program
University of Connecticut Health Center, Celebrate Health Programs
Witness Project of Connecticut, Inc.
Women and Family Life Center of Guilford
YWCA Northeast Regional Council

Testimony of Kevin Lembo, State Healthcare Advocate
Before the Public Health, Insurance and Real Estate and Human Services Committees

***In Support of* HB 6582, SB 1022, SB 1045, SB 1046, SB 1049, SB 1050, SB 819, HB 6600**
***In Partial Support of* HB 5172, SB 988, HB 6417, SB 1048**
***In Opposition to* SB 990, SB 992**

March 2, 2009

Good morning distinguished members of the Public Health, Insurance and Real Estate and Human Services Committees. For the record, my name is Kevin Lembo, and I am the State Healthcare Advocate. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

INSURANCE

Bills We Support

1) **HB 6582**, *An Act Establishing the Connecticut Healthcare Partnership*

OHA supports the creation of the Connecticut Healthcare Partnership. H.B. 6582 seeks to provide coverage for public employees and employees of certain nonprofit employers in the state of Connecticut by allowing these employees to enroll in the State of Connecticut employee plan, effectively expanding the State of Connecticut employee pool which should increase the state's leverage in bargaining with insurers, but also decrease the number of uninsured in the state of Connecticut.

H.B. 6582 is one of several promising proposals circulating through the Capitol for committee action. The goals of this bill are good and the bill needs to be examined in tandem with similar and already enacted laws involving public employees such as MEHIP.

SB 1049 adopts the provisions of the successful Massachusetts law prohibiting almost all gifts from pharmaceutical and medical device companies to health care providers and their employees. Samples and payments for participating in clinical trials would still be permitted under SB 1049. This is especially important for those patients who do not have insurance and for ongoing medical research.

SB 1049 also requires the disclosure or certain financial assistance to providers from pharmaceutical manufacturers and medical device companies for scholarships or other educational funds to permit medical students, residents, fellows and other health care professionals in training to attend educational conferences.

4) **SB 1050** – *An Act Concerning the Establishment of an Academic Detailing Program*

OHA supports the establishment of an academic detailing program to educate providers on the details, including the costs and benefits of new medications. Such education is necessary to ensure ongoing unbiased medical education for providers on newer pharmaceuticals. Allowing for continuing medical education credit detailing education should provide the incentive providers need to obtain unbiased education about newer pharmaceuticals. The bill allows the Commissioner of DPH to seek non-governmental funding for the program and encourages the Commissioner to work with DSS to seek Medicaid reimbursement for the program.

4) **HB 6600** – *An Act Concerning the Establishment of the SustiNet Plan*

OHA supports the establishment of SustiNet. So many people worked very hard to put this piece of legislation together, and they deserve praise from all of us. The development of the proposal is consistent with the federal movement to expand health insurance availability. SustiNet, like the Connecticut Health Partnership and the work of the HealthFirst Authority have brought together some of the best minds in the state and country to tackle the critical need for healthcare reform in Connecticut.

The SustiNet proposal contains many sound ideas based the adoption of the Institute of Medicine's principles of healthcare reform. Section 16 authorizes OHA to develop and update the model benefit packages and to recommend guidelines for establishing an incentive system to recognize employers that provide health benefits equal to or greater than the model plan. The inclusion of our office in Section 16 is an appropriate evolution of our work and is keeping with the spirit of our office's creations. We will work with OFA and the legislature to craft a fiscal note for the section.

Please note that on line 1170 of the bill, the word "contact" should read "contract".

Bill that We Partially Support

1) **SB 1048**. An Act concerning Bulk Purchasing of Prescription Drugs

CBIA

Connecticut Business & Industry Association

TESTIMONY
BEFORE THE
PUBLIC HEALTH, INSURANCE AND REAL ESTATE AND HUMAN SERVICES COMMITTEES
LEGISLATIVE OFFICE BUILDING
MARCH 2, 2009

My name is Eric George and I am Associate Counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents approximately 10,000 businesses throughout Connecticut and the vast majority of these are small companies employing less than 50 people.

Both nationally and in Connecticut, the health care system is in need of repair.

More needs to be done to improve the health of our citizens. Employers find health care costs rising faster than other input costs. Some providers are unable to generate sufficient patient revenue to cover costs. Some patients cannot get timely access to optimal care. And too many individuals remain without health insurance, engage in unhealthy behaviors and live in unhealthy environments.

For the business community, the issues of health care quality, cost and access are critical. After numerous years of double-digit and near-double-digit increases, health insurance has quickly become a product that many people and companies find they can no longer afford. In addition, the cost of health care directly affects businesses' ability to create new jobs. In fact, according to CBIA's latest membership survey, over two-thirds of our members indicated that rising health benefit costs alone are negatively affecting their ability to hire additional workers.

Therefore, CBIA would like to offer comments on the following bills dealing with health care reform in Connecticut:

- **HB 5172, AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM**
- **HB 6600, AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN**
- **HB 6582, AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP**

In reviewing these bills, my opinion and comments are guided by several factors.

First, improving health care in Connecticut must be achieved in a way that will meet people's needs -- and help the state's economy recover and grow. The best way to do that is to make our employer-sponsored health insurance system, with its public "safety net," the model for the nation.

Second, making the best use of our resources to promote quality and value, reduce costs, and increase access to coverage will enable us to accomplish this goal. Better health care means making private insurance more affordable and accessible.

And third, the public and private sectors must work together to improve our health care system, mindful of our precarious economy. Without a healthy economy and the good jobs and benefits it brings, meeting Connecticut's health care needs will be impossible.

So, truly comprehensive health care reform must encompass the following:

It Must Promote Quality

- Use value-based health plan designs that incorporate evidence-based medical practices, in order to give people better care and keep them healthier and more productive.
- Work with the private sector to ensure a "medical home" for all Connecticut residents, which will encourage greater care coordination among providers, improve the quality of medical care, reduce errors, and provide better chronic-disease management.
- Create public-private partnerships to improve people's health status through wellness and chronic-disease management programs.
- Make health care information more accessible to consumers, and the overall system more efficient, by promoting greater use of technology in data collection, transparency, electronic medical records and e-prescribing.
- Adopt pay-for-performance programs to increase patients' safety and quality of care.

It Must Reduce Costs

- Encourage small employers to use wellness and disease-management programs by exempting them from the state's insurance premium tax if they offer and maintain those programs. Educate small employers and the public about the importance of healthy lifestyles and wellness programs .

- Enable employers to purchase health care plans that are appropriate for them and their employees, in particular by not burdening small businesses with expensive new health benefit mandates.
- Make private insurance more affordable by increasing Medicaid reimbursement rates and eliminating cost-shifts to the private sector.

It Must Increase Access

- In addition to the above reforms that will increase access to private-sector health insurance by making it more affordable, the following will also help increase access:
  - Raise Medicaid reimbursement rates, which will encourage more health care providers to participate in public programs.
  - Increase outreach efforts for HUSKY and other public health care programs.
  - Expand the use of community- and school-based health centers, to provide better care to more patients and improve access to providers.

Here are my specific comments on several of the bills before you today:

1. **HB 5172, AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM**

HB 5172 raises critically important issues that must be considered as Connecticut moves towards reforming its health care system. It touches upon improving the quality of health care and reducing its costs in an effort to increase health care access. It also strongly focuses on improving the health status of Connecticut's residents in an effort to improve the overall system.

CBIA supports the provisions contained in **HB 5172** that focus on affordability (those concerning mandate review, reduced mandate products, employer tax credits to name a few). CBIA also supports the provisions of **HB 5172** that address the overall health status of Connecticut residents through promoting healthy lifestyles.

HB 5172 goes a long way towards improving Connecticut's health care system.

2. **HB 6600, AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN**

There is much to like in **HB 6600,** but there are provisions in the bill that are concerning as well.

First, **HB 6600** contains many positive provisions, including those that promote:

- Provider rate reimbursement increases
- Medical homes
- Health information technology
- Health status improvement
- Health care quality improvement
- Preventive care
- Health care cost and quality data compilation and transparency

However, **HB 6600** also contains several provisions that are troublesome. These include provisions focused on:

- Folding all employers and other groups into one, self-insured pool that would be administered by the state (this would move the state much closer towards establishing a completely government-run health care system).
- Forcing employers to pay for this new health care system either through an employer voucher system or a "pay or play" health care tax contained in the bill (this tax couldn't come at worse time, given the dire state of our economy and our businesses' lack of financial health – and, moreover, the tax is likely prohibited outright by federal law) .
- Ceding the legislature's power to a newly created SustiNet board of directors with regards to changing the SustiNet enrollment rules in the future (taking such an integral piece of the health care reform puzzle away from the legislative process is simply bad policy).

HB 6600 does have many positive reform measures, but also several measures that could be damaging and should be removed from the bill.

3. HB 6582, AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP

The general concept of **HB 6582** is to have municipal employees, small employers and nonprofit organizations join the expensive state employee health insurance plan.

This is troubling since the state has not done a particularly good job in containing its own health care costs — such as the nearly $22 billion unfunded liability for state retiree health care costs and the fact that one level of state employee health plan for a family of four costs more than $21,000 a year.

It is also concerning that this pooling system would operate outside of Connecticut's insurance laws — which would adversely affect many small businesses. Moreover, any employer group participating in the program would have to make a very lengthy two-year commitment.

Despite what proponents of the bill say, other large-scale purchasing pools have actually not addressed the high costs of health care. For example, America's automobile industry has a very large health care purchasing pool, but despite its considerable "purchasing power," the system's cost has nearly toppled U.S. automakers.

HB 6582 would move Connecticut closer to a government-run health care system. This simply is not in line with public opinion. According to a CBIA/Zogby International survey, nearly three-quarters of state residents said that the best health care reform would be to control health care costs to make private insurance more affordable rather than moving towards a government-run health care system.

And it should be recognized that according to this survey, 69% of state residents have insurance through their employer, or individually in the private market, and an overwhelming 83% are satisfied with their coverage.

It is also important to recognize that the HealthFirst Connecticut Authority recently released its recommendations for health care reform to the legislature. In that report, the Authority stated that:

> On this subject [of opening the state employee health plan to other groups], the Authority recognizes that there are strongly held views for and against this step... [and] that there is no consensus opinion.

Given the controversial nature of **HB 6582** and the strong consensus proposals contained in **HB 5172,** and partially in **HB 6600**, CBIA urges the committees to reject **HB 6582.**

Thank you for the opportunity to testify on these proposals and we look forward to working with you on this tremendously important issue.

JOINT
STANDING
COMMITTEE
HEARINGS

PUBLIC
HEALTH
PART 4
932 - 1237

2009

CHAIRMAN: Senator Harris
Representative Ritter

MEMBERS PRESENT:
SENATORS: Coleman

REP.S: Gentile, Ayala, Bye
Conroy, Esty, Grogins, LeGeyt,
Lyddy, O'Brien

HB6600

LARRY DEUTSCH: Alright, well, my remarks are actually -- I had planned on -- believe it or not -- being silent most of the time so that you can read a set of questions as you evaluate the various health proposals that are before you. And I would say from listening to the testimony and reading the plans, that there are certain questions at the bottom of my questionnaire which I hope you get and I can also hand out to the audience -- which draw attention not just to the issues of coverage and universality which we all think is crucial. That universality is a central issue which -- about which other issues resolve in terms of all of us achieving quality, resolving disparities and so on.

But I would like you also -- again looking at this little quiz which I even simplified and put the answers on the back at least as I see them, that you also look at questions of making sure that the capacity is there as we expand the numbers of those covered, that we have a good health workforce and among the questions, will the health workforce be well trained and well

paid. And will it also be involved in the decision making process as healthcare is delivered.

There -- there are questions here that also draw your attention to achieving a much improved public health structure which means assisting local health departments and other structures because if we solely pay attention to the financing and the insurance aspects, we'll fail in the goal of saving healthcare costs and improving quality. So again, one question is -- the ninth question I think you can look at is -- are communities funded and empowered to govern and adjust health services for their local populations? I think we want to make sure that the health care system is successful by having democratic involvement of not only the local populations, but also those who work in the healthcare professions.

And the tenth question -- are healthcare workers at all levels adequately compensated and empowered to evaluate and adjust a working conditions. So the -- I think we all agree that the -- our new system should be comprehensive in benefits. I hope we all agree that mental and dental health are integral parts of general health. I hope we all agree that we need a well trained and diverse health workforce which is insufficient right now and that health is a human right and that it be funded in the just and progressive manner. These are questions which, again, I -- I leave you all to -- all of us to contemplate as we evaluate all the proposals and

-- and I even have it as a grading system and I hope that contributes to your deliberation, especially calling attention to the public health aspects in which are -- are being involved.

I like to conclude there and yield my time otherwise or if there are any questions, I'd be happy to answer them.

SENATOR HARRIS: Thank you, Doctor, any questions? Thank you very much.

LARRY DEUTSCH: Thank you.

SENATOR HARRIS: And now we'll go on to sign up for Senate Bill 1045 -- Jim Iacobellis. Good afternoon, Jim.

JIM IACOBELLIS: Good afternoon. Good afternoon, Chairman Ritter, Senator Harris, Senator (inaudible), and Senator Doyle and distinguished members of the Public Health, Human Services and Insurance Committee. My name is Jim Iacobellis. I'm Vice-President of Government Relations for the Connecticut Hospital Association. And I'm here this afternoon to testify on Senate Bill 1045, An Act Concerning Responsibility for Hospital Never Events.

I think to simplify the issue, Senate Bill -- and I won't -- I have submitted testimony on this and I will just summarize some -- I think what is the key point here.

JOINT
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2009

And that's what 1049 undermines and I've said in my prior testimony is so duplicative of and we're more than happy to sit down with this Committee and Committee staff to go through the existing web of federal and professional conduct regulations that I think cover all the concerns in 1049.

REP. RITTER: Thank you very much. Are there questions from the Committee? Hearing none. Thank you very much.

PAUL PESCATELLO: Thank you.

REP. RITTER: Our next Bill is House Bill 6600 and our first speaker is Frances Padilla, followed by the Reverend James Walker and then Kevin Galvin.

FRANCES PADILLA: Good afternoon, distinguished Committee Chairs and members. I come before you in support of House Bill 6600, an act to establish a SustiNet Plan. This Bill is based on the most detailed policy analysis for healthcare reform the General Assembly has before it. Universal Health Care Foundation seeks to improve the health of the people of Connecticut and make the healthcare system work for everyone.

To inform this -- the design of this policy proposal, our Foundation evaluated health outcome and healthcare spending data and sought the ideas and advice of a wide range of stakeholders. Thank you for the chance to present upon this proposal last week. I want to make three

clarifying points about SustiNet. First, even before the economy began shrinking in 2008, we understood the prudence of phasing in the various groups to be covered. The economic impact of the policy design was thus stimulated over a five year period, from 2011 through 2016. With SustiNet, coverage costs are first incurred in 2012. The micro stimulation shows that by 2016, if measures such as chronic illness management through value based benefits design, electronic medical records and quality standards are robustly implemented, Connecticut can expect to slow the rate of total healthcare spending. With SustiNet fully implemented by 2016, that rate will begin to decline by two to three percent. Left unchecked, the rising cost of medical care will dominate the Connecticut economy and swamp the State budget.

Second, SustiNet leverages the State of Connecticut's ability to secure better value for the healthcare dollar. Think about the residents of this State as shareholders. What other multi-billion corporation wouldn't use its negotiating power to deliver greater value to its shareholders. SustiNet will save businesses and households $1.7 billion in lower premiums and out of pocket costs. Its expansion of coverage eligibility will leverage at least $800 million in new federal money. That's a return of $2.60 for every dollar of State investment.

My third point is about the sources of new costs to the State government. If we begin coverage in

2012, by 2014 98 percent of the State's uninsured will have coverage either through SustiNet our through their employers' plan. In 2014, the State of Connecticut begins full scale provision of premium subsidies to that part of the working middle class whose earnings make them ineligible for Medicaid, but who still cannot afford the coverage their employers may offer them. I'm almost done. That year the State also increases on a graduated basis, reimbursement rates to providers who care for people on Medicaid and HUSKY there by reducing the shift of cost for uncompensated care to the private sector.

Members of Connecticut's business community have made it clear to us that the cost shift is a problem that must be addressed in any healthcare reform. For the same reason, in 2007 the Connecticut Insurance Policy Council also recommended increased Medicaid rates.

We are in the position in Connecticut to demonstrate that a public health insurance plan alongside the private market coupled with prevention, cost control and quality enhancement can improve the health of our State and make us more economically competitive. In the short run, passage of HB 6600 will enable Connecticut to make maximum use of stimulus funds for electronic health records thereby building data capacity. SustiNet will make Connecticut action ready to use resources from the Obama administration's healthcare reform initiative. As a panelist

last week all said in one way or another, only systematic reform will get us there.

I respectfully submit to you that SustiNet is your most complete and effective blueprint for that reform. Thank you, I'll take any questions.

SENATOR HARRIS: Thank you. Any questions from the Committee? Thank you, Ms. Padilla.

FRANCES PADILLA: Thank you.

SENATOR HARRIS: Next, the Reverend James Walker followed by Kevin Galvin and then Lee -- Linda St. Peter.

REVERAND JAMES WALKER: Good afternoon honorable Chairs and members of the Committee. Thank you for the opportunity to support HB 6600. I am the senior past of Phillips Metropolitan Christian Methodist Episcopal Church here in Hartford. I'm a member of the Interdenominational Ministerial Alliance as well as a co-chair of the Interfaith Fellowship for Universal Health Care. I'm here because people are suffering.

One hundred years ago, we were a society afflicted by infectious diseases and death or recovery came fairly quickly. Today, we are a people afflicted by chronic diseases requiring long term treatment, long term care, lots of doctors' visits, lots of medication. People are suffering. That situation is getting worse and this -- and thus, we must reform healthcare in

Connecticut and we ought to do it now. We have the reform for Connecticut. It's called SustiNet. It is the basis of House Bill 6600. It is well researched. It is reasonable. It is timely. It saves money as well as saves lives.

It represents not only a good plan for the State of Connecticut, but I believe it also represents leadership for the national dialogue as well. We need your leadership on this issue. Much like the abolitionists who took the bold stance to completely abolish slavery, we call upon you to take that traditional stance -- to abolish the condition of the uninsured in the State of Connecticut. The community I serve is disproportionately affected by coronary heart disease, by hypertension, diabetes, colon cancer, breast cancer, prostate cancer, stroke, kidney disease, chronic obesity, mental illness, sleep disorders, asthma as well as incidences of cold and flu of which I am a prime example today.

Additionally, people of color are significantly more likely to be uninsured creating thusly, the perfect storm for ill health, financial instability as well as premature death. But this is simply not an issue for African-American alone. Every year, over 500,000, some estimate, people die prematurely. These are persons of every color and every stripe. This is an untenable result that we can rectify and I will be finished in just one second.

Recently, our congregation decided to provide coverage for full time employees who are uninsured. We learned, however, that not all insurances are created equally. So, in addition to playing for the -- paying for the premiums, we also had to help with co-pays and deductibles out of human concern. We believe that SustiNet provides a better alternative for Connecticut. From where I stand and where I sit, your leadership in passing this (inaudible) reform is critical. Because at a time when many residents are losing jobs as well as their healthcare benefits, we really need you and we need you now.

We're going on Thursday to the Governor's office to repeat our request -- the same request that we have made to you because we feel just as it is right to say and request for you this bold reform, it is right to ask for her leadership as well.

I thank you for the opportunity to testify.

SENATOR HARRIS: Next, again, Kevin Galvin followed by Linda St. Peter and then Ben Stango.

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KEVIN GALVIN: Good afternoon. My name is Kevin Galvin. I'm here as a small business owner here in Connecticut for nearly 30 years. I own a small service in West Hartford and employ a staff of eight. I'm also here today as Chair of the Advisory Committee for the Small Business for Health Care Reform, an organization of nearly

20,000 small businesses concerned about healthcare.

There are many things we can probably agree on today. One is our healthcare system is broken. The other -- another is the broken healthcare system isn't good for economy. (Inaudible) probably is -- we're not trying -- we're not -- we're not fixing it fast enough. And, yet another is, this is a moment in time where we really can create dynamic change in a healthcare system and I think session is when it has to happen.

As a small businessman when it comes to healthcare, I can't wait anymore. The problems around the lack of healthcare is one of the first things small business owners bring up when you ask them about their -- the staying power of their business. In my case, in the four previous years, I've had the -- I've had the business and the ability to double the size of my staff and my business from eight to 16. That means I'd be employing 16 state residents, not the eight great staff I have presently. The single thing to stop that growth is my inability to attract qualified employees because I don't provide healthcare. That lack of healthcare is killing me in other ways.

Of my staff -- staff of eight, four have never had a family doctor. They've never had a physical in a doctor's office. They've never had a dentist appointment that wasn't an emergency.

In one case, I had a staff member out for 11 weeks for a very preventable dental infection -- a 28 year old man with two kids. It nearly killed him. These eight men need to work. I need them to work. Their families need them to work. The State needs them to work. They can't work if they're out sick for preventable medical issues. They can't be in work. They spend days (inaudible) in emergency rooms getting help, basic medical needs, that could happen in a doctor's office.

My story is one of thousands that my members could tell you. In lieu of that, I'm here today for those thousands of owners to say something has to give with regard to healthcare. And it's got to give now. And we feel it's in the form of getting quality and affordable healthcare into our toolboxes as business owners. We feel SustiNet is the best plan. I have one more minute.

SustiNet calls for structural changes. It offers choice. We as business owners don't have to -- have to take it. Our brokers that we know and trust can sell it. So all businesses for healthcare reform came around this issue of healthcare because we feel small businesses do not have a true independent voice in the legislative process up until now. We feel the subject of healthcare is too important for our voice not to be heard.

SustiNet is the answer to us. If you want small business in Connecticut to survive and build our economy -- help rebuild our economy, we need -- we need healthcare -- help with healthcare -- we -- we want the SustiNet product. If you don't find a way to get quality healthcare available to people with the desire and guts to run a small business, it'll yet be another reason for these people not to invest in Connecticut's economy.

I'd be happy to take any questions you may have.

SENATOR HARRIS: Thank you, Kevin. Any questions? Representative Fontana.

REP. FONTANA: Thank you, Chairman and good afternoon, Kevin.

KEVIN GALVIN: Good afternoon.

REP. FONTANA: A couple questions for you. First, you're a member of a group call the Small Business --

KEVIN GALVIN: For -- for Health Care Reform.

REP. FONTANA: Very good. Can you tell us a little bit about your group. How many members do you have? Or how many employees does your group represent? And can you tell us (inaudible).

KEVIN GALVIN: It is -- it is a -- an organization of small business that are throughout Connecticut --

the number right now in the area of 19,000. It's growing in leaps and bounds --

REP. FONTANA: 19,000 businesses?

KEVIN GALVIN: Businesses -- individual business owners. It -- it got our attention very quickly as a small group of people got together to talk about healthcare -- how many people were interested and how many people were so emotional and so invested in -- in this conversation. And it wasn't hard to build an organization. So we're still in our -- still in our informative moments.

REP. FONTANA: That's fine. And actually your final statement leading to my second question, I believe you just said it wasn't hard to build interest in healthcare reform among small businesses in Connecticut. Is that what you said?

KEVIN GALVIN. Absolutely.

REP. FONTANA: Okay. The second question I had is we heard testimony earlier in the day from the Secretary of the State who in her capacity as Secretary of the State meets with small businesses on a number of issues throughout the State, throughout the year. And she testified that there was a problem getting affordable, quality health insurance out to small businesses in the State. Then we heard from the Secretary of the Office and Policy Management who described

the small group market as healthy and viable. So I'd just like to sort of get your feedback on those two sort of polar opposites that we heard one --

KEVIN GALVIN: We he or she at a hearing in Connecticut?

REP. FONTANA: Well, unless I was in some other planet or place it was about four hours ago right here.

KEVIN GALVIN: My apologies for being flip.

REP. FONTANA: No, no don't apologize, I'm just saying.

KEVIN GALVIN: I've -- I've been in small business for 30 years. I can tell you that there are -- is only two times that I've been on the fringe of going out of business and one time is when I really made an effort to bring a healthcare plan on board. It took me almost four years to survive that, to move away from it, get my people established on their own and then -- and then go back to doing business. I'll also share with you the fact that I'm a past president of the West Hartford Chamber of Commerce that had at the time upwards of 700 members. This was a few years again. And even a few years ago, the discussion of having healthcare available at a -- at a fair price. That was, you know -- that would be an actual consumable for a small business was not there then. So in the -- in the -- in nearly that whole decade not much has changed. And

frankly, I've been at this since 1976 and not much has changed.

REP. FONTANA: So, it would be fair to say then that the interest of your members in healthcare reform has come about as a result of a lack of health and viability to the small group market in Connecticut.

KEVIN GALVIN: There's absolutely no question that that's an accurate statement.

REP. FONTANA: And -- and you're experience personally as a small business owner testifies to that as well.

KEVIN GALVIN: That is true.

REP. FONTANA: Very good. Thank you.

SENATOR HARRIS: Thank you. Chairman Ritter.

REP. RITTER: Thank you. Thank you, Kevin, for your testimony. You're a wonderful advocate for your 19,000 members.

KEVIN GALVIN: Thank you.

REP. RITTER: I think when we talked last week you told me it was 18,000.

KEVIN GALVIN: It's growing.

REP. RITTER: So, it's a --

KEVIN GALVIN: It's been a couple of days.

REP. RITTER: -- it's a wonderful growth rate other than the inflation rate or the rate of increase in healthcare costs, you know, and that's big numbers.

KEVIN GALVIN: It's a good number except I'm maintaining the website. It's not a (inaudible).

REP. RITTER: It's not a (inaudible) for you. Well, there's joy and success (inaudible).

KEVIN GALVIN: That is true.

REP. RITTER: But I want to thank you for advocating for those small businesses and actually Representative Fontana took quite a few of my questions away from me because I had asked them myself of the Secretary of OPM. Because it was my understanding from the small businesses I talk to and I represent a district in southeastern Connecticut that I just don't have anybody coming to me and saying they love their healthcare and their ability to be able to provide it for their employees. And so I'm --

KEVIN GALVIN: I'm -- I'm shocked.

REP. RITTER: But I wanted to ask if you and this is somewhat along the line of what Representative Fontana was asking. Do you -- are you aware of a differentiation among small business? Is it

possible that there are sectors in the small business world where this is not a problem?

KEVIN GALVIN: I don't -- I don't --

REP. RITTER: Do you understand (inaudible).

KEVIN GALVIN: Yeah, I understand your question. I don't believe that to be true. I do know that there is a large -- probably equally large number of small businesses that are concerned about what health -- what universal healthcare or a healthcare plan would cost them. I think that's a matter of education. Because in my -- when I look at my absentee rate -- look at my lack of productivity -- even if costs would have fallen on my side, I wouldn't have a problem with that. Because my -- because my productivity is just getting eaten alive with days off because of these young men and their families being ill and instead of having a doctor's appointment and going at three o'clock with their kid to get fixed up, they're in -- they're in an ER, shutting an ER down for -- for six or eight hours. So it's -- it's -- I find this very palatable. But I think with education, we can -- we can bring many of small businesses aboard that are not and I think that -- it's just -- it's just fear of the unknown -- in my opinion.

REP. RITTER: Well, thank you very much and I'm going to look forward to continuing to work together on this.

KEVIN GALVIN: Great. Thank you.

REP. RITTER: Thank you very much, Mr. Chair.

SENATOR HARRIS: Thank you. Any further questions? Kevin, good to see you. Thanks again.

KEVIN GALVIN: Thank you for your time. Linda St. Peter followed by Ben Stango and then Norma Franceschi (inaudible).

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LINDA ST. PETER. Good afternoon. Thank you all for braving the storm today to hear my story. You've got my written testimony but if you would allow me to please share my personal story. I think you'll find it perhaps more interesting.

My name is Linda St. Peter. I'm President of the Connecticut Association of Realtors. I've been a commercial realtor for almost 21 years. In fact, you might say realtors build communities. I've put tenants and clients in all of your communities to make them vital. But like most realtors, in 18 of those 20 years, I was dependant on my spouse. Fifty percent, by the way, of realtors depend on their spouses or dependant on others for their health insurance coverage. Through just a whole host of strange

events, only things stranger could happen to me. In Spring of 2006, my husband of 27 years was diagnosed with a chronic -- with an acute and virulent form of leukemia. Six months later he died and with it, my health insurance coverage. Well, the usual COBRA coverage was available, but that was approximately two times my mortgage payment. What you may not see when you look at me because I'm a 51 year old, healthy, vibrant, vegetable eating, yoga doing, do what my doctor tells me kind of person, is that I'm also a seven year breast cancer survivor because I was vigilant, because I went for mammograms, because I did all the right things. And I had health insurance coverage during that time. However, once my husband passed away, that health insurance coverage died with him. And I have this black mark on my permanent record.

My doctors assure me that 50 or so years from now I will die of something, but it won't be breast cancer. They allow me to do everything in life. However, the insurance company that had my every MRI, my every test, my every everything, would not at that point give me healthcare coverage because I was not yet five years out of diagnosis and full treatment. Doing everything right. Doing absolutely everything right.

This unfortunatey black mark on my permanent record is not unique to anyone. Of my 18,000 realtor members, I've got 13 percent who have no coverage at all and I could easily have been one of those. But because I am a business owner, I

struggled through that very high COBRA to search and find. For seven months, I paid that COBRA until I could find someone who would embrace me and embrace my good health and embrace the fact that I do take good care of myself.

Each and every day of my life, I eat five to ten servings of fruits and vegetables a day. I exercise. I do what's right. And to look at me, you'd never know. You'd never know.

Because I have my own business, I'm able to make that happen. My 18,000 realtor members, half of them are dependent on others. Another more than 2,000 have no coverage at all. 660 embraces us all as independent contractors and I fully express my gratitude at being able to speak before you today.

SENATOR HARRIS: Thank you, Ms. St. Peter. (Inaudible). You're lucky we're not four or five years old because the association of SustiNet with fruits and vegetables might not be positive for the plan. But I -- thank you very much, appreciate it.

LINDA ST. PETER: You're very welcome.

SENATOR HARRIS: Any questions? Chairman Fontana.

REP. FONTANA: Thank you, Mr. Chairman. Just -- Linda, quickly -- again, just to offer you the chance the same -- to testify that same point I made earlier, do you consider the small group or

individual health market healthy and viable right now, the health insurance market for you?

LINDA ST. PETER: Well, I have my own business. And health -- I believe that health insurance is something as a business owner I should be able to provide fro employees. And it has caused me to not grow my business because I -- I simply can't afford to do everything. So I don't grow that business.

REP. FONTANA: Thank you.

LINDA ST. PETER: Thank you.

SENATOR HARRIS: Any further questions?

LINDA ST. PETER: Thank you very much for having me and thank you for asking. Not everyone asks what we need.

SENATOR HARRIS: Next we have Ben Stango followed by Norma Franceschi and then Cornell Wright. No Ben Stango -- Norma here? So, Norma, Cornell Wright followed by Sharon Langer and then Rebecca Vall.

CORNELL WRIGHT: Good afternoon, distinguished Chairs and panel of members of the Committee. My name is Cornell Wright. I'm a small business owner. I'm a management consultant and I'm here to offer my support and ask for your support for House Bill 660. In regards to my business affiliations, I am a member of the Board of the Community Economic Development Fund, an

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organization that assists with financing of small business throughout the State of Connecticut. I'm a member of the Board of Directors of the Greater New Haven Business and Professional Association, a 40 year old association of the greater New Haven area assisting black and brown businesses. I'm on the Executive Committee and the Board of Directors of the New Haven Chamber of Commerce and I'm also on the aforementioned Small Business for Health Care Reform. From those perspectives as well as consulting and working with a number of small businesses, once again I ask and urge your support of House Bill 660. As you look at it now across the -- across our economic landscape not only of the State of Connecticut, but the entire nation, we're in a need for recasting, if you will, some key elements of our society. One of those recasting, I would submit, is healthcare -- the affordability and availability of healthcare which I think would be supported by House Bill 660 and SustiNet, in particular.

We're at a point in time in which part of my consultation and consulting factors is looking at a customer service and that of strategy. I have a client who is, in fact, a physician. He talks to me regularly about the difficulties that he has in managing his business because he's also confronted even as being a physician, but the healthcare for he and his family. He's also concerned about those of his patients and clients who come to him. Those friends of ours are associates (inaudible) our neighbors. All of us

have a story associated with the healthcare situation we are currently confronted with.

You have the opportunity of challenging that -- establishing a new framework for us moving into the future -- one that will be more sustainable -- one that will be more competitive and one that will allow our citizens to grow and become healthier. We have to change not only the structure. We have to change our culture. I have to try to eat differently. (Inaudible) eat differently. That's going to be a part of it. But if you will, along the broader scope, there also has to be some fundamental changes and availability for what's available to the citizens of Connecticut. With SustiNet and House Bill 660, it gets us closer to and, if not totally to that point, continue to refine it. So that's what we'll be looking for from you. We need that leadership and we need it now. Thank you very much.

SENATOR HARRIS: Thank you, Mr. Wright. Any questions? Seeing none, thank you very much.

CORNELL WRIGHT: Thank you.

SENATOR HARRIS: Sharon Langer? On to Rebecca Vall.

REBECCA BALL: Good afternoon, Senator Harris, Representative Ritter and distinguished members of the Public Health Committee. My name is Rebecca Ball and this is my son, Zachary Ball. He is a victim of medical malpractice. We are

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here today to ask that you do not support Section 7 of the SustiNet (inaudible) Bill. In one paragraph, it removes the constitutional right that every citizen has to have access to our courts.

Ten years ago, my son Zack's life changed forever and so did mine. My son's neck was broken in a tragic head on collision. He was sent to three different hospitals in one day and discharged and sent home three days after the accident. We were told he'd make a full recovery. He would be that happy bouncing two year old again despite having to wear a halo on his head. But he wasn't responding. I knew my child and they didn't. I trusted the doctors as we all do so I thought I should wait as they told me to do. The real tragedy that still haunts me as a mother, is that all of the healthcare professionals missed the spinal cord injury that could have caused his death, but has left him paralyzed from the chest down.

They did not do a simple full MRI despite warning signs that should have warranted investigation into the initial diagnosis. Calls were made to doctors. Calls were not answered. A nurse called the doctor and her phone call was unanswered. A slow progression of a hematoma that had formed on his spinal cord, cut off his blood supply and oxygen to the cord. That, in turn, killed the nerves and caused his paralysis. Your son will most likely never walk again will

forever burn in my heart because I felt the loss of the child I knew.

No child should have endure what Zack has because of others' negligence. The thought of a lawsuit was very scary to me and became part of the nightmare. His medical debt rose to over $1 million in a nine year period of time. We finally settled out of court and that debt was repaid. That settlement has allowed us the handicap accessibility to our home. It improves the quality of his life and the entire life of my family. I worry every day about Zack but the financial strain and anxiety has mitigated. You should know that the minute anything is labeled handicapped, it comes with enormous price tags. Capping non-economic damages in Zack's case would have been disastrous. The court's are our only access to justice.

Your job needs to be improving your healthcare system to better protect patients from being victims. My job continues to be taking care and loving my son, Zack. A sign hangs above his bedroom door that I believe to be true. It's never too late to be what you might have been. This is the hope we all hang on to. His life has been improved because he was able sue and was compensated for others' errors. Capping damages is simply unjust and unfair. Voting against Section 7 of the proposed Bill 6600 will help preserve the right to those who follow my son. We need to keep in mind holding doctors accountable for their devastating mistakes is one

of the key components to bringing awareness to the flaws in the medical system. Only then does that force doctors and hospitals alike to review their protocols and the treatment to patients and make changes to prevent further medical malpractice. These doctors are committing crimes against others that many feel that this proposal should go ignored. They continue to get to practice medicine while my son will never walk again. Are you willing to turn the other cheek and deny others their right to justice? I believe you would feel otherwise if you or your loved ones are a victim of their negligent hands. Thank you.

SENATOR HARRIS: Thank you, Ms. Ball. Any questions? Ms. Ball, thank you and Zack, thanks for the courage for sharing your story.

REBECCA BALL: Thank you.

SENATOR HARRIS: Next, Susan Manganello followed by Bill Tyra and then Leslie Mills. Good afternoon. Sorry if I mispronounced your name.

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SUSAN MANGANELLO: That's okay (inaudible). Thank you. Senator Harris, Representative Ritter and distinguished members of the Public Health Committee. Thank you for letting me share my story.

My name is Susan Manganello. I am currently Vice President of the Board of Directors for the Connecticut Center for Patient Safety. My

daughter, Jennifer, died in 2005 and I testified many times on her behalf. So I'm not going to reiterate what exactly happened to her but just share from heart how I feel about the opposition in Section 7 of Bill 6600.

She feel victim irregardless of my medical background and just that throw me through a web of medical mishaps. Doctors and other healthcare providers, me being one of them, I feel that we need some accountability for our actions. When she was 15 she suffered from a spinal fusion, paralysis which through her into many mishaps and medical errors. And I feel that there has to be some sort of accountability and some sort of justice for what was done. You know, you heard from the last story, nine years, a million dollars, she spent four months in the ICU in her last year of her death which was roughly about five, six thousand dollars a day. Her medical bills were -- were in the millions. And thank God for us to have that ability to be able to have some sort of recourse for these actions.

The reason for her mishap was due to negligence and many multiple errors throughout the process. A simple MRI test would have stopped the entire process. So I feel that in this whole venue there needs to be some sort of accountability and, otherwise, we're just going to get thrown into a web of different medical mishaps and there's no accountability. And, you know, you can just continue treating and then no one has to answer for any medical mishaps or any kind of

errors and there has to be some sort of accountability. Thank you.

SENATOR HARRIS: Thank you very much. Any questions? I just -- I appreciate you, again, coming back (inaudible) persistence in sharing your story and the courage to do that. I just -- there was -- there's been some (inaudible) kind of comment about the intent of the authors of the Bill. And I just want to make sure that while we have to look at the Section and obviously weigh its effect and review and Ms. Ball raised valid issues. (Inaudible) the intent does not (inaudible) people get away with anything it's just to try to come up with a system where people get their care and the balance that against some of the costs of the system. But nothing's perfect and we need to work on that, so your testimony's helpful.

SUSAN MANGANELLO: Yes.

SENATOR HARRIS: Thank you. Next, Bill Tyra followed by Leslie Mills, Maggie Adair.

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BILL TYR: Good afternoon, Senator Harris, Representative Ritter and members of the Committee. I'd like to reinforce the previous two testimonies. My name is Bill Tyra. I'm a retired colonel in the United State Marine Corp and I live in Trumbull. I'm also a military returned pilot and I currently work with American Airlines. I'm the father of a 16 year old daughter who died in a hospital due to unreported

malpractice. What I uncovered relies indifference to an uninjured -- to an injured patient's needs and I now have very great concern about the system that is in place.

I'm here today to strongly object to Section 7(c) in the SustiNet Bill. This paragraph is taking away -- or may take away -- the only course of action that's available to a consumer -- patient -- who is harmed. It is deeply troubling that this Bill disregards the 18 month study done by the Health (inaudible) Authority and its recommendations. Hospitals and doctors are often ill prepared to investigate the quality of medical care and demand accountability in complex events. These problems are often systemic and are pervasive. What doctors and hospitals quietly ignore is that the underlying source of malpractice is indeed malpractice, not lawsuits. Studies on medical malpractice reach the same conclusion -- preventable medical deaths kill often more than a 100,000 thousand Americans each year. That is more deaths than the United States suffered in both the Vietnam and Korean Wars and that is just in one year.

What 7(c) says is just because a doctor is participating in a SustiNet program or plan, he or she may no longer be accountable to the patient. That is simply wrong. In one paragraph, individuals' access to the courts as so clearly written in our Constitution, may be denied. As now a practicing airline pilot, may I remind you that the number of individuals who die

each year from medical negligence and misdiagnosis are equal to a fully loaded 757 wide body jet crashing everyday, 365 days a year. You can take a calculator and you'll see what I'm talking about.

Medicine needs to do what aviation has done -- bring an outside and independently (inaudible) experts to analyze the problems and then make changes. Therefore, Section 7(c)'s intent to limit liability is not the kind of change needed to protect patients from negligent treatment and often unreported medical malpractice. Thank you.

SENATOR HARRIS: Thank you, sir. Good timing. You are definitely a military person. Right on the nose. Next, we have Lesley Mills followed by Maggie Adair.

LESLEY MILLS: Good afternoon, ladies and gentlemen. It's time for a little levity. My name is Lesley Mills. I'm the past President of the National Association of Women Businesses here in Connecticut. It's the largest women business owners organization in the country and past Vice-President of the New Haven Chamber of Commerce. I support SustiNet because I'm a member of the Small Businesses for Health Care Reform you heard about earlier. And because I own Griswold Special Home Care. I have by the way turned in all my testimony but it hasn't been (inaudible) yet, but will be available.

We have 500 employees who can float between elderly clients and other employers. One employer cannot provide health insurance coverage for them. To attract the best caregivers, we spend 73 percent of our fees on the caregiver as opposed to the industry standard of 50 percent. Our mission is a 1 percent cost (inaudible). So there is nowhere for health insurance premiums to go other than to be passed on to the elders receiving care. SustiNet can stand outside the traditional employer model.

I can offer some history that puts SustiNet in good company. In 1973, Yale professors and I began working on the Medicare hospital reimbursement project. Computer languages allowed the first online analysis of millions of patients' records by doctors. In 1974, we coined the phrase, "diagnosis related groups", DRGs. In '81, they went nationwide and have determined hospital reimbursement Medicare patients for over 28 years. There are similarities between DRGs and SustiNet. Both have overcome similar challenges in the complexity and scale of the problem. Both offer opportunities and quality of care beyond the presented problems of economy and fairness. (Inaudible) is SustiNet. The problem has been thoroughly defined. The Foundation has spent years coordinating research in every sphere that has a vested interest in healthcare. Employers of all sizes, industry types and (inaudible), employees and their dependants on payroll or independent contractors, if they're full time, part time or unemployed and the health

of the market players is also taken into account -- whether they were providers, insurers or sales people.

Second, the solution was not developed by a political committee but by advisors with deep working knowledge of the field -- Stan Dorn, J.D., of the Urban Institute, Jonathan Gruber, Ph.D., of MIT. The expertise that these men represents all the constitutions, payers, providers, patients.

Third, SustiNet becomes economically viable as other vital changes developed to the healthcare delivery system are developed. Just as the advent of DRGs drove improvements in medical records, so SustiNet requires the medical home for each person and this requires confidential patient data across providers and payers providing the rich opportunity to eliminate duplicate diagnostic tests and provide the opportunity for enhanced diagnosis. And this also allows us to use advancing technologies and data storage and manipulation.

DRGs offered many opportunities for analysis that resulted in better cost management and improvement of care. Just for example, the DRGs for heart attacks used to have a 21 day length of stay. But it was analyzed and found that 10 day or 30 day stays made no improvement in outcome. And not only that, that the hospitals that did more open heart surgeries actually had better outcomes. I look forward to the wealth of

systemic improvement that SustiNet can provide. I'm almost (inaudible).

SENATOR HARRIS: Thank you.

LESLEY MILLS: Finally, it makes economic and ethical sense that all people should be afforded healthcare and it makes sense that this care should be monitored from a medical home that does not change due to circumstances. The advent of DRGs extended the Medicare Trust Fund by 18 years. A national SustiNet model with its underlying economics can yield an equally successful outcome. DRGs were developed here first, at Yale, but tested in New Jersey. Let's be able to say 28 years from now that the national system was developed and tested in Connecticut. Thank you.

SENATOR HARRIS: Thank you, Ms. Mills. Any questions? I thank you for your levity and it's actually very appropriate because it's my father's birthday today. And last night I took a break from reading bills and my mother had a little birthday party for him. And I bought him a book for his birthday called "A Woman in Business", the Beatrice Fox Auerbach story and your hat reminds me of Fox's and you're a woman in business. And it's my father's birthday. So, happy birthday, Dad and thank you.

LESLEY MILLS: Wish him a happy birthday.

SENATOR HARRIS: Thank you very much. Next, Maggie Adair followed by Ren Ra-Sheen Brown.

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MAGGIE ADAIR: Good afternoon, Senator Harris, Representative Ritter and members of the Committee. My name is Maggie Adair. I'm the Policy Director at the Connecticut Association for Human Services.

Faced with a precipitous drop in state revenue and a budget deficit in the billions, policymakers must now make very difficult decisions. CAHS believes that Connecticut's policy leaders should take the long view on priority, preserving programs and policies that support children, families and the well being of the State. One of those largest priorities is fixing a broken healthcare system to ensure that all Connecticut residents have access to comprehensive, affordable, quality healthcare.

Healthcare reform is critical to the future of our economy. We cannot afford not to fix it. CAHS is testifying in support of the SustiNet Bill. Many of the bills that you've heard today address pieces of the healthcare puzzle. The SustiNet Plan detailed in this Bill is the most comprehensive Connecticut specific plan for universal healthcare ever presented to the Legislature. SustiNet is a product of the best thinking of experts and the combined ideas of many stakeholders. We applaud the Universal Health Care Foundation of Connecticut for its leadership, tenacity and vision in producing this

plan. Connecticut must not shrink from this challenge and this great opportunity.

Some have raised questions about the cost. Experts estimate the implementation of SustiNet by 2014 will cost the State $950 million. We cannot afford not to invest $950 million in healthcare reform. Why? With SustiNet fully in place by 2014, 98 percent of Connecticut residents will have access to quality, affordable, comprehensible healthcare coverage. No one will ever have to worry about losing health insurance regardless of the status of their employment. Medicaid and HUSKY reimbursements will rise to commercial levels which means more doctors will participate in the program. And finally, more low income people will have real access to good care.

As a result of expanding Medicaid and HUSKY, Connecticut will receive an extra $800 million in federal matching funds. That's $800 million pumped into the local economy. One Bill before you today, Senate Bill 988, An Act Concerning Medicaid Funding For SAGA and Charter Oak, will bring in some of that $800 million in federal matching funds. By moving the SAGA program under Medicaid, SAGA clients are the very poorest of our poor, will finally have greater access to care and receive more comprehensive health services. And finally, its estimating that employers and residents will save $1.7 billion in healthcare costs. I call that a deal.

Just days ago, President Obama shared with a nation his commitment to reforming healthcare in America. His plan to build up a $634 billion reserve fund for healthcare reform provides an opportunity here in Connecticut. We have an opportunity to provide the roadmap through SustiNet that can guide healthcare reform efforts at the national level. Connecticut has a great opportunity and it's critical that we do not pass it by. We cannot afford not to do this. Our people and our economy depend on it. SustiNet is smart. It's right. And it's time. Thank you for giving me the opportunity to testify.

SENATOR HARRIS: Thank you. Thank you, Maggie. Any questions? Chairman Ritter.

REP. RITTER: Thank you. Thank you, Maggie, for your testimony. And you were talking about the estimated cost in the year 2014. In this process of discussing the plan, we've had discussions around about cost and, of course, as sadly we must occasionally do and I wanted, seeking some clarity for the Committees about that. The $950 million cost cited in the plan for year 2014, is that net of federal reimbursements or is that before we receive federal reimbursement?

MAGGIE ADAIR: That is net. The 800 -- it's -- it's a true $950 million cost. We're bringing in $800 million, but it's a true $950 million cost. But when you look at the, you know, lost productivity, how the healthcare system is a drag on our economy, this is a good investment. And

it's an investment we can't -- we can't afford not to take.

REP. RITTER: Well, I wasn't -- I wasn't prepared to go there. I was just seeking clarity because I might submit and we have asked repeatedly actually for several weeks now for some more discussion around that cost. Because I believe that that cost -- that implementing the plan also removes certain other costs that we are used to paying in the system. And so my next question is -- is it net. Do you know is that net, net, net? Or, you know --

MAGGIE ADAIR: That I do not know. And I'm sure other people who have been working on the SustiNet Plan can get that information. We can get that to you.

REP. RITTER: That would be particularly helpful. I might augment my request by suggesting that a detail of those numbers in each of the fiscal years contemplated up to and including, I think, say maybe around through 15. You probably heard this morning when the Secretary of OPM was here and he cautioned us about the exuberance of spending money in future years that are beyond the immediate budget woes that we are facing. And so I think it's important that we all understand exactly the components of that cost. So I'd appreciate it.

MAGGIE ADAIR: Absolutely. And SustiNet -- this is a blueprint. And, you know, we have to take this

very seriously. It's been moved to the legislative session. I'm understanding that it's going to be incredibly important for all stakeholders to get to the table and be looking through this, taking a look at the cost. But I think we also have to take a look at all of the costs that we are incurring by having a broken healthcare system.

REP. RITTER: And I think we are hearing very compelling testimony about those costs. No question about it. But thank you very much.

MAGGIE ADAIR: Thank you.

REP. RITTER: And we'll look forward to more information.

MAGGIE ADAIR: Thank you very much.

SENATOR HARRIS: Any further questions? Maggie just so people can put that $950 million into context. It's my understanding, and correct me if I'm wrong, that currently, and this was a figure that was thrown out a year or two ago so it can even be more now, but in the State of Connecticut total spending on healthcare is about 21 to $22 billion dollars?

MAGGIE ADAIR: Yes. That's -- that's in the whole -- not by the State of Connecticut --

SENATOR HARRIS: Right, the whole state --

MAGGIE ADAIR: That's the whole cost to the State and the private market sector.

SENATOR HARRIS: Right.

MAGGIE ADAIR: Yes.

SENATOR HARRIS: And that's not including some of the other ripple effects, I believe, from a healthcare system that doesn't work.

MAGGIE ADAIR: Right. That's not taking into account people who are -- lose their job. They go -- they lose their houses because they go, you know, they lose their house because of healthcare costs. It's not about loss productivity to employers. All those costs are not factored in.

SENATOR HARRIS: I had just wanted to do that because, support or not support SustiNet, when you throw out numbers like $950 million, people listening might be thinking, oh my God. How can they do this? But, in the context of, you know, 20 plus billion dollars in spending and it's not working, that's -- that's what -- the way people at least have to think about it when judging the costs.

MAGGIE ADAIR: And -- and when you look at -- you have to look at the cost of like the reimbursement rates for doctors under Medicaid and HUSKY, they're so low that many of the doctors are not participating. So people who are on these programs, they can't get access to doctors so they get sicker and sicker and they end up in the

emergency room. So we're talking about, you know, much more expensive care. SustiNet, I mean, I didn't go into the specifics about medical home and e-health technology and evidence based medicine which is all about lowering costs and really thinking much, much smarter about healthcare delivery.

SENATOR HARRIS: Thank you very much. Thanks Maggie.

MAGGIE ADAIR: Thank you.

SENATOR HARRIS: Next, Ren Ra-Sheen Brown followed by Melissa Karvelis and Kathleen Nastri. Good afternoon.

REVERAND RA-SHEEN BROWN: Good afternoon. How are you all doing today?

SENATOR HARRIS: Good.

REVERAND RA-SHEEN BROWN: I just wanted to thank you all for giving me the opportunity to speak in front of you wonderful people today. It's my first time. So, a little shaky, but very confident. Amen. My name is Reverend Ra-Sheen Brown. I'm from New Britain, Connecticut where I'm the Senior Pastor of Right Now Ministries. And Right Now Ministries is a very intriguing place because it's a ministry that really helps a lot of young people basically between the ages of 16 to 25. And one of the scariest things for me and while I'm here today on behalf of SustiNet, is that I have a lot of young kids who are in

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school, who's working at the same time, who may not be under their mothers' or their parents' care because their mother or father may be incarcerated or addicted to drugs or just not around. And at the same time, they're suffering because they don't have the proper care for their medical situations.

One of the things that I've noticed is that I have a young man inside the church. And one day I caught him using an asthma pump. And I said, oh, I didn't know you had asthma. I never seen you use an asthma pump before. And he said to me, he said, well, Pastor, to be honest with you, I can't afford the medication, nor can I really afford to go to the doctor and I don't have the proper insurance that I may be able to go. And he was using someone else's pump because he couldn't breathe. Now, I'm 280 pounds and walking up the stairs sometime for me, is sometime tough and I could imagine what it is for a 22 year old man, young, very well in shape, but still not being able to breathe on a regular basis. I don't know about you, but seems scary to me.

I have a young lady who is in school and is working two jobs, but still cannot afford healthcare and, yet, she's afraid to go to the emergency room because of the cost that it's going to cost her, but yet she's had -- she has blood coming out of her bowels. But she's more concerned about the price that it's going to cost her to go to the hospital than -- than really

worry about her healthcare. Because some people credit is already messed up because they can't even afford to pay the bills that they've already accumulated.

I don't have a whole to say on the policies, but I do have to say that if we look at it on a broad scope, something is wrong, somewhere. Something is broke somewhere. And we as a people have to come together and fix it and I'm looking at a great State. So therefore I know that our leaders inside this State are great and I know that your minds are great. And I know that we can come together and everything I've heard about this has been great. So I'm going to ask you at the sign of that bell, to really think very positively on -- on passing this Bill so that we cannot just help everybody but help our future with these young people and their health. Thank you. Any questions (inaudible).

SENATOR HARRIS: Thank you, Reverend. First of all, I apologize here that you're -- you're -- the first v little tail looks like the first n so --

REVERAND RA-SHEEN BROWN: That's okay.

SENATOR HARRIS: I apologize. Any questions? I think your message is clear.

REVERAND RA-SHEEN BROWN: Thank you.

SENATOR HARRIS: Oh, Jim, Representative O'Brien.

REP. O'BRIEN: Sorry, over on the end. I mean how would you react to, and you may already now this, but knowing that the -- that as a country we spend more per capita on healthcare than any other country anywhere. And yet many of the things that you've described there -- the injustice of people being denied access to the care that they need still goes on. Even counting the fact that we spend that much on healthcare. What would be your reaction to that?

REVERAND RA-SHEEN BROWN: Once again, that would show me that something's wrong -- something's very scary. For instance, just to -- just to take point for an example. We spend so much money on -- on medical issues. We spend money on people who are addicted to drugs to go into these programs. But I just tried to get somebody into a program the other day and they told me that they -- they're insurance wasn't right. But yet this person has been on a drug run for two weeks. It finally got to a point that where they said, Pastor, listen, man I need help. Can you help me. And when we tried to help, there wasn't even a bed available because their insurance wouldn't cover it. So now they're going to go back to the streets and not only are we going to have a problem health wise, but now, they're going to go back to the streets, get strung out on drugs even more and then start robbing people and now, we got to worry about housing them inside our prisons, therefore, costing us more money.

REP. O'BRIEN: So it's penny wise and pound foolish. Or maybe not even penny wise --

REVERAND RA-SHEEN BROWN: Just pound foolish.

REP. O'BRIEN: Just pound foolish.

REVERAND RA-SHEEN BROWN: Thank you.

SENATOR HARRIS: Thank you.

REVERAND RA-SHEEN BROWN: Thank you.

SENATOR HARRIS: Thank you, Reverend. Next, Melissa Karvelis followed by Kathleen Nastri and then Mary Jane Lundgren.

MELISSA KARVELIS: Hello. My name is Melissa Karvelis and I'm here to speak on House Bill 6600 and I'm also a member of Connecticut Parent Power.

I'm the mother of four children and I've had the range of insurance situations. I firmly believe that every resident in the State of Connecticut should have quality, affordable healthcare. As far back as I can remember, we have always been considered the insurance capital of the world. SustiNet can be a model to other states and to the federal government as a universal healthcare policy that can and will work. SustiNet provides a piece of mind for its clients that until now has not been available. This policy aims to keep us healthy and get us restored to health when we are sick.

Until May of 2008, I had employee sponsored healthcare through my husband's job. He lost his job and our benefits ended. While on our insurance, our monthly -- our share of the monthly coverage was almost $400 per month and what it provided was minimal at best. We had a co-pay of $25 per visit. With four children, that meant a $100 a pop when somebody got sick because strep throat lacks to pass between them all. We had a deductible of $900 for the first person and then an additional $900 for the combination of the rest of the family. And an 80/20 split for any covered hospital stay -- makes for very expensive hospital stays. This made for tough decisions when the coverage was needed. There were more instances than I can count where I had to figure out how to purchase a necessary prescription and still buy food to feed the family for the next day.

When my husband lost his job, I had no idea what we were going to do. I had always known about the HUSKY program, but never thought I would need it. Boy, was I glad it was there. So I have learned that navigating the HUSKY system is not as easy as it should be and there are not nearly as many providers as I thought there might be to serve the clientele. With all of the recent HUSKY changes, finding a doctor has been even more difficult and the member handbooks and websites don't always match making it still more confusing and stressful.

Thankfully for the time I've been on HUSKY, I have not needed to use it all that much, but that doesn't make me any less thankful to have it. The present changes being proposed to HUSKY scare me as they will make it even more difficult to receive care.

Finding out about SustiNet and what it will do for Connecticut residents has given me a glimmer of hope. But I depend on you, our Legislators, to make the right decision. Right now, there's a very skewed healthcare system. It is tiered and that is not fair to anyone. There is no reason in a state that consistently ranks in the top three wealthiest in this country, that we should have residents who do not know how or where they will be able to obtain the healthcare that they will need. In my mind, access to quality, affordable healthcare should be a right, not a privilege. We should all be able to obtain the healthcare necessary to maintain our health.

Keeping Connecticut residents healthy is far cheaper than letting them get sick especially when we cannot or do not feel able to obtain services until we wind up in the emergency room.

I hope that you, my Legislators, will the importance of this legislation to all the residents of this fine State. I pray that you will follow your conscious in this and remember that we are all entitled to quality, affordable healthcare. Please give us that piece of mind. Thank you for your time.

SENATOR HARRIS: Thank you, Miss Kavelis. Any questions? Would you like to introduce us to your co-pilot?

MELISSA KARVELIS: This is the middle of my children, Jacob.

SENATOR HARRIS: Hey Jacob. How you doing? Thanks -- thanks for coming out.

MELISSA KARVELIS: Thank you.

SENATOR HARRIS: You have a good mom. Next, Kathleen Nastri followed by Mary Jane Lundgren and then Brian Ellsworth. Ms. Nastri is not here. Is Mary Jane here? Okay. Brian Ellsworth? He was. There he is. Followed by Steve Karp?

BRIAN ELLSWORTH: Good afternoon, Cochairs and members of the Committees. My name is Brian Ellsworth. I am President and CEO of the Connecticut Association for Homecare and Hospice whose members serve over 100,000 elderly, disabled and terminally ill Connecticut citizens. The Association is pleased to provide comments on HB 6600 which proposes to establish the SustiNet Plan. The Association commends the authors of this proposal for their thoughtful approach to the vexing issue of providing a comprehensive and cost effective health insurance option. The Association will briefly highlight several issues raised by the proposal.

First, we are very pleased to see that the minimum standard benefits package includes home health and hospice services. These are important cornerstones of any health insurance plan. Both have been repeatedly found to be cost effective and are strongly desired by the general public. Section 6 of the Bill introduces the concept of a medical home with priority implementation for those enrollees that are chronically ill. The medical homes will focus on assisting chronically ill enrollees with self-management, provide care coordination across settings and be accessible on a 24 hour basis. These concepts are not new for home care and hospice providers. In fact, we have been providing a medical home for patients in their own homes for many years. The Association strongly encourages the General Assembly to ensure that there is a central role for home health agencies in any health insurance reform approach that adopts a medical home model.

Section 5 of the Bill discusses interoperable health information technology and Section 8 focuses on prevention. The Association is hopeful that a properly structured health reform plan would motivate the widespread adoption of home based telemonitors for chronically ill persons and increase rates of immunization of enrollees. Home health agencies have been successful in applying these prevention strategies to Medicare patients, but we have encountered roadblocks in the form of coverage limitations when attempting to do so for Medicaid patients.

Finally, we are pleased to learn that the SustiNet Plan intends to bring provider rates up to quote market levels. Commercial insurers and the Medicaid program are both notoriously low payors for home healthcare necessitating that such care be subsidized from other sources primarily the Medicare program. The penny wise, pound foolish practice of inadequate reimbursement by insurers and the State results in missed opportunities for even bigger savings and enhancements to enrollees' quality of life. It should be ended in any comprehensive health reform plan.

CAHCH appreciates the opportunity to provide these brief comments to the General Assembly as it embarks on the process of reforming the healthcare system. We are ready to provide assistance and further detailed comments as the process unfolds. Thank you. And I've not been in the military.

SENATOR HARRIS: But you -- you might have been here once or twice before though.

BRIAN ELLSWORTH: Once or twice.

SENATOR HARRIS: You look familiar. Thank you. Any questions for Brian? Thank you very much.

BRIAN ELLSWORTH: Thank you.

SENATOR HARRIS: Next, Steve Karp followed by Sarah Guggino and then Marybeth McNamara.

STEPHEN KARP: Good afternoon. I'm Stephen Karp. I'm Executive Director for National Association of Social Workers Connecticut Chapter. We support SustiNet on three levels -- a policy because of what it does for small businesses and how it would help our members. HB 6600

Over the years, the Legislature has struggled to address ways to cover the uninsured, provide access to care, assure quality healthcare, make healthcare affordable, have healthcare coverage that's comprehension, expand preventative care, offer portability of benefits and eliminate disparities in healthcare. Until now, attempts to achieve these goals, while commendable, have come through incremental steps that only address a piece of the healthcare system. It is finally time to admit that incrementalism and tinkering around the edges has failed.

The healthcare system in Connecticut, or if we want to call it a system in Connecticut, remains fragmented with high numbers of uninsured, untold numbers of underinsured. SustiNet is the most comprehensive proposal we have seen to date that addresses issues of affordability, access, universality, quality, comprehensive coverage and racial and economic disparities.

As far as small businesses go, I represent a small nonprofit. This year we had a 42 percent

increase in our health premium because one employee went into a new age bracket. In order to deal with that, we changed our policy so we now have a -- we quadrupled the cost for hospitalization. So we now only had a 25 percent increase in our healthcare premium. What this really has meant for us is -- it has kept our salaries down. In fact, I have a couple of employees who have opted out. If all my employees opt into my healthcare plan, I would have one less employee most likely because I wouldn't be able to afford it. It means that we can't expand programs. Clearly, healthcare costs are clobbering small businesses and nonprofits like NASW and we do walk the talk. We talk about comprehensive coverage. We offer comprehensive coverage. We offer 85 percent of the cost of premiums -- is paid by -- by NASW for -- for our employees.

Finally, on the third reason we talk in favor of this is for our members. Many of our members are independent practitioners. Some of them are able to get coverage through spouses. Others are unable to do that which means they're probably going into the individual market -- a marketplace where if you have a -- a pre-existing condition, you can't get coverage, a marketplace where limited coverage is available and a marketplace where it's extremely expensive particularly considering I represent social workers who are not exactly making huge salaries to start with.

I just wanted very quickly -- just one quick story about one of my members in Fairfield County. She used to out and visit elderly -- homebound elderly -- very hard to find a clinician who actually goes out and does therapy in people's homes. She's able to that because her husband was covering her. Her husband retired. He went on to Medicare. She had to close down her business because it cost so much money for her to be able to get healthcare insurance. So she had to go work for an agency. She was actually -- according to her -- she was the only person in lower Fairfield County that was providing that nature of service, clinical social work services in someone's home.

So clearly, we need a system that is comprehensive. We need a system that's going to make big changes. SustiNet is the only proposal we've seen to date that really addresses so many different levels and it really does address healthcare as a system, not just healthcare as insurance. So we encourage you to pass it. Thank you.

SENATOR HARRIS: Thank you, Steve. Any questions? Thank you very much. Sarah Guggino, Marybeth McNamara followed by Beverly Brakeman.

SARAH GUGGINO: First of all, thank you on the correct pronunciation of my name. That's almost impossible for 90 percent of people.

SENATOR HARRIS: I have to give credit to Chairman Fontana.

SARAH GUGGINO: The Italian. Honorable Senators and Representatives, my name is Sarah Guggino. I am a graduate student at the University of Connecticut working towards a Masters in Public Administration and Policy. I am here to testify on Bill 6600. I very strongly support the SustiNet Bill and I urge you to also support it. It is crucial for you, for me and for everyone in Connecticut.

I grew up in a family that had very poor and unreliable health insurance. My father was, and still is, a business owner -- a small business owner -- with a serious medical condition. My younger sister was diagnosed with cancer at two years old. Because of the financial impact of our medical bills coupled with extremely high costs and a large inaccessibility to an insurance company that would cover us, my parents struggled -- struggled to provide for us. Growing up, there were years when things were so bad that I found it difficult to sleep at night. I was constantly worrying about what would happen to my father and my family or my sister if -- if he or my sister were to get sick again. My parents bickered incessantly and each fight stemmed from the same issue -- financial distress due to poor and costly healthcare.

Worries like this can have a profound effect on the happiness of -- and healthiness of anyone,

young or old. Children are not blind to their parents' struggles and as a ten year old, I was altogether too aware of the harsh realities of our lives more than any ten year ever should be.

This May I will graduate from UCONN. I am extremely fortunate right now to have good health insurance for the first time in years through my position as a graduate assistant. I should be excited about what comes next in my life. However, with the job market in disarray and the economy a disaster, I am desperately worried about using my -- losing my health insurance. Unfortunately, this is a very harsh reality for many young adults in Connecticut. Young people are already leaving the State at an alarming rate further damaging Connecticut's tax revenue.

So give me and my generation a reason to stay in Connecticut. Make us feel safe and secure enough to take that first job. SustiNet can be the reason for us to choose Connecticut. It will give us piece of mind by providing quality, affordable healthcare even if we're in between jobs or more importantly, between school and a job. Now I understand your concerns. My education has trained me to think about the costs and benefits associated with policymaking. This is tough and Connecticut's budget is in terrible shape. But SustiNet is sustainable and will lead to cost savings in the long run.

Yes, I am young and healthy. But I also recently learned that I have a health condition that needs

to be monitored. Had I not had insurance, I would have never known this. And if I don't have coverage after graduation, and I can't pay for regular checkups, I could face very serious health repercussions in my future. I would risk indebting both myself and my family beyond our ability to pay and I might end up further indebting the hospital and medical offices that help me. This is important and this is an important aspect of the preventative care concept found in the SustiNet bill.

My point is this. I'm almost done. The healthcare crisis is only going to worsen unless significant action is taken now. SustiNet is the best, and you've heard this, most complete piece of healthcare reform legislation these Committees or the State of Connecticut will see this year. We can be at the national forefront of innovation in healthcare. We need to break away from the short sidedness that has taken us to this point and this mess in the first place.

Please think for a moment, all of you, what you would do if you were to lose your next election. Would -- how -- how difficult or how would difficult would it be for you to find health insurance for you and your family? Think about your children and all the children of Connecticut. We're talking about saving lives. SusiNet is smart. It's right and we need it now.

I graciously thank you for your time and would be happy to answer any questions.

SENATOR HARRIS: Thank you, Sarah. Any questions? Good luck to you -- appreciate it. Marybeth McNamara followed by Bev Brakeman and then Phil Sherwood.

MARYBETH MCNAMARA: Good afternoon, my name is Marybeth McNamara and I'm a graduate student at UCONN as well in the School of Social Work. I'm here to testify on Bill 6600 and I'm in favor of this Bill and strongly encourage you to support it.

I'm very lucky to sit before you today because it was access to quality, affordable healthcare that held my family together and saved my life. Eight years ago, I became very ill and was admitted to the hospital. Fourteen days into my hospital stay, I was diagnosed with Crohn's Disease. For those of you who are unfamiliar with Crohn's Disease, it's a chronic condition but there is no cure for yet. I spent 29 days in the hospital. I was discharged home on more than 30 pills per day for three months following my diagnosis. Thankfully, I was still covered under my parents' health insurance plan.

Now that I'm old enough to support myself, my biggest worry is about losing health coverage. I know what it means to have a pre-existing condition. I can never have my health insurance lapse, not even for one day, for fear of never finding health insurance again. Sometimes I feel like I'm being held hostage by the current

system. Thankfully, I am no longer paying the $500 a month for my COBRA payments because I became eligible for coverage through my part-time job at a local grocery store. My number one worry is that, after I after I graduate from UCONN, I will not have access to quality, affordable healthcare.

I still consider myself very lucky. My disease has been in remission for two years. I'm able to work hard and complete graduate school. However, I never lose sight of how quickly life can change. We're all vulnerable to this issue. It's an absolute shame that there are people in this country who are losing their homes due to this issue. People's lives hang in the balance as we speak about this today. The people in this State do not deserve to worry about losing their homes while they battle illness. SustiNet would offer all Connecticut residents the peace of mind that they deserve. We can't be making excuses. We can't keep telling people that they have to wait because, in many cases, waiting means getting sicker. The economic turmoil and poor job market only magnify the issue and reinforce the need for SustiNet.

There are people in every town in this State who are looking to you for serious leadership on this issue. The nation is watching and let's let Connecticut lead the way the healthcare reform with SustiNet.

Thank you for your time and for what you've done so far on this issue and I welcome any questions.

SENATOR HARRIS: Thank you, Marybeth. Any questions? Representative Cook.

REP. COOK: Don't go away yet. How old are you?

MARYBETH MCNAMARA: 21.

REP. COOK: I'm sorry, you're never supposed to ask a woman how old they are. I, too, have Chrone's Disease.

SENATOR HARRIS: Or a man.

REP. COOK: Well, you know, okay. I want to thank you for coming out. And that's -- Chrone's Disease is a relatively new and (inaudible)up and coming disease of which as you say, there is no cure for.

MARYBETH MCNAMARA: Right.

REP. COOK: And we do run the risk of never having health insurance again. So I say to you keep fighting the fight because it's very important for the generations as the young lady that spoke before you, to make sure that the generations of where you are and to come, are well taken care of and thank you very much. And for you, too. Thanks.

SENATOR HARRIS: Thank you. Bev Brakeman. Phil Sherwood.

BEVERLY BRAKEMAN: Good afternoon, Senator Harris, Representative Ritter and members of the three Committees. My name is Beverly Brakeman. I'm here on behalf of the United Auto Workers Region 9A, our director, Robert Madore, to urge you to pass House Bill 6600. There's not a whole lot more I can say that doesn't indicate the need for a SustiNet plan that that last two speakers haven't said already. But I have a couple thing I'd like to add.

There are several components of this proposal before you today that are particularly exciting to the UAW. Pooling our large numbers of people for healthcare is very important. Using the State employee plan as a pool to be grown in membership by those in Medicaid and SAGA ensures that costs can be kept down, risk can be spread and healthcare can be provided to more people. The medical home is a very important model that I find particularly exciting -- the care coordination, the 24 hour consultant services and the patient education. The electronic medical records also, I think, are extremely important. I have a brother who has a chronic illness that has been ongoing for probably over ten years. And when I think about the times I spent in the emergency room with him having to tell nurses six and seven times in a four hour period his medical history, I can only think that something like electronic medical records would make a

difference. And the medical home, too, I can't tell you how many things he's had to do on his own to figure out how to get through. In his case, it wasn't Chrone's. It was ulcer diverticulitis. He had to have his colon removed and the patient education, the consultive services, the care coordination -- he'd be a much healthier young man today if he had some of that.

The minimum benefits that are in this I think are very comprehensive. The fact that it addresses not only people who have insurance but the uninsured -- the accountability built in and the fact that we're not going to deny anyone based on their immigration status are very important parts of this plan.

This is a big plan designed to address a really big problem. Despite the economic times, this is not the time for incrementalism and microcosmic thinking. It is a time to act now and act big and rather than be daunted by the challenges of this plan's implementation, tap into your collective creativity to figure out how to get this done. Thank you.

SENATOR HARRIS: Thanks, Beverly. Any questions? Thank you very much. Phil Sherwood followed by Samuel Aygei, Jon Green and then City Council, Luis Cotto.

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PHIL SHERWOOD: Good evening. My name is Phil Sherwood. I'm the Deputy Director of the Connecticut Citizen Action Group. Thank you for

the opportunity to express our support for House Bill 6600. CCAG has approximately 25,000 members in its organization.

We all know -- we've heard some pretty heartening personal stories -- that it's getting tougher to get good, affordable healthcare no matter how hard we work. We can make all the right decisions for ourselves and our families -- even be a little bit lucky and still at the end of the day, have no guaranty that we're going to have quality healthcare.

Skyrocketing healthcare costs, as we're discovering now, is crippling state budgets and local budgets. It's stalling job growth and making it more difficult for families to get by. Never has the length between our broken healthcare system and the current state of our economy been more clear. Health insurance and premiums in Connecticut have been increasing more than eight times faster than wages -- not sustainable to say the least. And every 30 seconds, someone else in the United States declares bankruptcy due in part to medical costs.

The problem, we believe, is that too many individuals have been left at the mercy of private insurance companies with no option. SustiNet offers comprehensive reform that includes the choice of public health insurance plan so we're no longer left at the mercy of private industry. SustiNet is more than another name for a healthcare reform bill. It

establishes a clear set of principles that define quality, affordable healthcare. It recognizes that a critical component of healthcare reform is having the choice of a public health insurance plan that guarantees families the peace of mind and the guaranty that it's going to be there when you need it.

When I think of SustiNet, I, you know, looking at the details and the personal stories, I think of my two parents who have done everything right. Both of them have worked two jobs for the majority of their life -- put three sons through college. They paid their dues several times over I would argue. The only reason they're still in the workforce -- they could retire now -- the only reason they remain in the workforce is to maintain healthcare benefits. Only reason. My father could have been retired five years ago except they wanted -- they need the healthcare. It's unfortunate that many families are in this situation.

Rather than -- and there are some who believe that government should have no role in guaranteeing that individuals have quality access to healthcare. The SustiNet -- SustiNet Plan, again, understands the need for individuals to have that choice. Private insurance companies have continued to fail consumers. There needs to be another choice. This plan is it. Private insurance companies currently have little incentive to control healthcare premiums and deductibles reaping huge profits while working

families struggle to pay their bills. A choice of a public health insurance plan, such as SustiNet, that competes directly with private insurers will help control healthcare costs for Connecticut's families. Thank you for your time.

SENATOR HARRIS: Thank you, Phil. Any questions. Thank you, seeing none. On to Samuel Aygei, if you could help me with that pronunciation. Chairman Fontana is not here for this one. Jon Green and Luis Cotto.

SAMUEL AYGEI: Just for the record, I want to say you did very well.

SENATOR HARRIS: Thank you.

SAMUEL AYGEI: Yeah. The pronunciation is Aygei.

SENATOR HARRIS: Well, then Chairman Ritter would have been right this time. Thank you. Samuel, how about that.

SAMUEL AYGEI: Thank you.

SENATOR HARRIS: Welcome.

SAMUEL AYGEI: Senator Harris, honorable members of the Committee, (inaudible Chairs), follow concerned residents of Connecticut. Good afternoon. My name is Samuel Aygei. I'm a student of University of Connecticut of Social Work. I'm very honored for the opportunity given to me to testify in support of House Bill Number

6600, An Act Concerning the Establishing of the SustiNet Plan.

This plan seeks to guaranty all Connecticut residents access to their choice of high quality health coverage and healthcare. It also seeks to end worries about losing access to healthcare during major life transitions like changing jobs, finishing school or starting a new business, as well eliminate the racial and ethnic disparities in healthcare coverage.

Lack in health insurance has serious consequences. It is associated with increased severity of illnesses, increased cost of healthcare, reduced worker productivity and for children, lower educational attainment. The private and public cost that result from increased number of uninsured residents in Connecticut makes it essentially imperative to support SustiNet Plan for universal, affordable and sustainable healthcare for all residents of Connecticut.

According to research by Connecticut Health Policy Project, one in 11 Connecticut residents lack health coverage risking long term damage to their health and economic well-being. The uninsured often pay the highest prices for their care, full retail prices, not the discounted prices that HMOs and government pay. Two out of three uninsured adults are workers and this in effect leads to the lower worker productivity.

A SustiNet Plan is an opportunity for Connecticut to bring cost under control, to stimulate our State economy and serve as a model for the country. It is a system of continuous, coordinated and efficient service that will make the right amount of healthcare available to all at the right time. Furthermore, House Bill 6600 is compatible with the national reform plans which places our State at the forefront of states addressing healthcare issues and makes Connecticut a leader in America's quest for universal healthcare.

In conclusion, I would like to remind honorable Senators and Representatives that access to quality healthcare for all is a giant step toward eliminating racial and ethnic health disparities. So I urge you all to support the SustiNet Plan. Please, Senators, do no harm by unanimously passing this SustiNet Plan for the State of Connecticut. Once again, I thank you and now (inaudible) any questions.

SENATOR HARRIS: Thank you, Samuel. Any questions? Thank you very much. Jon Green, Councilor Cotto, Suzanne Haviland and then Dr. Bill Handelman.

JON GREEN: Hi, Senator Harris, Representative Ritter, members of the Committee. Thanks for hearing my testimony. My name is Jon Green. I'm the director of Connecticut Working Families. We're a coalition of labor unions, community organizations and concerned citizens that support economic justice policies like living wage jobs

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and universal healthcare. We support HB 6600, the SustiNet Plan, because we believe that this legislation has the potential to dramatically reduce costs and improve access to healthcare for working people. I should add as that as a small non-profit employer, we'd be interested in -- in seeing the potential cost savings that a public healthcare option could provide for our own organization.

Let me just say I think there's a temptation to view the healthcare problem, you know, by focusing on those that lack insurance altogether, the 300,000 or so that have no access to insurance and to look at this in a piecemeal way, if you could just find the product that meets that niche, then we'll all, you know, the whole thing will be fine. But just as serious, if not more so, is the problem of skyrocketing -- skyrocketing costs for those of us who do have insurance. Premiums for employers from employer sponsored insurance just in the last year increased by 5 percent, twice the rate of inflation. For firms with fewer than 24 employees like ours does, that increase was closer to 7 percent. Employees are chipping in at a much larger share of that contributing nearly $3,400 towards employer based health insurance in 2008 which is an increase of 12 percent from just one year ago. And the average employee cost for insurance premiums has grown 120 percent over the last decade while wages have risen by only 29 percent. Clearly that is not

sustainable and we wonder why so many families are up to their eyeballs in debt.

I think it's also clear that whatever steps have been taken to address this issue so far at the federal level or the state level have just not been sufficient. HB 6600 establishing the SustiNet Plan is a bold but reasonable policy for small businesses and low wage workers. Particularly, I believe that this legislation would establish a plan that offers quality benefits at a lower cost and at a lower cost for the entire State. I think there's little doubt that SustiNet offers the most comprehensive solution for our healthcare system. The only question is whether or not we as a State and our leaders in this building are ready to act. And I think that we are and I think that you are.

Of course, there'll be those you continue to say that our approach to this problem should only be incremental and narrowly targeted. But too often that amounts to merely throwing more money at a broken system. And, instead, I would urge you to summon the courage to make bold, decisive and meaningful change and support the SustiNet Plan. No military experience. Thank you.

SENATOR HARRIS: Community organizers count, too.

JON GREEN: We're notorious unprompt actually, but thanks.

SENATOR HARRIS: Okay.

JON GREEN: Thank you. Any questions?

SENATOR HARRIS: Any questions?

JON GREEN: Thanks.

SENATOR HARRIS: Thank you very much. Councilor followed by Suzanne Haviland and then Dr. Bill Handelman and for a returning appearance for this encore, Matt Katz.

LUIS COTTO: Good afternoon, Senator Harris, Representative Ritter and the members of these Committees. My name is Luis (inaudible) Cotto. I'm a live long resident of Hartford and currently a member of the Hartford City Council. Until December of 2007, I was also the co-owner of a family owned coffeehouse and bookstore just a few blocks away from here. In addition, my background for the previous 15 years has been working in nonprofit arts organizations such as Charter Oak Cultural Center, Real Art Ways and the Bushnell. My experience in each of these three arenas, a municipal elected official, a small business owner and a nonprofit employee have compelled me to come here to support House Bill 6600.

In each area, I personally witnessed and experienced how the cost healthcare is a major hurdle for employers, employees and taxpayers. As an employee working in the nonprofit sector, healthcare was usually but not always an option.

However, (inaudible) afford the cost of premiums for employees like me was simply more than I can afford. Like many people, I declined the insurance for this reason. In June of 2004, my sisters and I opened La Paloma Sabanera Coffeehouse and Bookstore. Legislators and legislative staffers frequented our store and I hope many of you still support this establishment.

As co-owner with a staff that fluctuated between a low of four people and a high of five people, we knew that offering healthcare was simply not a possibility. Even as the owners who never got healthcare for ourselves. In my first year of a four year term on the City Council, I've quickly learned that healthcare costs are a major challenge facing municipal employees, retirees and taxpayers. In the spring of 2008, the City of Hartford found itself facing a significant fiscal crisis. In an effort to reduce municipal costs, hundreds of municipal retirees were asked to pay substantially higher premiums out of pocket for their health insurance -- in some cases as much as 200 percent increases.

I say this to (inaudible) my support for House Bill 6600. The SustiNet Plan is the most comprehensive plan you will see all year. I realize Connecticut and really the whole nation is facing an economic downturn and during these challenging times, it may feel difficult to embrace a proposal so sweeping and so ambitious as this one. But I think if anything, we should

push for the most ambitious and most comprehensive solution available.

I encourage you to be bold. I urge you to support House Bill 6600. Thank you very much.

SENATOR HARRIS: Thank you, Councilman. Appreciate your service and for coming in today.

LUIS COTTO: Thank you.

SENATOR HARRIS: Any questions? Thank you very much. Suzanne Haviland, Dr. Bill Handelman, Matt Katz and Mike -- Dr. Mike Derren.

SUZANNE HAVILAND: Hi. My name is Suzanne Haviland and I'm testifying on behalf of the American Federation of State, Town and Municipal Employees Council 4. We have 35,000 public service members in Connecticut but we also represent Council 15 and Connecticut Health Care Associates representing nurses here in Connecticut. So we have a really broad and diverse membership. HB6600

We are also -- we help to cofound an organization called Health Care for America NOW! and I've been working with AFL-CIO Health Care Campaign and on the Connecticut Health First Authority. So there's a lot of different ways in which we're intersecting with reform and I have to echo the previous speaker's remarks in that this has been -- the SustiNet is a very bold plan and one which we're very excited about as a union and this is a pretty amazing time for healthcare reform.

We really strongly support this Bill because of a few reasons. But -- but first and foremost, and we believe that reform proposals really have to focus on slowing the growth of healthcare for everyone struggling with high prices including those who have health insurance. And we really believe that SustiNet goes far towards that goal by creating the public health insurance option and really having the bargaining power and clout.

It also requires employers to contribute which we feel is really important and prevents cost shifting by expanding existing public programs for -- to all lower income, uninsured adults. And all the critical system improvements that is has such as medical homes focusing on chronic illness, expansive of health IT, the auto-enrollment, these are all very special and very important components. And I also want to flag that it establishes a floor of benefits and allows even insured workers to enroll in SustiNet if their employer's insurance doesn't meet the floor. It establishes government rules to prevent the private market from denying us care.

We're especially pleased as I said with SustiNet's inclusion of a self-insured public health insurance plan as a choice for all Connecticut residents building on a pool of public employees and HUSKY enrollees. Pooling risk through a public insurance plan should be an essential component of reform and the public is on our side. We've done some recent polling with

the Health Care for America NOW! coalition. And it's really shown and I'll be happy to provide it to you that this idea of public health insurance option is extremely popular with the public. Obama's campaign has -- has public insurance in it. The Chair of the Finance Committee and the U.S. Senate Finance Committee has a plan that includes it. And then last week, or about a week and a half ago, the Commonwealth Funds came out with a plan that also includes and they have GE and Blue Cross Blue Shield in Massachusetts in that -- in that Commission.

So we'd really, really like to have -- see your support for this important plan this year. And we really believe that -- that there's a huge cost of doing nothing and we ask you to ask boldly and soon. Thank you.

SENATOR HARRIS: Thank you, Suzanne. Questions. Much appreciated. Next, Dr. Handelman. You playing Dr. Handelman, too?

A VOICE: (Inaudible) I don't play doctor.

A VOICE: Dr. Handelman apologizes but he is unavoidably delayed with patients --

SENATOR HARRIS: No problem.

A VOICE: -- and -- and I believe (inaudible)

SENATOR HARRIS: Thank you very much. And then Dr. Derren is next.

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MATTHEW KATZ: My name for the record again is Matthew Katz. I'm the Executive Vice President of the Connecticut State Medical Society. I'm very happy to be in front of you today on behalf of the more than 7,000 physicians that are members of the Connecticut State Medical Society. Today CSMS provides its strong, unwavering and unyielding support for the guiding principles of the SustiNet proposal and the associated legislation before you.

CSMS is proud to have been involved in this endeavor providing assistance in reviewing and evaluating the initial documentation and the approaches that have now become the SustiNet proposal in this legislation. CSMS believes that our healthcare system needs to be reformed and that such reform must provide a greater sense of access to medical care for all Connecticut residents. It must be based on scientific evidence and ensure quality medical care is delivered. It must be based on transparent information associated with how care is delivered, how it is paid for and must appropriately and adequately be funded. We believe that the SustiNet proposal meets all these objectives.

CSMS partnered with the Universal Health Care Foundation in 2008 to do a workforce study that I have in front of me today that showed unfortunately our system is in distress. More than 19 percent of physicians indicated they're

contemplating a career change. Ten percent are leaving the State, 90 percent of physicians in Litchfield, New London and Windham counties reported that recruiting physicians was very or somewhat difficult. Forty seven percent of physicians surveyed said they were expanding their work hours over the last three years. Forty percent said they are providing fewer high risk procedures and 34 percent fewer high risk -- seeing fewer high risk patients as a result of liability. And unfortunately, 90 percent of emergency room physicians and 72 percent of pediatricians indicated it's become more difficult to obtain referrals and consultations for their parent -- their patients. This is not something we can tolerate any longer.

The professional liability situation is depressing. The system needs some common sense reforms that we believe this proposal brings to the table. To increase physician retention and recruitment, CSMS has advocated for student loan forgiveness and forbearance in exchange for practicing in Connecticut's most fragile areas.

This proposal emphasis primary care and prevention through the medical home concept -- disease management, care coordination, quality review and quality guidelines without lapsing into what's commonly referred to as cookbook medicine. Certain limits on medical liability and expansion of health information technology specifically electronic medical records, electronic health records. And human approaches

that are not only rational but flexible and allow for changes as the system evolves.

These are all elements that CSMS believes are essential in a well thought out and structurally sound healthcare reform proposal. CSMS supports and is advocating for the adoption of SustiNet proposal guidelines for healthcare reform in order to move forward, not only the debate on true healthcare reform, but to speed towards a healthcare system that is based and will be judged on its collaborative approach to providing access to quality medical care that takes advantage of health information technology while still reminding us all that the individual patient mattes first and matters most. Thank you all very much and we urge your strong support of the SustiNet proposal in 6600.

SENATOR HARRIS: Thank you, Matthew and thank you for your patience today. Any questions? Thank you very much.

MATTHEW KATZ: Thank you.

SENATOR HARRIS: Dr. Derren, Dr. Ruscher, Dr. Vom Figen.

MICHAEL DERREN: Thank you very much. I'm Dr. Michael Derren. I'm a thoracic surgeon from New London and Chairman of the Board of Trustees of the Connecticut State Medical Society. And I want to thank you for the opportunity to testify here

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today in support of House Bill 6600, the SustiNet program.

I am here on behalf of the more than 7,000 physicians here in Connecticut who know firsthand that our healthcare system needs to change. Over the years, we have seen a lot of healthcare reforms proposed here. Many times they were written in a vacuum without a doctor in the room. They contained some interesting ideas but many of those ideas wouldn't work in the doctors' offices across Connecticut. That's not the case with House Bill 6600. The Connecticut State Medical Society has been pleased to be an advisor as this plan was developed. For two years, we've had a seat at the table talking about what works in our healthcare system and just as importantly what does not work. There's always a lot of talk about access to medical care. What does that really mean?

We're talking about making sure everyone who needs to see a doctor can see a doctor regardless of whether they have private insurance, Medicare, Medicaid, or HUSKY. We're talking about getting patients out of the emergency room and into physician offices and into a medical home. And we're talking about building a healthier Connecticut, something my organization has been dedicated to since its founding in 1792.

House Bill 6600 includes important provisions to do those things. For example, the CSMS workforce survey showed us that patients are having a

harder time accessing medical and surgical specialists throughout the State. This legislation proves that the situation through the medical home model can be improved. SustiNet makes significant inroads in addressing the spiraling costs associated with those who suffer from chronic disease through monitoring and coordination. Any physician in this room can tell you that a patient who does not comply with orders is less likely to improve than a patient who follows a physician's instructions.

The vast majority of Connecticut physicians are like me -- in small practices. We want to implement electronic medical record programs, but the costs are high and few of us have the extra funds to invest.

I choose to practice medicine to care for people not to argue with insurance companies about what my patients need. I practice medicine because I want to give my patients a chance at a better health and a longer life.

Quality healthcare must not be divided into the haves and haves not's. And in some rate, if the concepts in SustiNet Plan become law, important changes will bring more physicians to Connecticut at a time when we need more physicians. We believe today's proposals match many of the concerns expressed by physicians across the State and we urge you to embrace these concepts and make them a reality. Thank you very much.

SENATOR HARRIS: Thank you, doctor. (Inaudible). Any questions?

MICHAEL DERREN: Thank you.

SENATOR HARRIS: Thank you very much. Dr. Ruscher followed by Dr. Vom Figen and then Martha Kelly.

KIMBERLY RUSCHER: Thank you. My name is Kimberly Ruscher and I don't represent anybody except myself. I'm a surgical resident at the University of Connecticut. I'm in my third year of general surgery training. I'm here to support the SustiNet Plan. I must apologize if I stumble. I have been working since yesterday morning at one of our local area hospitals. So please forgive me if the fatigue takes over a little bit. HB6600

As a resident, I am part of sometimes the frontline of care for patients in Connecticut. Residents are at the bedside when the patients present with the asthma attacks that haven't been treated for years because no one could afford an inhaler. Yesterday I personally took care of patients who as referred to earlier have been ignoring bleeding from their rectum for months and came in when it was really severe and we had to undertake urgent measures. We, residents, see patients in the wards of the hospitals, in the clinic associated with our area hospitals and in the emergency department. My experiences in our Hartford area hospitals are what give me the

energy and drive to be here today to talk about SustiNet.

During my on call time yesterday and last night and then this morning, I encountered a few patients who brought principle to the plan to (inaudible)me as really critically important for our State and I wanted to use these patients to illustrate these points.

The first patient I'll refer to is someone who has a series of chronic diseases. There multiple healthcare providers can't talk to each other except through the pages of paper he carries around on laminated sheets and file folders. So when I want to talk to this person about their medical problems and what medications they took, I got handed a sheet a paper that I was suppose to go copy and not lose and not spill my hospital coffee on, and let me tell you, I worry about that piece of paper. Because it carries that patient's (in audible) or their aspirin dosage -- they take the low dose or the high dose. These aren't small matters. These are big mattes.

If we implemented SustiNet, we would have access to interchangeable electronic medical records so I can log on and see what his or her primary care provider said about their aspirin dose and why they weren't on a higher dose.

Further, the medical home concept came to light for me yesterday. We took care of a patient who had previously undergone an organ transplantation

but because of the cost of co-pays for some of the medications of which you have to take a lot of after organ transplantation, had recently stopped some of these medications. That patient was now with a complication in the emergency department. Having a medical home could have prevented some of those complications.

I can go on and on with anecdotes, but I think that the time in the healthcare reform debate has enough evidence and enough ethical principles behind it that we have to move forward on healthcare reform.

If we look at the highest ethical principles and evidenced based guidelines which guide the practice I'm learning, I believe we should reform healthcare in Connecticut according to SustiNet. Thank you for your time.

SENATOR HARRIS: Thank you, Dr. Ruscher. Any questions? When do you have to go back?

KIMBERLY RUSCHER: Five a.m.

SENATOR HARRIS: You should probably go get some sleep.

KIMBERLY RUSCHER: I plan on it. Thanks.

SENATOR HARRIS: That's another thing about the system that we'll have to talk about at another day.

KIMBERLY RUSCHER: I appreciate it.

SENATOR HARRIS: You're welcome. Dr. Vom Figen followed by Martha Kelly and then Deacon Dave Reynolds.

KEITH VOM EIGEN: Good afternoon. My name is Keith Vom Eigen. I'm a primary care internist on the faculty of UCONN Medical School. I work at the Burgdorf Health Center in the north end of Hartford where we provide primary care services to a mostly low income, minority, underinsured population and serve as a major teaching site for UCONN medical students and residents.

I am here today representing the Connecticut Chapter of the American College of Physicians which is the largest medical specialty organization and the second largest physician group in the United States. On behalf of the over 2100 members of the Connecticut Chapter of ASP, I would like to express our support for House Bill 6600 regarding the proposed SustiNet Plan for expanding health insurance coverage in Connecticut.

Every day in our clinic, I witness the suffering, inefficiency and waste that result from our disjointed, inequitable and dysfunctional healthcare system. We have reviewed the SustiNet plan along with our national health policy experts and believe that, if implemented, it will go a long way towards expanding access to care, improving quality and reducing the costs of care for Connecticut citizens. It coincides with ACP

policy and health reform recommendations in several ways.

The ACP supports State level expansion of access to healthcare coverage as a means to achieving universal access to healthcare. We believe that universal access to care is a key component of a system of healthcare that can provide high quality, cost effective, affordable and equitable healthcare for all Americans. The SustiNet Plan will significantly expand access to healthcare coverage for groups that currently are among those at greatest risk for being uninsured.

ACP believes that the patient center and medical home model of care delivery which is a central element of the SustiNet Plan can improve quality of care and reduce costs through improved coordination of clinical care and social services, more efficient communication, better management of complex chronic illnesses and more effective application of preventive measures.

We believe that primary care internists and other primary care physicians are best suited to serve as the leaders of the medical homes and we urge that in implementing the SustiNet Plan, compensation for clinical services and coordination of care be set at levels that ensure participation of physicians and maintenance of the primary care workforce.

By emphasizing prevention and coordination of care through the medical home model, the SustiNet

Plan promises to bring the overall cost of care down, improve health outcomes for its participants and provide better access to other beneficial services.

ACP also strongly supports the implementation of health information technology to improve the efficiency of healthcare to reduce errors in communication and to enable monitoring of care services and patient outcomes to improve quality and reduce the cost of care. We applaud the emphasis that SustiNet places on this.

And, finally, by mandating the establishment of quality care standards, we believe that -- the SustiNet Plan will have positive effects on the quality of care provided to patients.

Overall we feel that the SustiNet Plan is a well thought out and carefully crafted plan that brings together state of the art elements of healthcare reform to improve access and reduce cost of care to the citizens of Connecticut. We support this plan and we urge the Legislature to do as well.

SENATOR HARRIS: Thank you, Doctor. Any questions? Thank you very much. Martha Kelly followed by David Reynolds.

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MARTHA KELLY: Good afternoon. Thank you for giving me this opportunity to speak before and for raising this important legislation.

I'd like to -- to lend my support to House Bill 6600 because it represents the best proposal that I've heard yet to provide comprehensive integrated -- a comprehensive and integrated plan in Connecticut addressing the gaps and the failures of our current fragmented system of financing healthcare.

I represent one of the many people in this State who have been uninsured over all too much of for me the last ten years. In my earlier years, I had very stable employment and continuous health coverage in the insurance industry. I have a background as a life insurance underwriter so I'm of a lay person, a little be savvy about the delivery of medical care and I know how important it is to have care be coordinated and also preventative. The dollars that we spend on managing chronic illnesses are much better spent than dollars spent after somebody gets into a crisis in a hospital.

I personally have been fortunate not to have experienced catastrophic illness but I have at 57 a handful of chronic illnesses that need to be managed. Recently I had a job loss and was applied and was given SAGA coverage but once my unemployment insurance kicked in, I learned that I earned too much to qualify for it. I know you probably know quite well the limits, but some of us in the public tend to forget that different people are eligible for State insurance at different levels and for childless, adult, non-disabled adults, the income limit is 60 percent

of the federal poverty limit, or less than $500 a month.

So, anyway, I want to make a couple of small points about SustiNet. Many people before have spoken quite eloquently. I haven't heard anybody mention the fact that SustiNet includes dental benefits. Untreated dental disease can contribute to poor control of chronic illness like diabete, which are very costly, and it can lead to trigger heart attacks. So, again, this is an example of how this bold legislation would provide important savings as well both in terms of quality of life for individuals and burden on the State.

So, I ask you to move this legislation forward. Thank you.

SENATOR HARRIS: Thank you very much. Any questions? Thanks.

A VOICE: (Inaudible).

SENATOR HARRIS: Thanks. Nope, that's okay, there were none anyways. Just wanted to make the record clear. David Reynolds followed by Alyssa Norwood and then Ellen Andrews.

DAVID REYNOLDS: Senator Harris, Representative Ritter, Representative Fontana, and members of the Committee. My name is Deacon David Reynolds. I'm Legislative Liaison with the Connecticut

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Catholic Conference and I'm also Cochair of the Interfaith Fellowship for Universal Health Care.

Today I come before you on behalf of the Connecticut Catholic Conference which is the public policy office of the Catholic Bishops of Connecticut to urge the members of these Committees to support HB 6600, An Act Concerning Establishment of the SustiNet Plan, and the concepts for healthcare that that plan incorporates. The Conference recognizes that there are many other efforts underway within the Legislature and the Executive Branch to improve our healthcare system but feels that HB 6600 is the most comprehensive proposal currently before the legislature.

We realize that many deliberations and compromises will occur before a final solution to the healthcare crisis is developed but that this Bill should be used as a centerpiece for any future healthcare discussions because of its comprehensive nature.

Catholic social teaching holds that healthcare is a basic human right. Therefore denying healthcare to any individual is denying them a basic human right. And this has long been reflected in the history of the Catholic Church and its vast involvement in providing healthcare services within our State, our nation and around the world.

The need for healthcare reform is clear as thousands of people of people within our State lack employer sponsored insurance or cannot afford to purchase insurance on their own. The design of the SustiNet Plan addresses key factors that other plans fail to do. They could make coverage available for all Connecticut residents despite their employment status. They have affordable co-pays and premiums, provide quality levels of coverage and also provide interesting medical management provisions and at reducing costs for better more comprehensive patient management.

Man of us don't have to look far to find somebody we know that doesn't have healthcare coverage. I can look at my own family with my three children. One's -- my 24 year old daughter is a teacher in public school system. She has health insurance. Her husband has his insurance through her insurance plan. I have a 26 year old son who's an EMT for an ambulance company, fulltime, within the State of Connecticut. He has absolutely no health insurance because he's -- available -- unable to pay the premium that the company wants for him to be covered. So he helps sick people, but he can't get medical attention himself. My oldest daughter, who's married and has one child, who -- she also has some health conditions. Through her company, she's covered -- I should say she has health insurance through her husband's company -- but they only pay a third of the premium. They could pay his coverage but they have to come up with $12,000 every year to

cover my daughter's coverage and their son's coverage.

So I think we all look at our friends or families -- we could all see where there's major problems within the healthcare coverage in the State of Connecticut. Because of that, the Connecticut Catholic Conference hopes that the Committees represented her today will recognize the basic right that all our citizens have to quality, affordable healthcare. And economic times are difficult, but they are only getting -- will get worse when many of the employed and unemployed of Connecticut's citizens, if healthcare reform is delayed any longer. Thank you.

SENATOR HARRIS: Thank you, Deacon Reynolds. Any questions? Thank you very much. Alyssa Norwood followed by Ellen Andrews and then Nancy Benedict.

ALYSSA NORWOOD: Good afternoon. My name is Alyssa Norwood. I thank you all for your patience on this long day of testimony. I invite you to stretch if you'd so like during my remarks. I take no offense. HB 6600

I'm here today on behalf of the Connecticut Public Health Association and also in my personal capacity as a resident of the Town of West Hartford as well as a graduate student at University of Connecticut's combined JD MPH program. I'm here to express my support of the SustiNet Plan primarily on two basis.

CPHA supports StutiNet first because of its commitment to prevention. And secondly, because it helps the critical issue of eliminating racial and ethnic health disparities here in the State of Connecticut. With respect to prevention, CPHA has long maintained that prevention is a critical piece of universal healthcare for without it, it's impossible to contain costs. And SustiNet does indeed meet the bar here. This past November, we had some folks from Massachusetts come to CPHA's annual meeting and share with us some statistics relating to the success with respect to prevention of Massachusetts universal healthcare plan.

In Massachusetts, since its implementation, flu vaccinations rose 3 percent for the 19 to 64 year old age group in that state at primary care sites as new patients came in to see primary care practitioners. Colonoscopy rates increases 6 percent in one year among the recommended age group as newly insured individuals got referrals for screening. And perhaps, most shockingly, smoking rates decreased 8 percent. This is after a ten year trend whereby at most smoking rates decreased 3 percent and in some years didn't decrease at all. There's mixed research but, by and large, the consensus is it's owing to the implementation of universal healthcare and nothing else -- not to the smoking ban in restaurants or a variety of other factors that this decrease occurred. For those reasons, with

respect to prevention, SustiNet is the answer here in Connecticut as well.

On the racial and ethnic health disparities, it's certainly a problem in this State that there's significant differences between different races and different ethnicities with respect to health outcomes. These differences are untenable. SustiNet helps to eliminate them.

For these reasons, we support your proposal and I thank you for your time.

SENATOR HARRIS: Thank you, Alyssa, appreciate it. Any questions? Ellen Andrews followed by Nancy Benedict and then Dr. David Thompson.

ELLEN ANDREWS: Hi.

SENATOR HARRIS: How are you, Ellen?

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ELLEN ANDREWS: I'm good, even better in three minutes. I'm Ellen Andrews. I'm the Executive Director of the Connecticut Health Policy Project. We're a nonprofit that does policy analysis and also assists consumers that are struggling to access the healthcare they need which is why we're very excited about HB 6600 and the SustiNet Plan. The proposal is the most detailed, thoroughly researched, specific and realistic plan to provide relief to Connecticut's struggling healthcare consumers and payers. This plan is clear about where we need to go -- how we'll get there -- what we need to do -- and we

can see success at the end of it. And I urge you to pass it.

SustiNet is the result of a very long, very thoughtful, inclusive and sometimes painful process of engaging stakeholders and incorporating input from across Connecticut's healthcare landscape. I want to focus on two pieces of the plan in my testimony -- promotion of a medical home and auto-enrollment in the absence of an individual mandate. Everyone should have a patient centered medical home. That's a primary care provider who knows you and your healthcare care needs, is available when you need help and coordinates your care. Patients are just not given referrals for needed specialty care and tests (inaudible) and say, good luck with that -- finding someone, but the provider makes the appointment, monitors care, collects test results and follows up with any necessary after care to make sure that you're well. Providers work in teams to help consumers manage their own conditions and maintain or improve their healthcare. Nationally, many provider and business groups have endorsed and are devoting resources to the medical home concept.

Connecticut has taken a step towards the medical home model and I know you will not be surprised. I never come up here and don't talk about PCCM, but that started on February 1st. We're very excited. A very small pilot of PCCM that is built on the medical home model. And we expect

that PCCM will save Connecticut's budget over $113 million every year.

The second piece of SustiNet that I'd like to emphasis is there's something that the planners left out. That's the individual mandate which is the legal requirement that every state resident obtain healthcare coverage. Not surprisingly, the insurance industry thinks it's a great idea. If I sold the product, I'd probably want everyone legally required to buy it, too. There is ample evidence that an individual health insurance mandate would not work in Connecticut and would cause significant harm to low income consumers which is most uninsured people are low income. And I attach to my testimony more than you want to know about why it won't work in Connecticut. But perhaps the worst part of an individual mandate is that it blames the victims of uninsurance for the problem. And -- and tries to reform healthcare by asking the most (unaudible) to pay for it and it's not right.

Instead, SustiNet includes thoughtful auto-enrollment measures to ensure that everyone has coverage while respecting consumers' rights. It would be very difficult to get through any system in this State without being auto-enrolled without taking serious time and trouble.

I want to thank you for your time and your commitment to the health of every Connecticut resident.

SENATOR HARRIS: Thank you, Ellen. Any questions? Chairman Fontana.

REP. FONTANA: Thank you, Mr. Chairman. Good evening, Ellen. Quick question -- I just wanted to actually follow up on your second half of your testimony regarding auto-enrollment -- (inaudible) mandate.

ELLEN ANDREWS: Yup.

REP. FONTANA: Auto-enrollment seems to me to be -- it was configured -- it's -- it's -- auto-enrollment with an opt-out provision.

ELLEN ANDREWS: Right.

REP. FONTANA: And --

ELLEN ANDREWS: And a lot of difficulty opting-out. If you have to really work --

REP. FONTANA: Right, Right.

ELLEN ANDREWS: -- hard to opt out.

REP. FONTANA: But, in essence, it's in some ways, it's a voluntary approach and it seems that, in general, we tend to as a society adopt voluntary measures before we adopt mandatory measures. That's my --

ELLEN ANDREWS: And that's a good thing.

REP. FONTANA: -- hypothesis, anyway, or my, yeah and right. And so it seems to me that if we jump to an individual mandate, we're essentially saying, we're going to throw out all of our other experience. We're just going to jump to a mandate and not try voluntary measures first. And auto-enrollment and perhaps you can expand upon it, but my understanding is either at the point of birth, or the point of enrollment in school or the point of enrollment in a job, or, not enrollment, but hiring or some combination of those, you essentially ensure that someone has health insurance -- not a specific kind of health insurance, but health insurance of some kind or you auto-enroll them in one of the existing number of choices. Is that correct?

ELLEN ANDREWS: Right. And, actually, when you file your taxes, when you get a job or when you lose a job, there are several places where, yeah, or you enroll your child in school, you would be auto-enrolled unless you opt out. You have to fully understanding of the to positively affirm that you understand what the risks are, the liability and that you may not, you know, you may not have the safety net that most of us who are lucky enough to have insurance will have and what that can mean to your family.

If -- this is a safety net for people though if, I mean we are very, very secure that SustiNet is going to create positive options, affordable comprehensive coverage for everyone. But if it

doesn't work for somebody, they still have the option to opt out.

REP. FONTANA: Does the SustiNet plan contain to your mind the optimal auto-enrollment mechanism or are there other mechanisms either from other states or of your own devise that would be preferable in some idealized sense.

ELLEN ANDREWS: As a consumer advocate, I was comfortable with this auto-enrollment. It is -- it is significant and I believe everybody should have insurance. And I believe that we should build something that works for everyone and I think we will. But as a consumer advocate, I felt that it was important and necessary to leave open that option. It's also important in that not to choose this where they do have an individual mandate -- California, Maine and Vermont -- chose not to pass the individual mandate. However, Massachusetts did and they've had to devote a lot of resources and actually it's gone swimmingly well, so far, for them. But they've had to devote a lot of resources to enforcing that. Those are resources that aren't going to healthcare. They're not going to reduce obesity, tobacco control, to providing subsidies for the 80 something thousand people who don't -- that they couldn't afford to subsidize but still said it wasn't insurable. So they were exempted from the mandate.

So it's problematic and it's -- and it just distracts from the really hard work that needs to

happen for healthcare reform. That didn't answer your question.

REP. FONTANA: Well, it did and it didn't. I mean, I think that you elucidated on the idea that individual mandate doesn't work for a lot of reasons. And as you and I have discussed in the past, it's not limited to people on one end of the ideological spectrum because it could be a Libertarian argument to be made about why --

ELLEN ANDREWS: I know, I'm not really comfortable being on the same side of the (inaudible)

REP. FONTANA: I know, but -- but I guess my (inaudible), and finally, I'm curious to explore the issue of auto-enrollment (inaudible) and so, if you had any additional documentation that you can share with me on what other states have done, and not necessarily limited to, well. I'm -- I'm curious to have an auto-enrollment mechanism in place regardless of whether or not SustiNet moves forward, regardless of whether one's talking merely as it relates to public programs or whether there's a private component as well. And I think that you're the kind of person who knows about what's been done in other states, so you'd be the person to talk to. So I'd just love to have some more on --

ELLEN ANDREWS: Sure.

REP. FONTANA: -- auto-enrollment and how one can --

ELLEN ANDREWS: There's actually --

REP. FONTANA: -- structure it.

ELLEN ANDREWS: -- a great book. It's called Nudge.

REP. FONTANA: It's from a professor of mine.

ELLEN ANDREWS: And it talks about ways to get people to do the right thing without necessarily forcing them into it. It's a great book.

REP. FONTANA: And if there's a way to use what they've got in there -- to get them to do the right thing here, that'd be great. But, thanks. Anything you can send would be great. (Inaudible).

SENATOR HARRIS: Ellen, thank you, first of all your the person that first taught me the word concept of medical home. So --

ELLEN ANDREWS: Good.

SENATOR HARRIS: I owe that to you.

ELLEN ANDREWS: Cool.

SENATOR HARRIS: I -- I think I might have missed something as the day grows long, but can you explain again why you don't think mandatory enrollment works - why you don't think the Massachusetts model works?

ELLEN ANDREWS: Well, we have mandatory -- a legal requirement that auto drivers have -- have insurance and 12 percent of drivers in Connecticut don't have auto insurance. It is -- it -- Connecticut is an expensive state. Connecticut -- we don't -- Connecticut and Massachusetts -- we're -- how am I going to say this. We -- they have very strong regulation of their insurance markets. They merged their small and individual group markets and made individual insurance much for affordable. I don't see that happening here. They also have a strong insurance department where you can go and get help if you bought something that isn't covering your needs. We don't always have that here for our consumers. The Office of the Health Care Advocate is a wonderful resource, but they don't have -- you know, they're advocates. It's not -- the protections are not as strong here as they are there.

We don't have $4.3 billion in extra federal money for subsidies as well to ensure that we can afford it. And I think, you know, the advocates are -- they're divided in Massachusetts. Some think it's a great thing. Some think it's not as such a great thing. But they also got on the other side a lot of money for subsidies. They got affordability. They got a voice at the table. They got an awful lot of other -- other things that came with it that we may -- we might not be -- we certainly wouldn't see in the insurance industries' proposal -- that includes an individual mandate -- that's centered on it.

SENATOR HARRIS: So, the crux of what you're saying is the consumer aspect.

ELLEN ANDREWS: Yes.

SENATOR HARRIS: Or the lack thereof, you would said here in Connecticut.

ELLEN ANDREWS: Yes, Massachusetts is a magical, special place.

SENATOR HARRIS: I went to school there, yes.

ELLEN ANDREWS: And if we pass SustiNet, we might be, too.

SENATOR HARRIS: The -- what we're talking about now and is part of SustiNet deals with coverage. Correct?

ELLEN ANDREWS: Yes.

SENATOR HARRIS: And to probably over simplify a very complex problem, two other major aspects of what we're dealing with here are actually access -- meaning having providers --

ELLEN ANDREWS: Uh-huh.

SENATOR HARRIS: -- there to take people into their chairs and their offices. And the final one is cost. Given -- if you had to sequence those three aspects of the problem, what would make the

most sense to you if you couldn't do them all at once.

ELLEN ANDREWS: Ouch. I don't know if I can separate them. I really don't. Massachusetts did because they had to. They had $385 million on the table they were going to lose. So, and the feds came in and said do coverage so that's what they did. Vermont hasn't. They've done all three together at the same time. They're making less progress, obviously, you know, than -- than they would if they focused on one thing. I think it's very difficult. But the great thing about SustiNet is that they do include, you know, they have task forces to talk about access. They have (inaudible) costs. They have, you know, electronic medical records. They -- and access, as well, is a big, big problem. We talked about this a lot and about Medicaid clients. And SustiNet (inaudible) are because of bringing Medicaid rates up to, you know, something that's more close to what the rest of us, you know -- our doctors get paid to see the rest of us. So I think that'll go a long way toward access. It would be really hard for me to say you can do one piece first without the others. It would be very difficult. I think we can do them all together.

SENATOR HARRIS: Fair answer. Any other questions? Okay. (Inaudible). (Inaudible) final question just on back to the medical home and back to PCCM. How many providers do we have as we sit here today? If you know.

ELLEN ANDREWS: There -- that have been --

SENATOR HARRIS: They're -- they're in -- they're actually in -- in the pilot right now.

ELLEN ANDREWS: There are seven sites. I don't know the number of providers.

SENATOR HARRIS: Seven sites meaning seven offices?

ELLEN ANDREWS: Yeah.

SENATOR HARRIS: Seven --

ELLEN ANDREWS: Seven practices.

SENATOR HARRIS: Seven practices.

ELLEN ANDREWS: Seven clinics (inaudible).

SENATOR HARRIS: And do you know the size of those sites as far as -- well, you wouldn't because you don't know the number of providers.

ELLEN ANDREWS: It -- 135 clients was the last the heard that who had enrolled in PCCM. That's far fewer than (inaudible) and St. Mary's in Waterbury, the largest pediatric provider in Waterbury. And they are PCCM sites. So, it's been very slow for enrollment in PCCM.

SENATOR HARRIS: Thank you for all your work.

ELLEN ANDREWS: Thank you.

SENATOR HARRIS: Thanks a lot. Next, Nancy Benedict followed by Dr. Thompson. Dr. Thompson?

DAVID THOMPSON: Senator Harris, Representative Ritter, other Committee members who are kind enough to stay until the end. I am Dr. David Thompson. I'm a practicing internist in Niantic, Connecticut next door to the town where Representative Ritter is from. And I'm also President of the Connecticut State Medical Society-IPA. I have heard from a lot of physicians today and they've brought up a lot of the points that I have in my written presentation. I'm not going to repeat them, about the medical home model, etc. But what I want to say is that our organization is a network type organization that tries to provide medical care to -- through various mechanisms to patients in Connecticut. We have 7,000 actively practicing physicians. We represent the vast majority of all the actively practicing physicians in the State.

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For the last 20 years, we have been the network for the -- what is now the Health Net -- didn't start out as Health Net, but now it's Health Net -- insurance plan. And that includes many State employees. So we're used to having State employees as people that are cared for by our membership. We also are the network for Health Net's Medicare Advantage Program? We were the network for the HUSKAY A program that Health Net ran until they pulled out of that business.

We're also the -- a network for a workmen's compensation program. So we have a lot of experience with healthcare delivery and our goal is to, you know, provide high quality, cost effective care. That's our mission statement.

Right now in Connecticut and in this country, we're faced with a major problem with healthcare that has two parts. One is the lack of universal coverage and the second is the cost. I have distributed a article from the Journal of the American Medical Association entitled The Perfect Storm of Overutilization which explains why the costs are totally out of control in this country. There was a question earlier about how the costs in other countries are much lower and, in some cases, less than half what ours are. And, also, that the health analysis that's done in those countries finds that the population is somewhat healthier than our country. Why is that? Well in our country, we emphasis treating people who are sick. In an emergency room, sometimes we wait until they get sick. That was brought out by other people who presented earlier. But, we don't emphasize keeping them healthy. And that's where the medical home model comes in because it -- it changes the emphasis of that and that's what SustiNet attempts to accomplish is to reverse this emphasis. Emphasize keeping people healthy instead of treating them when they're sick. And that's -- that's an emphasis that we -- we find very valuable.

Now in addition to that, it -- it includes getting involved electronic health records which is going to get a big push from the new stimulus package that was just passed by Congress where significant funding will come from the federal government to help physicians put electronic health records in their offices and our organization also helps with that. We also push e-prescribing either individually or as part of that electronic health records to try to cut down on drug interactions and it also allows for quality data aggregation and electronic data exchange which cuts down on overutilization.

Basically, our organization is also involved with a new medical advantage program that uses the medical home model as its basis for controlling costs and this model is already out there in other states. It's not here yet because it's just being presented. But in those states, it's very successful. So our Board of Directors supports the SustiNet proposal and would be available to work with the appropriate management team to work out details of providing physician services through the network to this program, if desired. So, in other words, our 7,000 physicians are ready to be part of this.

The IPA Board feels that the program such as SustiNet will help create universal coverage and control cost. And I -- I believe that both of them have to be done simultaneous.

SENATOR HARRIS: Thank you, Doctor.

DAVID THOMPASON: Thank you.

SENATOR HARRIS: Any questions? Have a good evening. Next, Eva Csejtey?

A VOICE: (Inaudible).

SENATOR HARRIS: Say that again? Say it in the record when you get up so I can hear it.

EVA CSEJTEY: It's Csejtey.

SENATOR HARRIS: Csejtey, cool. Thank you. Followed by and last on the signup sheet, Madeline McClave.

EVA CSEJTEY: Honorable Senators and Representatives. My name is Eva Csejtey, a social work graduate UCONN student and an intern at the American Friends Service Committee of Connecticut. I'm here today to support Bill Number 6600, An Act Concerning the Establishment of the SustiNet Plan.

You have heard today on the importance of passing Bill 6600 which provides healthcare for everyone who chooses SustiNet. You are informed on the rising 10 percent yearly healthcare costs consume over one-third of the State budget. You are aware each day more Connecticut residents are losing their employment which affects healthcare benefits.

You have heard testimony of the decline of quality healthcare while cost have increased. You are knowledgeable of insurance exclusions that refuse medical treatment for predetermined diseases such as diabetes, a growing and treatable disease. And your sensitivity to Connecticut residents who are dying because of the lack of quality healthcare is appreciated.

However, you may not have heard from testimonies that a lack of affordable healthcare does influence major life decisions. Twenty seven years ago, my decision to marry was connected to my need for healthcare. I was identified by insurance companies as a medical risk because of my age. And I was unable to afford an individual plan. Not much has changed since the 1980s except for escalating healthcare expenses and the decline of real spendable earnings. With the SustiNet Plan, Connecticut residents would be guaranteed quality healthcare and make life decisions based on the desire and not on their healthcare needs.

Let me provide an example of current public plans and their inadequacies which have been addressed by SustiNet. A colleague of mine explained his frustration due to the lack of immediate coverage, a back log of appointments, minimal physician availability, required long distance travel and lack of concern for patient circumstances. I have an example using fictitious names. Jill's two year old son, Jesus, has seizures and is referred to a

specialist by his pediatrician. Jill leaves early to the appointment an hour away. On the way, Jesus vomits in the car and Jill stops to buy items to clean up the mess and clean close for Jesus. Jill arrives 15 minutes late and is told rudely she would have to reschedule the appointment two weeks away despite her circumstance. This story is only one of many. SustiNet would eliminate these problems with better reimbursement rates, local physicians, improved communication and reimbursement for case management. So what price do you put on lives? I know that cost has been a major concern.

On behalf of the American Friends Service Committee, I implore you to address the health needs of Connecticut residents to live a healthy lifestyle and promote economic justice. Connecticut residents are counting on you to provide healthcare for everyone and start saving lives today. And I challenge the Honorable Senators and Representatives of Connecticut to lead the nation in healthcare reform.

I appreciate the opportunity to speak and would be happy to answer any questions.

SENATOR HARRIS: Thank you, Eva. Any questions? Thank you very much and final testimony from Madeline McClave.

MADELINE MCCLAVE: (Inaudible). Good afternoon, Senator Harris, Representative Ritter, members of the Committee. My name is Madeline McClave. I'm

HB6600

the interim Executive Director of the Connecticut Oral Health Initiative or COHI. And I'm here to encourage you to support SustiNet because it will increase access to comprehensive, affordable, portable and efficient healthcare and very key for us, it includes dental services.

SustiNet would benefit huge numbers of Connecticut residents as well as small non-profits just like the one I work at COHI. We ask that you make sure that oral health or dental services continue to be included in the definition of healthcare and covered in this plan and in any plan for expanded or universal coverage through your work going forward.

I just wanted to mention three of the most compelling reasons to make sure that oral health is included. The first is that oral health is linked to a wide range of very serious overall and systemic health problems. Second, the cost effectiveness of ensuring that residents get early, regular and preventive dental care. And three, the difficulty that so many Connecticut residents have in accessing oral healthcare.

Research supports what professionals have long contended that we can't separate oral health from overall health and we applaud SustiNet for recognizing this. COHI urges you as you craft any future State healthcare plans not to ignore this science.

Former U.S. Surgeon General Chick Coop coined a phrase -- you're not health without good oral health. And this is something that most of us who have access to good oral healthcare and dental coverage really don't have to think about. In addition, recent settlement of Harvey Wilson-Coker lawsuit has lead to significant improvements and access to dental care within the HUSKY plan. They're well documented deficiencies of access across all Medicaid programs to dental care. And this really underscores the need to include it in any new plan.

In addition, I think you probably all know that Medicare does not cover dental services so it's particularly important for the older adults and through SustiNet, Connecticut could finally address the real and sustained crises that children, pregnant women, older adults and others face every day in trying to get dental care.

Thanks to the efforts of the General Assembly to ensure the settlement of Carr v. Wilson-Coker and the launching of the new dental carve out last September, there's been a good increase in HUSKY dental provider enrollment and better access to care now in a lot of parts of the State. However, there are many areas in Connecticut that still lack a good network of dental providers for HUSKY patients and adult rates remained so low that most providers don't accept them.

In closing, I just want to mention that New England states that have passed legislation for

expanded or universal healthcare in the past few years didn't include dental and we heard from all of them that they wished they had. We urge you to learn from the lessons of these other states and support a plan such as SustiNet that recognizes the mouth must have parity with the rest of the body. Thank you.

SENATOR HARRIS: Thank you very much. Any questions?

MADELINE MCCLAVE: Thank you for your long day and patience.

SENATOR HARRIS: Thank you. As we traditionally do, we're done with the signup sheet and now I will ask is there anybody who did not sign up to testify on one of the bills and if you have not, you can come up and you have three minutes. Dr. Deutsch.

SB1649

LARRY DEUTSCH: Thank you to the Committee. I failed to introduce myself after the last time. I'm on the City of Council -- the City of Hartford City Council. I guess we're all a little tired and I hope that we can conclude this hearing. I'm sure we all do soon.

I'm on the Hartford City Council and also before that was a pediatrician with University of Connecticut and some other places. And I'd first like to speak just briefly as a physician and -- and try to urge that we don't have to go through a process like this year after year. And the specific Bill among many I'd like to just draw

Frances G. Padilla, Vice President
Universal Health Care Foundation of Connecticut

Testimony before the joint public hearing of the
Public Health, Human Services, Insurance and Real Estate Committees

March 2, 2009

Good afternoon. I come before you in support of H.B. 6600, an Act to Establish the SustiNet Health Plan. This bill is based on the most detailed policy analysis for health care reform the General Assembly has before it. Universal Health Care Foundation seeks to improve the health of the people of Connecticut and make the health care system work for everyone. To inform the design of this policy proposal, our foundation evaluated health outcome and health care spending data, and sought the ideas and advice of a range of stakeholders.

I want to make three clarifying points about SustiNet.

First, even before the economy began shrinking in 2008, we understood the prudence of phasing in the various groups to be covered. The economic impact of the policy design was thus simulated over a five year period, from 2011 through 2016. With SustiNet, coverage costs are first incurred in 2012. The micro-simulation shows that by 2016, if measures such as chronic illness management through value-based benefits design, electronic medical records and quality standards are robustly implemented, Connecticut can expect to slow the rate of total health care spending. With SustiNet fully implemented, by 2016, that rate will begin to decline by 2-3%. Left unchecked, the rising cost of medical care will dominate the Connecticut economy and swamp the state budget.

Second, SustiNet leverages the state of Connecticut's ability to secure better value for the health care dollar. Think of the state's residents as shareholders. What other multi-billion dollar corporation wouldn't use its negotiating power to deliver greater value to its shareholders? SustiNet will save businesses and households $1.7 billion in lower premiums and out of pocket costs. Its expansion of coverage eligibility will leverage at

least $800 million in new federal money. That's a return of $2.60 for every dollar of state investment. The "SustiNet Authority" will govern both the policies of the health plan and health system innovations with a focus on results, accountability and transparency.

My **third point** is about the sources of new costs to the state government. If we begin coverage in 2012, by 2014, 98% of the state's uninsured will have coverage, either through SustiNet or through their employers' plans. In 2014 the state of Connecticut begins full-scale provision of premium subsidies to that part of the working middle class whose earnings make them ineligible for Medicaid but who still cannot afford the coverage their employers may offer them. That year, the state also increases, on a graduated basis, reimbursement rates to providers who care for people on Medicaid and HUSKY, thereby reducing the shift of costs for uncompensated care to the private sector.

Members of Connecticut's business community were clear to us that the cost shift is a problem they feel must be addressed in any health care reform. For the same reason, in 2007 the CT Insurance Policy Council also recommended increased Medicaid rates.

Business people from small and large firms throughout the state, residents meeting in churches and schools from Griswold to Norwalk, pediatricians to cardiologists have all weighed in and told us that coverage is key but that the system of health care as we know it is unsustainable and we can't build expanded coverage onto it. We as a state, they told us, must **also** tackle unabated cost growth and inconsistent quality of care relative to income, race and insurance coverage. These demands were affirmed in the Health First Authority's public hearings last year.

We are in a unique position in Connecticut to demonstrate that a public health insurance plan alongside the private market, coupled with prevention, cost control and quality enhancement strategies can improve the health of our state, and make us more economically competitive. In the short run, passage of H.B. 6600 will enable Connecticut to make maximum use of stimulus funds for electronic health records,

thereby building data capacity. SustiNet will make Connecticut "action ready" to use resources from the Obama administration's health reform initiatives. As the panelists last Thursday all said in one way or another, only systematic reform will get us there. I respectfully submit that SustiNet is your most complete and effective blueprint for that reform.

CONNECTICUT ASSOCIATION OF
REALTORS® INC.

Statement on

H. B. 6600: AAC THE ESTABLISHMENT OF THE SUSTINET PLAN

... SUPPORT

Submitted to the Public Health Committee, Insurance and Real Estate Committee
and Human Services Committee

March 2, 2009
by

Linda St. Peter
President of Connecticut Association of REALTORS®

Good day, my name is Linda St. Peter, and I'm the president of the Connecticut Association of REALTORS®. We have approximately 18,000 members in the state, the vast majority of whom are self-employed, independent contractors.

Quite simply, we support enactment of House Bill 6600 and its SustiNet health care plan. We do so because too many Realtors and members of the public are shut out of the rating structure currently benefitting large employers and unions. As a result, many must resort to being underwritten and rated as individuals – a very costly proposition. Many have to settle for inadequate coverage (high deductibles/restrictions due to pre-existing conditions) or depend on others for coverage. Worse still, thirteen per cent of our members have no health insurance at all with others struggling to maintain coverage due to high cost and/or underwriting criteria!

We could not agree more with the principles guiding the SustiNet Plan: 1) Health care coverage should be universal; 2) health care coverage should be continuous; 3) health care coverage should be affordable to individuals and families; 4) the health insurance strategy should be affordable and sustainable for society; and 5) health care coverage should enhance health and well-being by promoting access to high quality care that is effective, efficient, safe, timely, patient-centered and equitable.

The plan provides choices for Connecticut Citizens and creates competition within the insurance industry.

(continued)

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Allow me to make five quick points why we, as a major business group, favor SustiNet:

1) For years our Association has advocated for experimentation and innovation in the search for affordable, accessible individual and small business health insurance. We supported federal proposals to let self-employed people band together through national or statewide purchasing pools. Last year we backed legislation opening up the State employees plan to small employers. The proposed SustiNet plan is the most innovative and comprehensive effort to date and should be adopted in Connecticut. The public; small businesses and especially our members are eager for ACTION.

2) Realtor leadership, representing our members, agrees that private employer sponsored insurance plays—and must continue to play – a vital role in providing healthcare insurance to employees.

Families and businesses satisfied with their existing private insurance plans can keep them under this proposal. Still, since there remain huge holes in coverage that need filling, companies already in the market should not fear the competition and the choices given to the citizens of Connecticut under the SustiNet plan.
It is NOT a "single payer" proposal.

3) High health care costs put Connecticut businesses at a competitive disadvantage. Let's not wait for others, including the federal government, to act. Passing this legislation now is an economic imperative! Such innovation places Connecticut at the forefront of addressing not only the health insurance problems but affords the opportunity of improving healthcare delivery to citizens of Connecticut. Such a plan will provide an example to address the issues on a federal level.

4) Critics who claim that this new, self-insured risk pool will create a "huge bureaucracy" fail to point out that SustiNet will be a public-private partnership. The governance board will have experts on health economics, health care delivery, Medicaid and HUSKY, along with representatives from the Hospital Association, State Medical Society, Nurses Association, private employers and unions. Additional State Officials will be ex-officio members. The SustiNet Authority will be accountable for outcomes to the Governor, the General Assembly and most importantly the citizens of Connecticut.

5) Critics who say SustiNet is too costly fail to acknowledge that by doing nothing , total health care spending in Connecticut is expected to rise to $26.5 billion in 2016. SustiNet will not only control cost, it will correct "flaws" in the current system, including cost shifts.

Thank you for allowing me to testify before this joint hearing of your three committees. I would be happy to answer any questions.

111 Founders Plaza, Suite 1101, East Hartford, CT 06108-3212
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CONNECTICUT
VOICES
FOR CHILDREN

Testimony Supporting
H.B. 6600: An Act Concerning the Establishment of the Sustinet Plan
Sharon D. Langer
Before the Public Health, Insurance and Real Estate, and Human Services Committees
March 2, 2009

Distinguished Members of the Public Health, Insurance and Real Estate, and Human Services Committees:

I am testifying today on behalf of Connecticut Voices for Children, a research-based public education and advocacy organization that works statewide to promote the well-being of Connecticut's children, youth, and families.

We applaud the Public Health Committee for bringing forward House Bill 6600, AAC the Establishment of the Sustinet Plan (The Plan). This legislation implements the Universal Health Care Foundation of Connecticut's proposal to address the current shortcomings of health care coverage and access in our state.

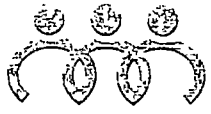
As a member of the HealthFirst Connecticut Authority which recently released its report on moving us toward universal coverage and access, I am heartened that so many of the building blocks contained in the HealthFirst report are reflected in this legislation. Many knowledge individuals and organizations involved in all aspects of the health care system had input into the development of the Plan.

The Plan adheres to the Institute of Medicine principles for health care reform. In addition, it provides for a health insurance connector and independent oversight body. As we have often stated, HUSKY and Medicaid must be part of the foundation of any health care reform proposal. This legislation builds on and improves our HUSKY program by raising the income limits for family coverage and gradually raising the fees paid to providers in order to increase access. The Plan seeks to reach and enroll individuals in health care coverage options through a variety of important new mechanisms.

As the federal government moves forward with reform on the national level, this plan can serve as a model for nationwide change.

Thank you very much for this opportunity to testify in support of House Bill 6600.

33 Whitney Avenue • New Haven, CT 06510 • Phone 203-498-4240 • Fax 203-498-4242
53 Oak Street, Suite 15 • Hartford, CT 06106 • Phone 860-548-1661 • Fax 860-548-1783
Web Site. www.ctkidslink.org
E-mail voices@ctkidslink.org



CONNECTICUT CENTER
FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT

Senator Harris, Representative Ritter, and distinguished members of the Public Health Committee

Hello. My name is Susan Manganello. I am currently Vice President of the Board of Directors of the CT. Center for Patient Safety. My daughter Jennifer died in 2005 a result of medical error and neglect. I spent 7 years advocating for her health care needs and she still fell victim to a continuous web of medical mishaps. Doctors and other health care providers need to have accountability for their actions.

I am here today in opposition to Section 7 of bill 6600.

My daughter Jennifer became significantly disabled following a spinal fusion seven years ago. She was fifteen years old at the time and lived the last years increasingly disabled, a prisoner in her own body. As a result of her surgery she became primarily wheelchair bound and had very little endurance. or strength.

Secondary to the nerve damage along the thoracic and lumbar region of her spine, she suffered from a neurogenic bladder, chronic and recurrent urinary inflections and reflux from high pressure into the kidneys. Complications intensified and she was diagnosed with end-stage kidney disease. She required regular kidney dialysis and she did not tolerate the dialysis.

Since her original surgery, she had many multiple hospital stays from urinary tract infections, fractured hips, dialysis complications and two hospital stays were for suicidal depressions. There was no escape. Never to run again, work after school, never mind attending school on a regular basis. Who can put a value on that?

She could not work nor live independently. She felt she was a burden to our family and loved ones. Jennifer would see her siblings planning activities with friends and feel lonely and sad. She never had a choice for a normal life. She had to live every day fighting to stay alive.

Our healthcare system needs to be held accountable for the "care" it provides. I am here representing all of our members' constitutional right to our court system.

Where in this section of the bill is there any accountability for mistakes so horrible that a victim and his family's life are changed forever?

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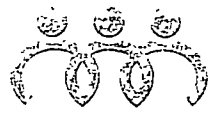

CONNECTICUT CENTER
FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT

Testimony
Public Health, March 2, 2009

HB 6600

Senator Harris, Representative Ritter and members of the committees

My name is Bill Tyra and I live in Trumbull. I am a retired Marine pilot and currently work with American Airlines. And most important, I am the father of a child who died in a hospital due to malpractice and to negligence. What I uncovered was cover-ups, lies and indifference to our needs and I now have great concern about the system that is in place.

I am here today to strongly object to section F in the SustiNet Bill. In one paragraph you are taking away the only course of action that is available to the consumer who is harmed. It is deeply troubling that this bill so cavalierly disregards the eighteen month study done by the HealthFirst Authority and its recommendations.

Hospitals and doctors are ill prepared to investigate the quality of medical care and demand accountability in complex events. The problems are systemic and are pervasive.

What doctors and hospitals quietly ignore is that the underlying source of the malpractice is indeed, malpractice. Every study on medical malpractice reaches the same conclusion: Preventable medical mistakes kill 100,000 Americans each year. That is more deaths than the US suffered in both the Vietnam and Korean wars. And in these same studies, it is also suggested that the actual number is much higher because many errors go simply unreported.

What this bill says is that just because a doctor is participating in the SustiNet plan, he or she is no longer accountable to the patient. That is simply outrageous and I am certain an oversight. In one paragraph, an individual's access to our courts, as so clearly written in our Constitution, is denied.

As a pilot, may I remind you that the numbers of individuals who die each day from medical error, negligence, and misdiagnosis are equal to a jumbo jet crashing for every day – all 365 days of the year. Medicine needs to do what aviation has done. Bring in outside and independently funded experts to analyze the problem and then demand change.

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Testimony on behalf of HB6600

Contact: Lesley Mills, Director/Owner
203 882-0831

I am here to support Sustinet as a health insurance model because I own a homecare company with up to 500 employees who often float between the needs of elderly clients who contract with different employers. As such, it is impossible for one employer to cover them. I attach for you a diagram of where the money goes in our company. In order to offer the best caregivers, we spend 73% of our fees on the caregiver as opposed to the industry standard. By looking at our mission of a 1% profit margin, you will see that there is no where for health insurance premiums to go other than directly to the elders receiving care. Sustinet offers a method that is outside the traditional employer model.

But perhaps **my value today is to offer some history that puts Sustinet in good company**. Once upon a time, long, long ago (that would be 1970) in a foreign land far, far away (that would be in the bowels of Yale research) an unlikely cast of odd characters came together. There was the wizened male nurse, a professor at the School of Epidemiology and Public Health (John D. Thompson); There was the tenured professor of Administrative Sciences – the forerunner of Organization and Management - (Bob Fetter). Enter the young Ph.D. student who possessed the talent to create computer languages that would allow statisticians AND doctors to study millions of patient records, the first "on-line" interactive analysis. (Ron Mills).
And his English wife who knew enough about medicine, statistics and computer science to be dangerous but her sole talent was the ability to translate their findings into her native tongue so that others could grok it. (That would be me) To grok is to share the same reality or line of thinking with another, from Robert Heinlein's best-selling 1961 book, Stranger in a Strange Land. I'm here today for you to grok this concept of Sustinet.

We worked for 3 years before coining the phrase Diagnosis Related Groups (DRGs) to describe what we thought would be a more rational way to predict the costs of, and reimburse hospitals for, treating Medicare patients. It took another seven years before the methodology went nationwide in 1981, determining the way in which hospitals have been reimbursed for Medicare patients for 28 years.
At a time when hospitals had always been reimbursed based primarily on the length of stay of each patient, the concept of defining different classes of patients for different reimbursement was revolutionary. It was also, to some, heresy.

There are many similarities between DRGs and Sustinet: both have overcome similar challenges in the complexity and scale of the problem; both have relied on the union of comprehensive economic and medical analysis; both offer opportunities in the improvement of quality beyond the presented problems of economy and fairness.

First, with Sustinet, there is the thoroughness of defining the problem. Over the last several years, the Universal Health Care Foundation has done a magnificent job of coordinating research by slicing through all the strata of every

sphere that had vested interest in health care. Employers of all sizes, industry types and seasonality were considered. Employees were included if they were on payroll or independent contractors, if they were full time, part time or unemployed, if they were native born or immigrant, English speakers or not. The needs of societal tribes were considered if they were heads of households, stay-at-home parents, dependent children, youths on college campuses or on the streets, our financially and physically independent elders or our frail and institutionalized elderly poor. And the health of the market players was taken into account whether they were providers, insurers or sales people.

Second, the presented solution was not developed by a political committee looking to solve some problems while protecting vested interests. Instead, the Foundation conducted its own research on advisors and selected two with deep working knowledge of the field: Stan Dorn. J.D., of the Urban Institute, and Jonathan Gruber. Ph.D., of MIT. The expertise of these men represents all the constituents, from government payors to self-payors, from the high tax bracket citizen to the uninsured child.

Third, Sustinet becomes economically viable as other vital changes to the health care delivery system are developed. Just as the advent of DRGs drove the improvement in the collection of medical records, so Sustinet requires a "medical home" for each person. This 'medical home' aggregates patient data across providers and payors providing rich opportunity to eliminate wasteful duplicative diagnostic testing while simultaneously providing opportunity for enhanced diagnosis. The scale of the 'medical home' for all patients allows Sustinet to take advantage of current and advancing technologies in data storage and manipulation. By comparison, the present state of dispersed medical data is woefully inadequate and more expensive.

Fourth, Diagnosis Related Groups offered many opportunities for analysis that resulted in better cost management *and* improved quality of care. For example, prior to 1981, the DRG for Acute Myocardial Infarction – heart attack – showed a highly consistent 21 day length of stay. Analysis of that DRG soon showed that there was little to no difference in outcomes for those patients who stayed 10 days or 30 days. Additionally, it was soon shown that those hospitals providing the greatest number of bypass surgeries had the most positive outcomes. A significant component of Sustinet is the requirement that all public and private insurors provide patient based anonymous data showing services, outcomes, quality of care and satisfaction. I look forward to the wealth of systemic improvement that this opportunity provides.

Finally, just as it made sense that there should be more than simply surgical or non-surgical patients for reimbursement, so it makes economic and ethical sense that all people should be afforded healthcare. And it makes sense that this care should be monitored from a central "medical home" that does not change due to age, or job change or insuror. Research has shown that the advent of DRGs has extended the Medicare Trust Fund by 18 years. I have confidence that a national Sustinet model with its underlying economics will yield an equally successful outcome if we provide the mandate. The DRGs were developed here but first tested in New Jersey. Let us be able to say, 28 years from now, that Sustinet was developed *and* tested in Connecticut.

CAHS

The Connecticut Association for Human Services
110 Bartholomew Avenue · Suite 4030
Hartford, Connecticut 06106
www.cahs.org

Michael Rhode, President
James P. Horan Executive Director
860.951.2212 x 235
860 951.6511 fax

Testimony before the Public Health, Human Services,
and Insurance and Real Estate Committees
Re: H.B. 6600 – An Act Concerning the Establishment of the SustiNet Plan
H.B. 6582 – An Act Concerning the Connecticut Healthcare Partnership
Submitted by Maggie Adair, Policy Director
Connecticut Association for Human Services
March 2, 2009

SB988

Good afternoon, members of the Human Services, Public Health, and Insurance and Real Estate Committees. I am Maggie Adair, Policy Director of the Connecticut Association for Human Services (CAHS). CAHS is a statewide nonprofit organization that works to end poverty and to engage, equip, and empower all families in Connecticut to build a secure future.

Faced with a precipitous drop in state revenue and a budget deficit in the billions, policymakers must now make difficult decisions. CAHS believes that Connecticut's policy leaders should take the long view on priorities, preserving the integrity of programs and policies that support children, families, and the well-being of the state. One of the largest priorities is fixing a broken health care system to ensure that all Connecticut residents have access to comprehensive, affordable, quality health care. Health care reform is critical to the future of our economy. We cannot afford not to fix it.

CAHS is testifying in support of **H.B. 6600 – an Act Concerning the Establishment of the SustiNet Plan.** We also support two other bills that you have heard earlier today, including **H.B. 6582 –An Act Concerning the Healthcare Partnership.** We commend Speaker of the House Chris Donovan for his leadership role in his efforts to make health care more accessible and affordable for municipalities, nonprofits, and small businesses. CAHS has testified and spoken publicly in support of the pooling proposal in the past, and we see the Speaker's work on this issue as critical in moving toward broader health care reform.

Many of the bills that you have heard today address pieces of the health care puzzle. **The SustiNet plan, detailed in H.B. 6600, is the most complete Connecticut-specific plan for universal health care ever presented to the Legislature.** SustiNet is the product of the best thinking of experts and the combined ideas of many stakeholders. We applaud the Universal Health Care Foundation of Connecticut for its leadership, tenacity, and vision in producing the SustiNet plan. **Connecticut must not shrink from this challenge and this great opportunity.**

SustiNet offers a high-quality health insurance plan that promotes healthy competition in the marketplace through new choices, and a new level of accountability and transparency. It invests heavily in evidence-based prevention strategies to keep people healthy, lower costs, and promote sustainability of the health care system. SustiNet addresses the uninsured and underinsured. It addresses inefficiencies, employs best practices that tackle care coordination and communication, and ultimately keep us healthier and saves us all money.

As advocates for low-income children and families, CAHS is very pleased with SustiNet's plan to improve health care access and quality to families on HUSKY and individuals on State Administered General Assistance (SAGA). More low-income people will be able to see a doctor and get the care they need, because once reimbursement rates rise, more doctors will take HUSKY and SAGA clients.

SustiNet proposes smart and logical ideas. For example, every person would have a medical home. What this means is one medical professional would manage a person's health care needs. Having a medical home would result in better coordination, avoid duplication of service, ensure appropriate care, and eliminate wasted health-care dollars. As another example, the plan implements universal health information technology. Health care records of one patient would be located in one central location, so different medical providers could see the entire scope of a person's health care history and needs.

A cornerstone of SustiNet is the creation of a large pool to create a critical mass of people, thus creating leverage and lowering cost. The pooling concept has opponents, many from the business community. Pooling exists in the private market place. Why can't it exist in a quality public health insurance plan?

Another key feature about SustiNet is choice. There is no mandate to participate in SustiNet. Workers can choose to remain with their current employer-sponsored health care plan. Businesses can choose to offer their current plan or they can choose to join the SustiNet plan. CAHS thinks expansion of choice in the health care system is a good thing. **Choice is healthy for the market place.**

Some will oppose SustiNet based on cost. Experts estimate that implementation of SustiNet by 2014 will cost the state $950 million. **We cannot afford not to invest $950 million in health care reform. Why?**

- With SustiNet fully in place by 2014, 98 percent of Connecticut residents will have quality health care coverage.
- No one will ever have to worry about losing health insurance.
- Medicaid/HUSKY reimbursements will rise to commercial levels, which mean more doctors will participate in the program and more low-income people will have access to good care.
- As a result of expanding Medicaid and HUSKY, Connecticut will receive an extra $800 million in federal matching funds – that's $800 million more pumped into the economy.
- One bill before you today, **S.B. 988 – An Act Concerning Medicaid Funding for SAGA and Charter Oak,** would bring in some of that $800 million in federal matching funds by moving SAGA and Charter Oak under Medicaid. By moving the SAGA program under Medicaid, SAGA clients would have greater access to care and would receive more comprehensive health services.
- And it's estimated that employers and residents save $1.7 billion in health care costs.

The current health care system is not sustainable. The ranks of the uninsured and underinsured continue to grow. Businesses are heavily burdened by the rising cost of providing health care coverage to their employees. Increasingly, small businesses are unable to provide health care coverage because they simply cannot afford it. As access to quality health care narrows, more and more people are not getting the health care they need, and they are getting sicker and sicker. As a result, the cost of treating much more serious conditions is going up. The health system is a drag on the economy and a drag on our people.

Just days ago, President Obama shared with the nation his commitment to reforming health care in America. His plan to build up a $634 billion reserve fund for health care reform provides an opportunity here in Connecticut. Because of the work of national experts and the commitment by the Universal Health Care Foundation, Connecticut is ahead of the curve in the movement to build a new health care system. **We have the opportunity to provide the roadmap through SustiNet that can guide health care reform efforts at the national level.** Connecticut has a great opportunity and it's critical that we do not pass it by. We cannot afford not to do this. Our people and our economy depend on it. **SustiNet is smart, it's right, and it's time.**

Thank you for giving me the opportunity to testify today.

March 2, 2009
Public Health Committee

HB 6600

Senator Harris, Representative Ritter and distinguished members of the Public Health Committee

My name is Rebecca Ball and I am here today to ask that you do not support section 7 of the SustiNet bill.

In one paragraph, it removes a constitutional right – the right of every citizen to have access to our courts.

Ten years ago, my son, Zack's life changed forever...and so did mine. My son's neck was broken in a tragic head on collision. He was sent to three different hospitals in one day and discharged and sent home three days after the accident. We were told he would make a full recovery. He would be that happy, bouncing two year old once again despite having to wear a halo on his head.

But he wasn't responding – I knew my child and they didn't. I trusted the doctors as we all do so I thought I should wait as they told me to do. The real tragedy that still haunts me as a mother is that all of the health care professionals missed the spinal cord injury that could have caused his death, but has left him paralyzed from the chest down. They did not do a simple Full MRI despite warning signs that should have warranted investigation into the initial diagnosis. Calls were made to doctors, calls were not returned. A nurse called the doctor, and her phone call was unanswered.

A slow progression of a hematoma that had formed on his spinal cord cut off his blood supply and oxygen to the cord. That in turn killed the nerves and caused his paralysis.

"Your son will most likely never walk again" will burn forever in my heart because I felt the loss of the child I knew. No child should have to endure what Zack has because of other's negligence.

The thought of a law suit was very scary to me and it became part of the nightmare. His medical debt rose to over $1,000,000 in a nine year period. We finally settled out of court and that debt was repaid. That settlement has allowed the handicapped accessibility to our home that improves the quality of his life and the life of my entire family. I worry every day about Zack but the financial strain and anxiety has mitigated. You should know that the minute anything is labeled handicapped, it comes with an enormous price tag. Capping non economic damages in Zack's case would have been disastrous.

The courts are our only access to justice. Your job needs to be improving our health care system to better protect patients from becoming victims. My job continues to be taking care and loving my son Zack A sign hangs above his bedroom door that I believe to be true. "It's Never Too Late to Be What You Might Have Been." This is the hope we all hang on to. His life has been improved because he was able to sue and was compensated for others' errors.

Voting against section 7 of the proposed Bill 6600 will help preserve the rights of those who will follow my son. We need to keep in mind holding doctors accountable for their devastating mistakes is one of the key components to bringing awareness to the flaws in the medical system. Only then does that force doctors and hospitals alike to review their protocols in the treatment of patients and make changes to prevent further medical malpractice. These doctors are committing crimes against others that many feel with this proposal should go ignored. They get to continue practicing medicine while my son will never walk again. Are you willing to turn the other cheek and deny others their right to justice?? I believe you would feel otherwise if you or your loved one, fell victim at their negligent hands.

HB 6600

Hello! My name is Melissa Karvelis. I am the mother of 4 children and have had the range of insurance situations. I firmly believe that every resident of the state of CT should have quality, affordable health care. We have always been considered the insurance capital of the world. Sustinet can be a model to other states and to the federal government as a universal healthcare policy that can and will work. Sustinet provides a peace of mind for its clients that has not been available before. This policy aims to keep us healthy and get us restored to health when we are sick.

Until May of 2008, I had employee-sponsored health care through my husband's job. He lost his job at the end of May and our benefits ended at that time. While on this insurance, our share of the monthly coverage was almost $400 per month and what it provided was minimal at best. We had a co-pay of $25 per visit - with 4 children that meant $100 a pop when someone got sick. We had a deductible of $900 for the first person and then an addition $900 for the combination of the rest of the family and an 80/20 split for any covered hospital stay. This made for touch decisions when the coverage was needed. There were many instances where I had to figure out how to purchase a necessary prescription and still buy food for breakfast the next day.

When my husband lost his job, I had no idea what I was going to do.. I always knew about the HUSKY program but never thought I would need it. Boy was I glad that it was there when I needed it. Though I have learned that navigating the system was not as easy as it should be and there were not nearly as many providers as I thought there might be to serve the clientele. With all of the recent changes, finding a doctor has been even more difficult and the member handbooks and websites don't always match which makes for more confusion and stress. Thankfully for the time I have been on HUSKY I have not needed to use it much but that doesn't make me any less thankful to have it. The changes that have been proposed scare me as they will make it even more difficult to receive care.

Finding out about Sustinet and what it will do for CT residents has given me a glimmer of hope but I depend on you, our legislators, to make the right decision. Right now there is a very skewed health care system. It is tiered and that is not fair to anyone. There is no reason in a state that consistently ranks in the top 3 wealthiest in the country that we should have residents who do not know how or where they will be able to obtain the healthcare that they will need. In my mind, access to quality, affordable health care is a right not a privilege. We should all be able to obtain the health care necessary to maintain our health. Keeping CT residents healthy is far cheaper than letting them get sick, especially when we can not or do not feel able to obtain services until we wind up in the emergency room.

I hope that you, MY legislators, will see the importance of this legislation to all the residents of this fine state. I pray that you will follow your conscience in this and remember that we are ALL entitled to quality, affordable health care. Please give us all that peace of mind.

Thank you for your time.

Melissa Karvelis
64 Michael Ave.
East Hartford CT 06108
extremeocean@hotmail.com
860-930-5409

HB 6600

Kathleen Nustri

CONNECTICUT
TRIAL LAWYERS
ASSOCIATION

CTLA . 100 Wells Street, Suite 2H. Hartford, CT 06103
Phone: (860) 522-4345 . Fax: (860) 522-1027
www.ct-tla.org

Raised Bill 6600
Public Hearing 3/2/09

TO: **MEMBERS OF THE PUBLIC HEALTH COMMITTEE**

FROM: **CONNECTICUT TRIAL LAWYERS ASSOCIATION**
DATE: **MARCH 2, 2007**

RE: **RAISED BILL 6600 – AN ACT CONCERNING THE ESTATBLISHMENT OF THE SUSTINET PLAN**

While the Connecticut Trial Lawyers Association (CTLA) fully supports the goal of expanding access to quality health care, it is disappointed that the SustiNet plan's authors have failed to follow the example of the HealthFirst Connecticut Authority (HealthFirst), which, insofar as it addressed medical liability issues, focused on measures which increase patient safety. In contrast, the authors of the SustiNet plan, the Universal Healthcare Foundation, have created unprecedented special rights and immunities for physicians and hospitals, which will do great harm to those Connecticut citizens who suffer injuries as a result of negligent medical care. Section 7(c) of the Raised Bill completely undermines the goal of increasing access to quality health care by putting the goal of immunizing negligent medical care before that of increasing patient safety. CTLA completely rejects the premise that health care providers should be afforded special rights for merely doing what is in their patients' best interest.

Section 7 of Raised Bill 6600 contains eight subsections, seven of which describe mechanisms for the development of "recommended clinical care and safety guidelines." All eight, with the exception of Section 7(c), are consistent with the recommendations contained within the HeathFirst draft report, wherein "the Authority recommends at this time that greater emphasis be placed on improving safety and the reduction of medical injury" See, Draft Report at page 35. Any attempt at health care reform should have as its central goal an effort to avoid medical errors, as "over 75,000 people die every year from medical malpractice, more than the total number of deaths from automobile and workplace accidents combined." Baker, Tom, Journal of Law, Medicine & Ethics, "Reconsidering the Harvard Medical Practice Study conclusions about the validity of medical malpractice claims." Sept. 22, 2005.

Increasing patient safety should be the one goal that all sides of the healthcare debate can unify around and the development of "clinical care and safety guidelines" could have such an effect. Unfortunately, the SustiNet plan attempts to take away the rights of Connecticut citizens, injured or killed by negligent medical care, by allowing an appointed Board, rather than a court or jury, to determine if medical care was negligent under all of the applicable circumstances.

To the extent such clinical guidelines exist and/or could be developed, CTLA believes that physicians and hospitals should adopt them immediately. Health care providers should do so because they believe that such guidelines improve patient safety and outcomes. However, guidelines should NOT be adopted in order to create special rights and immunities for health care providers. As written, Section 7(c) of the

Raised Bill would lead to guidelines of the latter type, as the section provides health care providers with immunity from suit when they follow an applicable guideline. Given this section, the "health care provider committee" would have every incentive to create broad, general guidelines which could be used a defense to even the most meritorious medical malpractice action. Such guidelines are all too common these days when medical societies such as the American College of Obstetrics and Gynocology have produced numerous "guidelines" which contradict well established medical authorities in an effort to insulate its members from liability.

Moreover, Section 7(c) of the Raised Bill contains no estimate of the cost of the "no fault" system it proposes to the State of Connecticut. According to every estimate, a "no fault" system which compensates patients injured by medical malpractice will either, (1) cost far more than the current system where negligent physicians must be proven liable in court; or (2) unfairly harm the patients who are most seriously injured by negligent medical care.

Insofar as any universal health care proposal encourages the adoption of best practice guidelines, health care providers should be encouraged to follow such measures. CTLA submits that a law which created a presumption of negligence would create a far greater incentive to follow an applicable guidelines than the provision of an unprecedently legal immunity.

In conclusion, CTLA would submit that HealthFirst has addressed the issue of patient safety in way that is much more consistent with the goals of increasing the availability of quality medical care than this Raised Bill and would urge the Committee to reject any bill which includes a provision like Section 7(c).

Thank you.

National Association of Social Workers / Connecticut Chapter

2139 Silas Deane Highway
Suite 205
Rocky Hill, CT 06067
(860) 257-8066 • (860) 257-8074 FAX

Sherry Ostrout, MSW, CMC President
Stephen A Karp MSW Executive Director
naswct@conversent net
www naswct org

Testimony on Raised H.B. No. 6600
An Act Concerning The Establishment Of The SustiNet Plan
Public Health, Human Services, Insurance and Real Estate Committees
March 2, 2009
Submitted by: Mary Jane Lundgren, RN, MSW

Members of the Public Health, Human Services, Insurance and Real Estate Committees.

I am here today on behalf of the National Association of Social Workers Connecticut Chapter. We believe that it is morally and fiscally imperative that every resident of Connecticut should have equal, comprehensive and affordable access to health care. With the current national, state and world economic crisis, the numbers of uninsured (currently 50 Million) will be exploding. Along with the current cost of health care, Connecticut employers, private payers, and the State are approaching the crisis stage. While the United States spends far more per person on health care than any other country (75% more than Canada or France), we have the distinction of higher infant mortality and substantially lower life expectancy. The current health care system is on the brink of disaster. The State of Connecticut can no longer deny or delay the need for a more comprehensive, universal health plan for all residents. Piecemeal reform will be more expensive and will not provide adequate coverage for all residents. Toward that end, we strongly urge you to support the establishment of the SustiNet Plan.

The SustiNet Plan is comprehensive, inclusive, sustainable and economical. We have known for far too long that our current system is financially burdensome. Yet, we have continued to allow health care costs to spiral out of control. This results in many Connecticut residents being either uninsured or underinsured. By leveraging the purchasing power of the state, SustiNet is designed to reduce costs and improve health care. Employers will pay more affordable premiums for their employees. Households will have lower

personal health care costs. Fewer uninsured and higher payment rates to providers will reduce the cost shift to private insurers.

Using Connecticut taxpayers dollars, SustiNet merges state employees and retirees with HUSKY and SAGA participants into a self-insured pool. Self employed individuals, municipalities, sole proprietors, small businesses, and non-profits are allowed to join.

Under this plan, all Connecticut residents will have access to their choice of high quality health coverage and health care. No resident will be denied care because of pre-existing conditions. Mental health, dental care coverage and medical home services are included. Most importantly, premiums and co-pays are subsidized based on income. Many Connecticut lower income residents on HUSKY have been denied care by providers due to lower reimbursements. Under SustiNet, these providers will receive a fair compensation for the care they provide. The elimination of racial and ethnic disparities in health care will be a moral and economic bonus for Connecticut. Focusing on illness and disease prevention, a healthy population will enhance job productivity and creativity. Our students will be able to maximize their educational experience and enable Connecticut to compete in the global economy.

Connecticut has a unique opportunity to be a leader in the United States. Our leadership on this issue will resonate across the country. The current health care system is in grave danger of collapsing. The burgeoning numbers of uninsured will overwhelm the system. SustiNet gives us the solution to the health care crisis that faces Connecticut and the Nation. Universal Health Care time has come and the Connecticut Chapter of NASW will not rest until the Legislature approves this plan. There is no turning back on this issue. We need to join the ranks of all the other industrialized nations in the world and provide universal health care for all our residents!

Submitted by: Mary Jane Lundgren, RN, MSW, Chair NASW/CT PACE
89 Cherniske Road
New Milford, CT 06776
860-354-6757

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TESTIMONY BEFORE THE PUBLIC HEALTH, INSURANCE & REAL ESTATE AND HUMAN SERVICES COMMITTEES REGARDING **H.B. 6600** -
AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN

March 2, 2009

Co-Chairs and members of the Public Health, Insurance & Real Estate and Human Services Committees, my name is Brian Ellsworth and I am President & CEO of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens. The Association is pleased to provide comments on H.B. 6600, which proposes to establish the Sustinet Plan.

The Association commends the authors of this proposal for their thoughtful approach to the vexing issue of providing comprehensive and cost effective health insurance option. The Association wishes to briefly highlight several issues raised by the Sustinet proposal.

First, we are very pleased to see that the "minimum standard benefits package" includes home health and hospice services. These are important cornerstones of any insurance plan. Both home health and hospice care have been repeatedly found to be cost effective and are strongly desired by the general public.

Section 6 of the bill introduces the concept of a "**medical home**," with priority implementation for those enrollees that are **chronically ill**. The medical homes will focus on assisting chronically ill enrollees with self-management, provide care coordination across settings and be accessible on a 24-hour basis. These concepts are not new for home care and hospice providers...in fact we have been providing a "medical home" for patients in their own homes for many years. The Association strongly encourages the General Assembly to ensure that there is a central role for home health agencies in any health insurance reform approach that adopts a medical home model.

110 Barnes Road | Wallingford, CT. P O Box 90 | 06492-0090 | Phone 203.265 9931 | Fax 203.949 0031 | www.cahch.org

Section 5 of the bill discusses interoperable health information technology and section 8 focuses on prevention. The Association is hopeful that a properly structured health reform plan would motivate the widespread adoption of home-based **telemonitors** for chronically ill persons and increase rates of **immunization** of enrollees. Home health agencies have been successful in applying these prevention strategies to Medicare patients, but we have encountered roadblocks in the form of coverage limitations when attempting to do so for Medicaid patients.

Finally, we were pleased to learn that the Sustinet Plan intends to bring provider rates up to "market levels." Commercial insurers and the Medicaid program are both notoriously low payers for home health care, necessitating that such care be subsidized from other sources – primarily the Medicare program. The penny-wise, pound-foolish practice of **inadequate reimbursement** by insurers and the State results missed opportunities for even bigger savings and enhancements to enrollees' quality of life and should be ended in any comprehensive health reform plan.

CAHCH appreciates this opportunity to provide brief comments to the General Assembly as it embarks on a process of reforming the health care system. We are ready to provide assistance and further detailed comments as the process unfolds.

Thank you.

110 Barnes Road | Wallingford, CT. P O Box 90 | 06492-0090 | Phone 203.265.9931 | Fax 203 949 0031 | www.cahch.org

National Association of Social Workers / Connecticut Chapter

2139 Silas Deane Highway
Suite 205
Rocky Hill, CT 06067
(860) 257-8066 • (860) 257-8074 FAX

Sherry Ostrout, MSW CMC, President
Stephen A Karp MSW, Executive Director
naswct@conversent net
www naswct org

Testimony on Bill 6600: AAC The Establishment of the SustiNet Plan

HB6582

March 2, 2009
Presented By: Stephen A. Karp, MSW

The National Association of Social Workers, Connecticut Chapter supports Raised Bill 6600, that will create the SustiNet Plan, a comprehensive approach to health care coverage for Connecticut residents.

Over the years the Legislature has struggled to address ways to cover the uninsured, provide access to care to Connecticut's residents, assure quality health care, make health care affordable, have health care coverage that is comprehensive, expand preventive care, offer portability of benefits, and eliminate disparities in health care delivery. Until now, attempts to achieve these goals, while often commendable, have come through incremental steps that only address a piece of the health care system. Even today we see bills being debated that take this piece meal approach. It is finally time to admit that incrementalism and tinkering around the edges has failed. The health care system in Connecticut remains fragmented, with high numbers of uninsured and untold numbers of underinsured. SustiNet is the most comprehensive proposal we have seen to date that addresses issues of affordability, access, universality, quality, comprehensive coverage, and racial and economic disparities.

Part of what we find particularly appealing about SustiNet is that it builds a new health care plan using a self-insured pool approach to comprehensive and affordable health care. This approach does not replace current insurers, but rather enhances market place competition. At the same time, SustiNet goes beyond just health care insurance, by moving us toward a system of health care that will ultimately be a model for rebuilding health care delivery in Connecticut. It should also tie in nicely with potential federal reforms, while not waiting for the long promised but not delivered federal action.

Besides our support of SustiNet from a policy perspective, NASW/CT, as a small non-profit business sees SustiNet as great option for our organization's employee health care coverage and an opportunity for affordable coverage for many of our members who are in independent practice without spouse or family coverage.

NASW/CT does not only politically support comprehensive health care coverage we "walk the talk" by offering our employees such coverage. At this time, the chapter pays 85% of the premium for the employee's medical coverage and 100% of the dental premium. This commitment is not however without a financial struggle. As a small group we are rated by gender and age and this year saw a 42% increase largely due to one employee entering a new age bracket. This forced us to switch to a plan that quadrupled the employee's deductible for

hospitalization and even then we still had a 28% increase in premiums. Our health care costs have limited employee salaries over the past few years and continued increases will eventually force us to pass along a greater share of the premiums to employees. With SustiNet we will have a have a health insurance pool that we believe will reduce our insurance costs, allowing us to improve salaries and have funds to expand members programs and services. We note that HB: 6582 also offers small non-profit businesses such as ours the opportunity for joining a health care pool, which we feel must be part of the solution to affordability for small businesses.

As for our hundreds of members who are independent practitioners, many of them find themselves without any choice but to move into the individual insurance market, where coverage is often limited, very expensive (especially for social workers who are not making huge salaries) and for those with pre-existing conditions finding insurance coverage is nearly impossible. These independent practitioners, be they in solo practice or a group practice, are by definition small employers that would be eligible for SustiNet coverage.

Finally, as an organization that represents social workers, the profession that provides approximately two-thirds of all mental health services in Connecticut, we support SustiNet for its inclusion of mental health coverage. Recognizing the mind/body connections in health care is essential to the delivery of complete and holistic health care services.

We urge the Legislature to pass Bill 6600 this year so that we can begin the process of creating an interconnected health care system in Connecticut.

Bill 6600: An Act Concerning the Establishment of the SustiNet Plan

Sarah Guggino: Graduate student at the University of Connecticut, Department of Public Policy, Master's of Public Administration

March 2, 2008

Honorable Senators and Representatives:

I very strongly support this legislation and I urge you to support it. It is crucial for you, for me, and for everyone in Connecticut.

I grew up in a family that had very poor and unreliable health insurance. My father was a small business owner with a serious medical condition. My younger sister was diagnosed with cancer at 2 years old.

Because of the financial impact of our medical bills, my parents struggled all through my childhood and adolescence to provide for us. Growing up, there were years when things were so bad that I hardly slept at night. I was constantly worrying about what would happen to my father and my family if he were to get sick. My parents bickered incessantly. Each fight stemmed from the same issue—poor health care and endless medical bills.

Worries about inadequate health care and unpaid medical bills can have a dramatic effect on the happiness and healthiness of an entire family, young and old. As a 10 year girl, I was overly aware of the harsh realities of our lives - more than any 10 year old ever should be. Children are not blind to their parents' struggles.

I grew up much too quickly.

This May I will graduate from UConn. Right now, I am extremely fortunate to have good health insurance for the first time in years through my position as a graduate assistant. Months away from graduation, I should be excited about what comes next in my life. Instead, I am just worried. Worried about losing my insurance. Worried about losing what I have.

The job market is in disarray, the economy a disaster. Yes, I am young and healthy, but I recently learned that I have a health condition that needs to be monitored. Had I not had insurance, I would never have known about this condition. If I don't have coverage after graduation, and I can't scrape together the cash for regular checkups, I could face serious health repercussions in my future.

Unfortunately, this is the very harsh reality for young adults in Connecticut. Young people are already leaving the state at an alarming rate in search of jobs – further damaging Connecticut's tax revenues.

So give me and my generation a reason to stay in Connecticut. Make us feel safe and secure enough to *take* that first job, to *buy* that first car, to start *saving* for that first condo – or even for that *new business* we have dreamed about.

SustiNet can be the reason for us to choose Connecticut. It will give us peace of mind by providing quality, affordable health care coverage if we're in between jobs or in between school and a job.

I understand your concerns. My education here has trained to think about the costs and benefits associated with policies. This is tough and Connecticut's budget is grossly exhausted.

But SustiNet is sustainable and will lead to cost savings.

Think about the concept of preventative care with respect to my situation. If I did not have health insurance right now, I would not be receiving the care I'm getting. A few years down the road, I may discover - too late - that I have cancer. At that point, the only option I would have is to receive extremely costly treatment. I would risk indebting both myself and my family beyond our ability to pay. I might end up further indebting the hospital or medical offices that help me.

My point is this: The *health care crisis is only going to worsen unless significant action is taken now* If we continue to wait to address this problem, we are going to end up spending more money than we ever thought possible.

Modern medicine teaches us that we can get sick because we are stressed But we are stressed because we don't know what to do when we get sick. Please, think for a moment about what *you* would do if you were to lose your next election. Would you lose health insurance? How easy and affordable would it be for you and your family to get insurance elsewhere?

Think about your children, and all of the children of Connecticut. We are talking about saving their lives.

SustiNet is the best, most complete piece of health care reform legislation this committee or the state of Connecticut will see this year. We could be at the national forefront of innovation in health care. We need to break away from the shortsightedness that put us in this mess in the first place. SustiNet is smart, it's right, and we need it now.

Honorable Senators and Representatives,

My name is Marybeth McNamara. I am a proud graduate student at the University Of Connecticut School Of Social Work.

I am here today to testify on Bill number 6600, "An Act Concerning the Establishment of the SustiNet Plan." I am in favor of this legislation and strongly encourage you to support it.

I am so very lucky to sit before you tonight because it was access to quality health care that held my family together and saved my life.

Eight years ago, I became very ill and was admitted to the hospital. Fourteen days into my hospital stay, I was diagnosed with Crohn's Disease. (For those who are unfamiliar with Crohn's Disease, it is a chronic disease of the digestive system for which there is not yet a cure.) I spent 29 days in the hospital. I was discharged home on more than 30 pills per day for the 3 months following my diagnosis. Thankfully, I was still covered under my parents' health insurance plan during that period.

Now that I am old enough to support myself, my biggest worry is about losing health insurance. I know what it means to have a "pre-existing condition." I can never let my insurance lapse, not even for one day, for fear of never finding quality, affordable care again. Sometimes I feel as if I am being held hostage by the current system.

Thankfully, I am no longer paying 487 dollars per month for COBRA payments because I recently became eligible for coverage through my part-time job at a local grocery store. My number one worry is that after I graduate from UConn I will not be able to find a job that offers health insurance. Access to quality, affordable health care is my number one priority.

I still consider myself lucky. My disease has been in remission for 2 years. I am able to work hard and complete graduate school. However, I never lose sight of how quickly life can change. We are all vulnerable to this issue.

It is an absolute shame that there are people in this country who are losing their homes due to this issue. People's lives hang in the balance as we speak about this today. The people in this state do not deserve to worry about losing their homes while they battle illness.

SustiNet would offer all Connecticut residents the peace of mind they deserve.

That is why we can't keep making excuses. We can't keep telling people they have to wait because in many cases, waiting means getting sicker.

The economic turmoil and poor job market only magnify the issue and reinforce the need for SustiNet. There are people in every town of this state who are looking to you for serious leadership during these difficult times. The nation is watching. Now is the time to prove that you take this issue seriously.

Thank you for your time and I welcome any questions you may have.

Marybeth McNamara
1665 Main St.
Glastonbury, CT 06033

860-986-1886

Testimony of Phil Sherwood
Deputy Director of the
Connecticut Citizen Action Group
March 2, 2009

Good afternoon members of the Insurance & Real Estate, Human Services and Public Health Committees. My name is Phil Sherwood and I am the Deputy Director of the Connecticut Citizen Action Group (CCAG). CCAG has approximately 25,000 members and is currently the state's oldest and largest public interest group. CCAG strongly endorses HB6600 AAC The Establishment Of The Sustinet Plan.

We all know it's getting tougher to get good, affordable health care no matter how hard we work. Even when one takes responsibility for themselves and their families and makes good choices, there is still no guarantee they will have quality, affordable health care that they can count on.

Skyrocketing health care costs are crippling state and local government budgets, stalling job growth, and making it more difficult than ever to afford the health care a family needs while making ends meet. Never has the link between our broken health care system and the economy been more apparent.

A recent health care study showed that health insurance premiums in Connecticut have been increasing more than 8 times faster than wages and every 30 seconds someone else in the United States declares bankruptcy due in part to medical costs.

Too many individuals have been left at the mercy of private insurance companies with no other choice. Sustinet offers comprehensive reform that includes the choice of a public health insurance plan so we're no longer at the mercy of the private insurance industry.

Sustinet is more than another bill name for health care reform. Sustinet establishes a clear set of principles that define quality, affordable health care for all. It recognizes that a critical component to health care reform is having the choice of a public health insurance plan that will guarantee families peace of mind and that is guaranteed to be there when you need it.

Sustinet will establish:
Coverage You Can Afford

- Health coverage that is affordable for every person, family, and business.
- Coverage with premiums and out-of-pocket costs based on your ability to pay.
- Government acts as a watchdog, setting and enforcing rules so private insurance companies can't deny coverage or raise rates based on health history, age, or gender.

Comprehensive Benefits You Can Count On

- Standard, comprehensive health care benefits that meet your needs from preventative to chronic care.
- Low out-of-pocket costs (like co-pays) so you can afford to get medical care when you need it.

Choice of Private or Public Health Insurance Plan

- Keep your current private insurance plan or join a new public health insurance plan.
- The choice of a new public health insurance plan is a guaranteed backup that will always be there to ensure quality, affordable health care coverage no matter what.

Equal Access to Quality Care

- Equity in health care access, treatment, research, and resources to people and communities of color and strengthen health services in low-income communities.

There are some who believe that government should have no role in guaranteeing quality affordable health care and that it should be left to the whims of the private markets. The Sustinet Plan understands the need for individuals to have the choice of a public health insurance plan so that we:

- Have a guaranteed backup that will be there no matter what happens.
- Have guaranteed, standard, comprehensive benefits that meet our needs.
- Can afford health insurance based on our ability to pay.
- No longer have to watch our hard earned money go to paying high CEO salaries and corporate profits.

Rather than government acting as a lap dog when the companies charge whatever they want and drop coverage for those that need it the most, the public expects government to act as a watchdog of the insurance industry.

Private insurance companies have continued to fail consumers. There needs to be another choice. People also know that the insurance companies' huge profits and negative practices, like denying insurance to people with pre-existing conditions, have stifled health care reform. Private insurance companies currently have little incentive to control health care premiums and deductibles, reaping huge profits while working families struggle to pay the bills. A public health insurance plan such as Sustinet that competes directly with private insurers will help control health care costs for Connecticut's families.

Thank you for your time.

Phil Sherwood,
Deputy Director
Connecticut Citizen Action Group

TESTIMONY ON PROPOSED HB 6600.

Mr. Chairman, Honorable Senators and Representatives, fellow Concern Residents of Connecticut: Good afternoon/morning. My name is Samuel Agyei. I am a student of the University Of Connecticut School Of Social Work. I am very honored for the opportunity given to me to testify in support of **HB 6600,** ***AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.***

This plan seeks to guarantee all Connecticut residents access to their choice of high quality health coverage and health care. It also seeks to end worries about losing access to health care during major life transitions like changing jobs, finishing school or starting a new business as well as eliminate racial and ethnic disparities in health care coverage. Lacking health insurance has serious consequences. It is associated with increased severity of illness, increased cost of health care, reduced worker productivity and for, children lower educational attainment. The private and public cost that results from increase number of uninsured residents in Connecticut makes it essentially imperative to support SUSTINET'S plan for universal, affordable and sustainable health care for all residents of Connecticut. According to research by Connecticut Health Policy Project, one in eleven Connecticut residents lacks health coverage risking long term damage to their health and economic well-being. The uninsured often pay the highest prices for their care, full retail prices not the discounted prices HMOs and government pay. Two out of three uninsured adults are workers, this in effect leads to lower worker productivity. The SUSTINET plan is an opportunity for Connecticut to bring cost under control, stimulate our state's economy and serve as a model for the Country. It is a system of continuous, coordinated and efficient service that will make the right amount of health care available to all at the right time. Furthermore **HB 6600** is compatible with national reform plans with places our dear state

at the fore front of states addressing health care issues and makes Connecticut a leader in America's quest for Universal Heath Care.

In conclusion I will like to remind honorable Senators and Representatives that access to quality health care for all is a giant step toward eliminating racial and ethnic health disparities, so I urge you all to support the SUSTINET plan. Please Legislators do no harm by unanimously passing the SUSTINET plan for the state of Connecticut.

I sincerely appreciate the opportunity offered me to testify and express my support for HB 6600.

Thank You.

Testimony of Suzanne Haviland, Health Policy Analyst

American Federation of State, County and Municipal Employees, Council 4
Before the Insurance and Real Estate, Human Services and Public Health Committees
on House Bill 6600, *An Act Concerning the Establishment of the Sustinet Plan.*
March 2, 2009

My name is Suzanne Haviland and I am testifying on behalf of the American Federation of State, County and Municipal Employees (AFSCME) Council 4. In Connecticut, our union represents more than 35,000 state, municipal and private contract public service workers in Council 4, as well as police in Council 15, and health care providers in CT Health Care Associates. AFSCME is the labor representative on the state Health First Authority, is a co-chair of the national AFL-CIO health care campaign and co-founder of Health Care for America NOW! (HCAN).

AFSCME strongly supports the intent of Proposed Bill 6600 to move us towards guaranteed, comprehensive, affordable health care to all residents. Reform proposals must focus on slowing costs for everyone struggling with rising prices, including those who have health insurance. Sustinet goes far towards that goal by creating a public health insurance option with bargaining power and clout. It requires employers to contribute. It prevents cost shifting by expanding existing public program eligibility for uninsured adults. It makes critical system improvements (such as medical homes, focusing on chronic illness, health IT, and auto enrollment). It establishes a floor of benefits and allows workers to enroll in Sustinet if their employer's insurance doesn't meet that floor. It establishes government rules to prevent the private market from ripping us off and denying care.

We are especially pleased with Sustinet's inclusion of a self-insured, public health insurance plan as a choice for all Connecticut residents – building on a pool of public employees and HUSKY enrollees. Pooling risk through a public insurance plan should be an essential component of reform, and the public is on our side. Recent polling has shown that public insurance choice is very popular with the public. Obama's campaign plan has it. The Chair of the US Senate Finance Committee has a plan that includes it. Even the Commonwealth Fund, including representation from GE, Blue Cross Blue Shield of Massachusetts, just came out with a national proposal featuring a choice of a public insurance plan.

HB 6600 is an impressive document. As we move forward this session in the legislative process, some areas for further development include increasing the employer contribution, developing affordability guidelines for higher income folks, and broader patient representation on the Sustinet Board.

Our union understands there is a big cost of doing nothing this year. Most AFSCME members have good benefits, yet they feel the insecurity and system crisis firsthand. They grapple with un-and-underinsured family and friends. They are hurt by the downturn of the economy and attacks on their health benefits, and feel the impact of the cost-shifting onto the public sector that causes job loss and shifts in resources that worsen their working conditions. We cannot afford to wait.

Last week, President Obama made it clear he understands this cost clearly, saying, "The cost of our health care has weighed down our economy and the conscience of our nation long enough . . . we can no longer afford to put health care reform on hold." He allocated a $634 billion fund in his budget for reform, and is moving forward this week with the Health Reform Summit. Yet there is no formal plan for the reform reserve fund, and every idea will be on the table. Connecticut has an opportunity to help lead the nation's choices, and Sustinet can help get us there. Thank you. (end)

AFSCME Council 4, 444 East Main Street, New Britain, CT 06051 (860) 224-4000

160 St Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society Testimony
House Bill 6600 An Act Concerning the Establishment of the Sustinet Plan
March 2, 2009

Senator Harris, Representative Ritter and members of the Public Health Committee, Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, Senator Doyle and Representative Walker and members of the Human Services Committee, my name is Matthew Katz, Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members thank you for the opportunity to testify before you today on **House Bill. 6600, An Act Concerning the Establishment of the SustiNet Plan**

CSMS provides its strong support for the guiding principles of the SustiNet proposal and the associated legislation. CSMS is proud to have provided its assistance in reviewing and evaluating the initial documentation and approaches that have now become the SustiNet proposal.

In 2007, CSMS was one of the first organizations, medical or otherwise, that called for a statewide comprehensive health care system that provides access to affordable quality patient health and medical services. CSMS then and now believes that our health care system needs to be reformed and that such reform must provide for greater access to medical care for ALL state residents; must be based on scientific evidence and ensure quality medical care is delivered; must be based on transparent information associated with how care is delivered and how it is paid for; and must be appropriately and adequately funded. We believe that the SustiNet proposal meets these objectives.

CSMS partnered with the Universal Health Care Foundation of Connecticut to issue the first physician workforce survey of its kind in the state.The results from the 2008 CSMS Physician Workforce Survey show too many practicing physicians are actually considering leaving Connecticut or no longer practicing medicine, and we know that recruitment of new physicians is difficult if not practically impossible within certain specialties and subspecialties of medicine.

The seven-page self-administered survey sought physician opinions on a broad range of issues ranging from satisfaction with their chosen career to the kinds of challenges they face in caring for Connecticut's citizens and how those challenges affect patients' access to quality medical care. Surveys were completed by 1077 physicians in 17 specialty areas spread across the state's eight counties, of varying ages. A majority of survey respondents were in solo practice or groups of five or fewer physicians, and 57% were self-employed. Some key findings included:

- 19% of physicians indicated they are contemplating a career change because of the practice environment in Connecticut. 10% plan to leave the state because of the practice environment.

- More than 90% of respondents in Litchfield, New London and Windham counties reported recruiting physicians was very or somewhat difficult.

- 47% of surveyed physicians increased their work hours seeing patients over the course of the last three years.

- 32% of payments to physicians surveyed came from Medicare; 13% of payments came from Medicaid/HUSKY; and 7% of care was delivered for free.

- 40% of respondent physicians said they are providing fewer high-risk procedures and 34% are seeing fewer high-risk patients due to professional liability concerns.

- 90% of emergency room physicians and 72% of pediatricians – specialties that make the most referrals and see high rates of uninsured or underinsured patients – indicated that it has become more difficult to obtain referrals and consultations.

- The longest mean average wait time for new-patient office visits was 24 days, reported in Windham County, which also reported the biggest reduction in provision of high-risk services, the second-largest reduction in care of high-risk patients and the highest percentage of physicians contemplating a career change.

- Physicians were supportive of creating a large insurance pool to cover the uninsured, those on public insurance programs and others; they were equally supportive of backing expanding current safety-net programs.

The Connecticut Workforce Survey 2008 provides valuable, never-before-available information about the reality of practicing medicine in Connecticut. Physicians are working more while patients are waiting weeks for appointments. Physicians are cutting back on seeing some of the patients who need them the most because of the professional liability climate. Practices are having a harder time recruiting colleagues to work here. Increased specialization and sub-specialization mean physicians are less interchangeable than they once were; bare totals of the number of physicians in an area do not paint an accurate picture of patient access to medically necessary care.

The professional liability situation is depressing the availability of physicians and procedures for Connecticut patients. This is where common-sense reform that respects both patients and physicians would be most welcome. To increase physician retention and recruitment, CSMS has advocated student loan forgiveness and forbearance in exchange for practicing in Connecticut's most fragile areas.

SustiNet was developed with input from physicians, health care economists and policy experts, residents statewide, business, labor and policy-makers and consumer advocates. It emphasizes primary care and preventive services through the medical home concept; disease management, care coordination, quality reviews and quality guidelines without lapsing into what is commonly referred to as "cookbook medicine;" certain limits or safe harbors from medical liability; health information technology, specifically electronic medical records and electronic health records; and payment approaches that not only increase the level of payments to physicians and other providers but anticipates further changes in payment approaches and provides the flexibility necessary to account for this evolution in payment methodologies. These are all elements that CSMS believes are essential in a well-thought-out and structurally sound health care reform proposal.

CSMS also commends this proposal for its approach to assisting physicians in the redesign of their offices to allow for more rapid transition to a computerized, interoperable and interconnected system of health information through training and associated consulting services, as well as access to and incentives and discounts for electronic medical record and health record systems, similar to what CSMS presently offers its membership.

In addition, CSMS appreciates how SustiNet could negotiate on behalf of physicians who participate in the SustiNet plan to obtain discounted prices for vaccines and other health care goods and services. This is critical as so many of Connecticut's physicians are solo- and small-practice physicians that there is very little economy of scale in negotiating for goods and services necessary to manage and run a practice and provide quality patient medical care.

Furthermore, CSMS, a recent recipient of a grant from the Connecticut Health Foundation for physician education on health disparities, believes that educational services, programs and materials designed to assist physicians and their offices provide effective access and quality medical care regardless of patient background is essential in any progressive and effective health care delivery system.

CSMS also believes that SustiNet, if implemented effectively, could strengthen insurance markets through providing consumers as well as providers extra choices and increased transparency. SustiNet will establish a repository of claims and patient information that can be used to improve both the transparency of care, through cost information, and the quality of care through education based on the tracking of medical care provided and the associated outcomes.

CSMS also appreciates the phased-in approach of SustiNet, that avoids issues with implementation, such as inadequate networks of physicians, especially medical specialists and subspecialists.

CSMS strongly believes that physicians can, will and must be part of all facets of the body politic, the "SustiNet Authority," including, but not limited to its board, and its associated committees and task forces: physicians are the foundation of the health care delivery system in Connecticut and have been so since before the founding of the Connecticut State Medical Society in 1792. The guidelines and procedures specific to how medical care is delivered within the SustiNet plan, must be based on sound scientific evidence and a rational understanding of medical care, but also must allow for the necessary flexibility associated with the uniqueness that each patient and each episode of care or treatment requires.

CSMS supports and is advocating for the adoption of the SustiNet proposal's guidelines for health care reform in Connecticut in order to move forward not only the debate on true health care reform, but to speed toward a health care system that is based, and will be judged on, its collaborative approach to providing access to quality medical care that takes advantage of health information technology while still remembering that the individual patient matters most.

160 St Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Testimony of Michael Deren, MD,
Connecticut State Medical Society
House Bill 6600, An Act Concerning the Establishment of the SustiNet Plan
March 2, 2009

Senator Harris, Representative Ritter and members of the Public Health Committee, Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, Senator Doyle and Representative Walker and members of the Human Services Committee, my name is Dr. Michael Deren and I am currently the Council Chairman of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 member, thank you for the opportunity to testify here today in support of the **House Bill 6600**, the SustiNet program.

During my career as a practicing physician, I have reviewed many proposals for healthcare reform and both the state and federal level. Many times, they were written in a vacuum, without a doctor in the room. They contained some interesting ideas, but many of those ideas couldn't work in the doctors' offices across Connecticut.

That's not the case with **House Bill 6600.**

The Connecticut State Medical Society has been pleased to be an advisor as this plan was developed. For two years, we've had a seat at the table talking about what works in our health care system – and just as importantly – what doesn't.

There's always a lot of talk about "access to medical care." What does that really mean?

- We're talking about making sure everyone who needs to see a doctor can see a doctor, regardless of whether they have private insurance, Medicare, Medicaid or HUSKY.
- We're talking about getting patients out of the emergency room and into doctor's offices.
- And we're talking about building a healthier Connecticut, something my organization has been dedicated to since 1792.

House Bill 6600 includes important provisions to do those things. For example, the CSMS Workforce Survey showed us that patients are having a harder time

accessing medical and surgical specialists. This legislation improves that situation through the establishment of what are known as medical homes.

SustiNet makes significant inroads in addressing the spiraling costs associated with those who suffer from chronic illness through monitoring and coordination. Any physician in this room can tell you that a patient who does not comply with orders is less likely to improve than a patient who follows a physician's instructions.

The vast majority of Connecticut physicians are like me, in small practices. We want to implement electronic medical records programs, but costs are high, and few of us have extra funds to invest.

I chose to practice medicine to care for people – not to argue with insurance companies about what my patients need.

I practice medicine because I want to give my patients a chance at better health and a longer life.

Quality health care must not be divided between "haves" and "have-nots."

If the concepts in the SustiNet plan become law, important changes will help bring more doctors to Connecticut at a time when we need more doctors.

We believe today's proposals match many of the concerns expressed by physicians across the state. And we urge you to embrace these concepts and make them reality.

Thank you.

Dr. Keith vom Eigen

Statement from the Connecticut Chapter of the American College of Physicians (ACP)
In Support of
House Bill 6600 – An Act Concerning the Establishment of the SustiNet Plan
Public Health, Insurance and Real Estate, and Human Services Committees
March 2, 2009

The American College of Physicians (ACP) is a national organization of internists — physicians who specialize in the prevention, detection and treatment of illnesses in adults. With 126,000 members ACP is the largest medical-specialty organization and second-largest physician group in the United States. On behalf of the over 2100 members of the Connecticut Chapter of ACP, I would like to express our support of House Bill 6600 regarding the proposed SustiNet Plan for expanding health insurance coverage in Connecticut.

The ACP supports state level expansion of access to health care coverage as a means to achieving universal access to health care. We believe that universal access to care is a key component of a system of health care that can provide high quality, cost-effective, affordable, and equitable health care for all Americans. The SustiNet Plan will significantly expand access to health care coverage for groups that currently are among those at greatest risk for being uninsured or underinsured against the vagaries of illness – the self-employed, employees of businesses unable to offer adequate coverage, individuals with "pre-existing conditions" and those undergoing transitions in employment.

In achieving expanded access to health care coverage for the underinsured, the SustiNet plan incorporates a number of elements that are in accordance with ACP policy and recommendations for health care reform, such as the Patient Centered Medical Home as the basis for primary health care, an emphasis on prevention and coordination of care, expansion of Health Information Technology to improve storage and exchange of health information, quality of care improvement programs, portability of coverage, and incentives to promote high quality, cost-effective care.

The Patient Centered Medical Home

ACP believes that the Patient Centered Medical Home model of care delivery, which is a central element of the SustiNet Plan, can improve the quality of care and reduce costs through improved coordination of clinical care and social services, more efficient communication, better management of complex chronic illnesses and more effective application of preventive measures. The ACP, along with other major medical organizations, such as the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (APP), strongly supports implementation of the Patient Centered Medical Home as the basis for a more efficient and effective system of care. The SustiNet Plan will promote the Medical Home model by setting standards for qualification as a Medical Home provider, compensating providers for coordination of care, and supporting infrastructure to enhance the function of Medical Homes. We believe that primary care internists and other primary care physicians are best suited to serve as the leaders of Medical Home teams, and should be directly involved in committees that set standards for care and the operation of Medical Homes. We urge that in implementing the SustiNet Plan, compensation for clinical services and coordination of care be set at levels that ensure adequate participation of providers and maintenance of the primary care workforce.

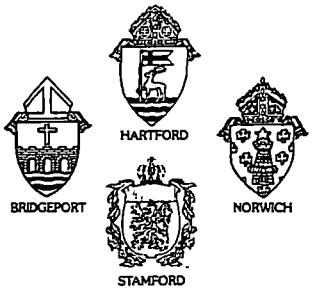
Prevention and Coordination of Care
The key to reducing the burden and cost of significant illnesses is to prevent them from occurring in the first place, to identify them early when they can be treated more effectively, and to provide coordinated care when they do occur. By emphasizing prevention and coordination of care through the Medical Home model, the SustiNet Plan promises to bring the overall costs of care down, improve health outcomes for its participants, and provide better access to other beneficial services. Its effects in terms of better outcomes and lower costs may also go beyond participants in the plan by promoting better standards of care among Connecticut providers that other patients may benefit from as well.

Health Information Technology
ACP strongly supports the implementation of Health Information Technology to improve the efficiency of health care. Better information systems are necessary to insure that vital patient information is available when and where it is needed, to reduce inefficiencies in the coordination of care, to reduce errors in communication, and to enable monitoring of care services and patient outcomes to improve quality and reduce the costs of care. We applaud the emphasis that the SustiNet Plan places on improving information systems, and its efforts to set standards for such systems to ensure they are effective and can work together. Cost has been a barrier to the adoption of such systems, and since all will benefit, we feel that physicians alone shouldn't bear the entire cost of the transition. We agree with the plans of SustiNet to support financing for the transition, but feel other sources of support, perhaps from federal programs, may help to increase participation.

Quality of Care Monitoring and Improvement
By mandating establishment of quality of care standards and improving Health Information Technology tools to collect, analyze and report performance data, we believe the SustiNet Plan will have positive effects on the quality of care provided to patients. We strongly support the participation of physicians in the process of developing quality standards and analyzing data collected. We also support the concept of risk adjustment in evaluating performance data to ensure fair comparisons and prevent barriers to care for the sickest patients. ACP has been in the forefront of establishing guidelines for the care of numerous medical conditions, which could serve as the basis for SustiNet quality standards. We support the plan for requiring quality improvement and patient safety programs among participating providers. We also support the plan for a no-fault compensation system for patients harmed despite adherence to quality guidelines.

ACP Supports the SustiNet Plan
Overall, we feel that the SustiNet Plan is a well thought out, carefully crafted plan that brings together state of the art elements of health care reform to improve access and reduce the costs of care for the citizens of Connecticut. Although adoption of such a plan can be daunting at a time of economic stress and uncertainty, we feel that in the long run it will reduce costs and promote economic development while improving the quality and length of life for our citizens. The Connecticut Chapter of ACP supports the SustiNet Plan, and we and encourage our legislators to do so as well.

For further information, please feel free to contact.
Eric Mazur, MD, Governor of the Connecticut Chapter of ACP, Eric Mazur@Norwalkhealth.org
Robert McLean, MD, Governor-Elect of the Connecticut Chapter of ACP, rmmclean@optonline net
Keith vom Eigen, MD, Health Policy Chair, Connecticut Chapter of ACP, vomeigen@adp uchc edu



CONNECTICUT CATHOLIC CONFERENCE
134 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06105-3784

MICHAEL C. CULHANE
EXECUTIVE DIRECTOR

DEACON DAVID W. REYNOLDS
LEGISLATIVE LIAISON

Testimony before a Joint Hearing
of the Committees on Public Health,
Insurance and Human Services on
H.B. 6600 An Act Concerning the
Establishment of the Sustinet Plan
March 02, 2009

The Connecticut Catholic Conference, the public policy office of Connecticut's Catholic Bishops, and a member of the Interfaith Fellowship for Universal Health Care, would like to urge the members of the committees represented here today to support H.B. 6600 "An Act Concerning the Establishment of the Sustinet Plan" and the concepts for health care reform it incorporates. The Conference recognizes that there are many other efforts underway within the legislature and the executive branch to improve our health care system, but feels that H.B. 6600 is the most comprehensive proposal currently before this legislature. We realize that many deliberations and compromises will occur before a final solution to the health care crisis is developed. H.B. 6600 should be used as the centerpiece for any future health care discussions because of its comprehensive nature.

Catholic social teaching holds health care to be a basic human right. This is reflected in the long history of the Catholic Church's involvement in providing health care services within our own state and throughout the world. The Catholic Church has long been an active participant in the call for health care reform in our state and nationally.

The continuing increase in medical costs and its financial burden on business and family budgets, and the large number of uninsured persons, are the two primary factors pushing the calls for reform. The need for health care reform is clear as thousands of people within our state lack employer sponsored insurance or can not afford to purchase their own health care coverage. The uninsured also cause a continuing strain on our health care system as doctors and hospitals continue to provide care, but with little or no compensation for their services. These providers are dependent on the state and its taxpayers to help cover these uncompensated expenses.

The design of the Sustinet Plan contained in H.B. 6600 addresses the key factors that some other plans presented to this legislature lack. H.B. 6600 makes coverage available for all Connecticut residents despite their employment status, has affordable co-pays and premiums, provides quality levels of coverage, including dental, and supports preventive medicine. It also has several medical management provisions aimed at reducing costs through better and more comprehensive patient management.

Our state and nation, along with many families, are currently facing very difficult economic times. However, this should not deter this legislature from undertaking much needed health care reform. In the long run a quality universal health care system may result in saving the state money and making life more manageable for Connecticut families. Health care expenses are an ever increasing burden on many of our state's families. Especially, as the number of unemployed continue to increase.

Most of you probably know someone, maybe even in your own family, who lacks affordable quality health care. In my own family I have three children in their mid-twenties. One daughter has full insurance coverage as a public school teacher. Another lacks any insurance coverage, despite the fact that he works a forty hour week as an EMT for a state ambulance service. He just can not afford the premium payments for the insurance offered by his company. And my oldest married daughter, who has to pay almost $12,000 dollars a year to cover herself and her one year old child, because her husband's company will only cover his premium. She is a stay at home mom and their savings, which they have used to pay the premium, will soon be depleted. They do not know what they will do for insurance coverage once this occurs.

The Connecticut Catholic Conference hopes the committees represented here today will recognize the basic right all our citizens have to quality, affordable health care. Economic times are difficult, but they will only get worse for many employed and unemployed Connecticut citizens, if health care reform is delayed any longer.

Deacon David Reynolds
Legislative Liaison, Connecticut Catholic Conference
Co-Chair, Interfaith Fellowship for Universal Health Care

Alyssa Norwood

WRITTEN TESTIMONY OF
CONNECTICUT PUBLIC HEALTH ASSOCIATION
REGARDING H.B. 6600
AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN

Public Health, Insurance and Real Estate, and Human Services Committees
March 2, 2009

The Connecticut Public Health Association (CPHA) thanks the Public Health, Insurance and Real Estate, and Human Services Committees for the opportunity today to support universal health care. CPHA is a non-profit, non-partisan organization that provides leadership for the promotion of the public's health among the people of Connecticut. CPHA supports the adoption and implementation of H.B. 6600, An Act Concerning the Establishment of the SustiNet Plan, to ensure improved health for all Connecticut residents. Given the current economic climate, jeopardizing the affordability of and accessibility to health insurance for everyone, there is no better time to establish universal health care.

The United States is the only industrialized nation that does not have some form of universal healthcare system.[1] Despite having the best training, healthcare providers, and medical infrastructure of any industrialized nation, the United State's healthcare system ranks poorly relative to other industrialized nations. The World Health Organization ranked the performance of the U.S.'s healthcare system 37th in the world.[2] Administrative costs are 50-100% more in the United States than in countries with a single-payer system.[3] Connecticut alone spends $22 billion every year on healthcare.[4] Despite the system's high cost, there are over 45 million Americans that do not have health insurance and millions more that are underinsured and do not have adequate financial protection for healthcare costs.[1] Lack of adequate and affordable healthcare is a serious problem that affects the health and well-being of all U.S. citizens.

Uninsured individuals have less access to quality healthcare. The uninsured are less likely to be able to fill prescriptions and more likely to pay much more of their money out-of-pocket for prescriptions. Studies show that the uninsured are three to four times more likely than those with insurance to report problems getting needed medical care, even for serious conditions.[5] The uninsured are also less likely to have a regular source of healthcare; 40% of the uninsured do not have a regular place to go when they get sick, compared to 10% of insured individuals. As a result, 20% of uninsured say their usual source of care is the emergency room, compared to 3% of insured individuals.[1]

Inadequate and delayed access to care adversely affects health. Uninsured individuals are less likely to get needed preventive care. Uninsured, non-elderly adults are 50% less likely to receive preventive care, including pap smears, mammograms, blood pressure checks, sigmoidoscopies, cholesterol screening and prostate exams. They are also more likely to receive poor care for chronic diseases, leading to an increased risk of hospitalization and disability.[2] Individuals who delay medical services get diagnosed later, negatively affecting disease prognosis. The Institute of Medicine estimates that the uninsured have an excess annual mortality rate of 25%, which translates into 18,000 excess deaths per year for people between the ages of 25-64.[6]

The costs of not achieving universal healthcare are high. The annual cost of diminished health and shorter life spans for uninsured Americans is $65-130 billion.[7] Uninsured children are more likely to suffer delays in development due to poor health. In addition, inadequate access to healthcare for children contributes to poor health later on in life, less productivity, and a greater burden to society.[1] Insured individuals are also adversely affected by high rates of uninsured persons. An estimated $43 billion was spent on uncompensated medical care for the uninsured in 2005.[8] In addition, people living in communities with a higher than average uninsured rates are at risk for reduced availability of healthcare services and overtaxed public health resources.[6]

SustiNet, a universal healthcare plan for Connecticut, would create a comprehensive, high quality and affordable healthcare system that would be available to all Connecticut residents. This plan would do a great deal to ensure universal, continuous access to quality healthcare services in a sustainable way. It will also save money by encouraging preventive healthcare and early interventions in medical illnesses.

The Connecticut Public Health Association wishes to thank the respective Committees before us for the opportunity to address this important public health issue. CPHA urges favorable legislative action on H.B. 6600. For additional information on CPHA's position on universal healthcare and other public health issues, contact CPHA's Advocacy Committee co-chairs Annamarie Beaulieu at annamarie.beaulieu@cpha.info or 860.301.8857, or Alyssa Norwood at alyssa.norwood@gmail.com or 860.424.1345.

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[1] Ruth, Erin. "Undercoverage: The Uninsured and Undercovered Medical Services." American Medical Student Association. Available http://www.amsa.org/uhc/AMSAUninsuredPrimer.pdf
[2] World Health Organization. "The WHO's ranking of the world's health systems." 2000 Available http://www.photius.com/rankings/healthranks.html
[3] Connecticut Coalition for Universal Health Care. Available http://cthealth.server101.com/index.html
[4] Universal Health Care Foundation of Connecticut. "The Issue." Available http://www.healthcare4every1.org/site/PageServer?pagename=learn_theissue
[5] Institute of Medicine (IOM). "Care without Coverage: Too Little, Too Late." 5/2002. Available http://books.nap.edu/html/care_without/reportbrief.pdf
[6] Institute of Medicine (IOM). "Insuring America's Health: Principles and Recommendations. 2004. Washington, DC: National Academy Press. Available http://www.nap.edu/openbook.php?isbn=0309091055
[7] Institute of Medicine (IOM). "Hidden Costs, Value Lost." 2003. Washington, DC: National Academy Press. Available http://search.nap.edu/openbook.php?isbn=030908931X
[8] Families USA. "Paying a Premium: The Added Cost of Care for the Uninsured." June 2005. Available http://www.pnhp.org/news/2005/june/the_uninsured_drive_.php

703 Whitney Avenue, New Haven, CT 06511
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

March 2, 2009

TESTIMONY
PUBLIC HEALTH, HUMAN SERVICES, INSURANCE AND REAL ESTATE COMMITTEES
HB 6600 – AAC the Establishment of the SustiNet Plan
Ellen Andrews, PhD
Executive Director

Thank you for the opportunity to voice our strong support for HB-6600 and the SustiNet Plan. This proposal is the most detailed, thoroughly researched, specific, and realistic plan to provide relief to Connecticut's struggling health consumers and payers. This plan is clear about where we need to go, how we will get there, what we need to do, and we can see success at the end. I urge you to pass this bill.

SustiNet is the result of a long, thoughtful, inclusive, and sometimes painful process of engaging stakeholders and incorporating their input from across Connecticut's health care landscape, including providers, payers, clergy, small business, labor, and very importantly consumers, in the shared goal of providing quality, affordable health care to every state resident. It fits into our state's unique health care environment. The Universal Health Care Foundation of Connecticut deserves a great deal of credit for managing the dance of competing interests. It took a great deal of time to plow through the policy and fiscal issues to find the right options that effectively meet the goals but are feasible and realistic. This plan is more than "good enough" or a "good start". This plan is a specific and responsive roadmap to covering everyone in the state.

I want to specifically focus my testimony on two parts of SustiNet – promotion of "medical homes" and auto-enrollment and the absence of an individual mandate.

Everyone should have a patient-centered medical home – a primary care provider who knows you and your health needs, is available when you need help, and coordinates your care. Patients are not just given referrals for needed specialty care or tests, but their provider makes the appointment, monitors care, collects test results, and follows up to ensure that the patient gets well. Providers work in teams to help consumers manage their own conditions and maintain/improve their health.

Nationally, many provider and business groups have endorsed and are devoting resources to promoting medical homes. NCQA is developing medical home standards for practices; payers, including Medicare, are beginning to provide specific funding to medical home practices.

Connecticut has taken a step toward the medical home model with a small pilot of Primary Care Case Management (PCCM) that began February 1st. PCCM is a way of running HUSKY that does not involve HMOs, which have had a troubling history in the program,

but emphasizes primary care and prevention. In PCCM, members choose a primary care provider (PCP) who is responsible for providing all necessary primary care services, with after hours access, and to coordinate other needed services for HUSKY families. Parents are not told their child needs a specialist or a test and left on their own to find someone willing to provide the needed service within the HUSKY program, but the PCP finds a provider, makes the appointment, coordinates among providers, and follows up with any needed aftercare. Getting access to specialty care in the HMO system is notoriously hard; it is far easier for a doctor's office to get an appointment with another doctor than a HUSKY parent. PCPs are paid on a fee-for-service basis for the health care services they provide as well as $7.50 per member per month for care coordination. Other states that have implemented PCCM have enjoyed significant improvements in health outcomes, reductions in ER use, better consumer and provider satisfaction and saved precious state dollars. We estimate that PCCM could save Connecticut's state budget over $113 million annually.

The second piece of SustiNet that I would like to emphasize is something that the planners wisely left out – an individual mandate – a legal requirement that every state resident obtain health care coverage. Not surprisingly, an individual mandate is the centerpiece of insurance industry reform proposals at the national and state levels. There is ample evidence that an individual health insurance mandate would not work in Connecticut and would cause significant harm to low income consumers. Mandates are no guarantee of compliance – despite a legal mandate, 12% of Connecticut drivers do not have auto insurance. There is a persistent myth that care for the uninsured is driving skyrocketing health costs; in fact, uncompensated care for uninsured patients accounts for only 2% of all US health care spending. Health insurance in Connecticut is very expensive, unaffordable for most uninsured residents. Regulation of the insurance market in Connecticut is weak; often the only "affordable" options do not cover patients' needs. Enforcement of an individual mandate would be expensive, attract lawsuits, and would distract from the important work of health care reform. Perhaps the worst part of an individual mandate is that it blames the victims of uninsurance for the problem. Only 1.5% of the uninsured are without coverage because they believe they don't need it; most are desperate for insurance.

Instead, SustiNet includes thoughtful auto-enrollment measures to ensure that everyone has coverage while respecting consumer rights. The proposal is to enroll anyone without insurance automatically when they begin or end employment, request unemployment benefits, file a tax return, seek health care and when children start school. People can opt out of coverage but must verify that they understand the risks and liability of that choice. The plan also includes intensive marketing and community outreach to educate consumers about the importance of coverage and disincentives for waiting until patients need care to enroll.

It has been suggested that Connecticut should not step out in front of health reform efforts at the national level. I remember that being said often in the early 90's as well, but national reforms never materialized and we missed an important opportunity. There are encouraging signs of energy at the national level, but national leaders have been clear that they intend to build on and learn from the success of states. With SustiNet, Connecticut is in a unique position to become a national leader in health system reform and to meet an immediate and substantial need facing our consumers and our economy.

Thank you for your time and your commitment to the health of every Connecticut resident.

Connecticut Health Policy Project

POLICYMAKER ISSUE BRIEF

No. 47 December 2008

An Individual Health Insurance Mandate: Could it Work for Connecticut?

There is a growing consensus that our health care system is broken. Costs are skyrocketing; government, employers and consumers are struggling to keep up. State and national leaders are considering policy proposals to fix our health care system. One option being considered is an individual mandate, a requirement that every resident get health coverage. If it is not available through employment or a public program, consumers would be required to buy it privately.

Research suggests that an individual mandate would not work in Connecticut.

- Mandates are no guarantee of compliance. Connecticut law requires drivers to have auto insurance, but 12% are uninsured.
- A mandate would not make much difference in rising health costs. Uncompensated care, services delivered but not reimbursed, are only 2% of US health care spending.
- Very few people are uninsured by choice; most cannot afford coverage. Only 1.5% of uninsured Americans go without because they don't believe they need it.
- Insurance in Connecticut is not affordable. Family health insurance premiums in Connecticut are the third highest in the nation. Between 2000 and 2007 Connecticut health insurance premiums rose 8.2 times faster than our incomes.
- There are not enough consumer protections in place to ensure that consumers are getting what they pay for. In 2006 without public notice, Connecticut's Insurance Dept. approved limited benefit policies that cover as little as $1,000 of health care treatments per year.
- Health insurance is no guarantee of access to care. Connecticut, like the rest of the country, is facing a primary care shortage. Consumers in Massachusetts, the only state to implement such a mandate, now wait 50 days for health care appointments on average and, in some cases, up to a year.

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Phone: 203.562.1636
FAX: 203.562.1637
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- Connecticut can't afford an individual mandate. Massachusetts created a new agency to administer their reforms and engaged thirty lawyers just to hear consumer appeals to the individual mandate.
- Enforcement of an individual mandate would be problematic, raising difficult and conflicting interests among policymakers.
- A mandate is not the best way to improve Connecticut's health. Each year 22,000 Americans die due to uninsurance, but 44,000 to 98,000 die of medical errors just in hospitals.
- A mandate would invite legal challenges.

Other states have considered mandates, including Maine and Vermont. California's reform proposal earlier this year failed in large part because of the individual mandate. In explaining his vote against the bill, a California Senator said **"I just came to the conclusion that the working people are going to end up paying for it. There's control for everybody else - the employers are protected and the insurance industry. The only group that's vulnerable is the working people."**

It is too early to tell whether Massachusetts' individual mandate is working. In its first year (2007) the rate of uninsurance was cut in half. However, the state passed significant expansions of public programs and large premium subsidies for lower income residents not eligible for state coverage. Massachusetts has access to an additional $4.3 billion in federal funds to support their programs through a pre-existing, recently renewed Medicaid waiver. Despite this effort, 62,000 state residents had incomes too low to be subject to the waiver but too high for subsidies, and remain uninsured. An additional 86,000 uninsured residents chose to pay last year's modest $219 penalty rather than buy coverage. This April the penalty rises to $912 per resident.

An individual mandate does nothing to address the flaws in our broken health care system - incentives to order more treatments and no incentives for quality, little emphasis on prevention or management of chronic illness, fragmented payment systems promoting cost shifting. The difficulties and costs of implementing an individual mandate will only delay and distract resources from fixing the real problems with our health care system. Fixing those problems have to be our first priority, so we can create a system that provides every Connecticut resident with affordable quality care that is worth what we pay for.

Bottom Line:

Connecticut cannot afford an individual mandate which would likely not work and would do nothing to fix our broken health care system.

Source:
E Andrews, *An Individual Health Insurance Mandate Could It Work for Connecticut?* CT Health Policy Project Issue Paper, December 2008, www.cthealthpolicy.org

Connecticut State Medical Society-IPA, Inc. (CSMS-IPA, Inc.)
Testimony Presented to the Public Health Committee, the Insurance and Real Estate Committee and the Human Services Committee
Regarding The Establishment of the Sustinet Plan

March 2, 2009

Senator Harris, Representative Ritter and members of the Public Health Committee, Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, Senator Doyle and Representative Walker and members of the Human Services Committee my name is David D. Thompson, Jr., M.D. and I am the President of the Connecticut State Medical Society-IPA, Inc. (CSMS-IPA, Inc.) a wholly owned subsidiary of the Connecticut State Medical Society. On behalf of our over 7,000 member physician network thank you for this opportunity to testify today on **H.B. No. 6600 An Act Concerning the Establishment of the Sustinet Plan.**

Healthcare reform, to be successful, must solve both major problems confronting our present system. It must create universal access and control costs.

A program that just creates access or mandates universal coverage but does not control costs will cause the present crisis as outlined in the JAMA article "The Perfect Storm of Overutilization" to intensify. Costs already high would escalate at even a faster rate as the increased demand would cause unchecked utilization to rocket even higher even more rapidly. I have read some recent articles that push for single payer systems but don't seem to address controlling these escalating costs. The costs of the single payer for the elderly, Medicare, are seriously out of control.

A program to help stabilize and begin to reduce costs such as the Primary Care Medical Home Model (which is the recommendation of the JAMA article previously mentioned) can be implemented and used to reduce costs and increase value. Presently our health care system is focused on management of disease rather than health. The system reimburses providers for caring for the sick instead of keeping them healthy. The Medical Home Model reverses this emphasis. Primary Care Physicians are paid to keep the patients healthy and to coordinate the care of people who are sick in a manner designed to keep them as healthy as possible while providing the appropriate resources. All other countries of the developed world spend less on healthcare then we do in the United States but score much higher in health analysis because they emphasize health rather than illness. They achieve much better value for their healthcare expenditures. These concepts are expressed in the plan SustiNet proposes.

The Medical Home Model would be further supported by adoption of Electronic Health Records (EHR) which incorporate e-prescribing and allow for quality data aggregation and electronic data exchange through EHealth Connecticut to improve quality and reduce needless duplication of testing and harmful drug interactions. The Connecticut State Medical Society – IPA (CSMS-IPA) is one of the founding members of the data aggregation project (now known as the Connecticut Health Quality Collaborative) being coordinated by EHealth Connecticut.

The CSMS-IPA has approximately 7,000 physicians, the vast majority of the active physicians in the state. We have been the physician network for what is now Health Net of the Northeast for 20 years. With Health Net, we create the fee schedule for the commercial membership (including state employees) and work with the Medicare Advantage program that Health Net has in Connecticut. In the recent past we were the network for the Husky A program that Health Net had with the state. We also provide the Workmen's compensation network for Health Net. We are presently contracted with a new Medicare

Advantage program which provides a Collaborative Payer Model and strongly supports the concepts emphasized within the Medical Home Model. This program is expected to begin seeing patients on January 1, 2010 (pending all necessary approvals). The CSMS-IPA is preparing our physicians for the myriad of changes this approach will require and working to create and support the technology opportunities which now may be funded largely by the federal government as part of the recent stimulus program and take advantage of the opportunities Information Technology will bring to healthcare.

The Board of Directors of the CSMS-IPA has reviewed the proposal of the Universal Health Care Foundation, supports the SustiNet proposal and would be available to work with the appropriate management team to work out the details of providing physician services through our network to this program if desired. The IPA Board feels that a program such as SustiNet will help create universal coverage and control costs.

The CSMS-IPA supports this approach and looks forward to the opportunity to help make it work for Connecticut.

Online article and related content
current as of March 1, 2009

The Perfect Storm of Overutilization

Ezekiel J. Emanuel; Victor R. Fuchs

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COMMENTARY

The Perfect Storm of Overutilization

Ezekiel J. Emanuel, MD, PhD
Victor R. Fuchs, PhD

A "PERFECT STORM" OCCURS WHEN A CONFLUENCE OF many factors or events—no one of which alone is particularly devastating—creates a catastrophic force. Such confluence is rare and devastating. Over time and through disconnected events, US health care has evolved into a "perfect storm" that drives overutilization and increases the cost of health care.

Higher Costs in the United States

The United States spends substantially more per person on health care than any other country, and yet US health outcomes are the same as or worse than those in other countries.[1,2] In 2005, the last year for which comparative statistics are available, the United States spent $6401 per person, whereas the next highest spending was in Norway and Switzerland, $4364 and $4177, respectively (TABLE).[3,4] Overall, US health care expenditures are 2.4 times the average of those of all developed countries ($2759 per person), yet health outcomes for US patients, whether measured by life expectancy, disease-specific mortality rates, or other variables, are unimpressive (Table).[1,3,4]

There are many explanations for the higher costs of US health care. Because health insurance must be underwritten and sold to individual employers and self-insured individuals, administrative costs exceed $145 billion. This does not include employers' costs for purchasing and managing employees' health insurance. One estimate suggests that the private employer insurance market wastes more than $50 billion in administrative costs.[5]

A second factor is higher prices in the United States for important inputs to health care, such as physicians' services, prescription drugs, and diagnostic testing. US physicians earn double the income of their peers in other industrialized countries (Table). Similarly, prices to the public for drugs in the United States are 10% to 30% higher than in other developed countries.[6] Disparities in prices of inputs to health care account for at least $100 billion annually of higher spending in the United States.[5]

A third contributor to US costs is the abundance of amenities. Hospital rooms in the United States offer more privacy, comfort, and auxiliary services than do hospital rooms in most other countries. US physicians' offices are typically more conveniently located and have parking nearby and more attractive waiting rooms.

Overutilization of Health Care

The most important contributor to the high cost of US health care, however, is overutilization. Overutilization can take 2 forms: higher volumes, such as more office visits, hospitalizations, tests, procedures, and prescriptions than are appropriate or more costly specialists, tests, procedures, and prescriptions than are appropriate.

It is more costly care, rather than high volume, that accounts for higher expenditures in the United States. The volume of services is not extreme. A hospitalization rate of 121 per 1000 US patients is higher than that of Japan (106) but considerably lower than the rate in Switzerland (157), Norway (173), and France (268) and lower than the Organisation for Economic Co-operation and Development (OECD) average (163) (Table).[3,4] The US hospitalization rate is 21st of 30 OECD countries. Similarly, US patients have 3.8 physician visits annually per capita, fewer than the OECD average of 6.8.[3,4,6]

In contrast with volume, in which the United States is not the leader, there are almost 3 times as many magnetic resonance imaging scanners in the United States as the OECD average, higher only in Japan.[3,4] US patients receive considerably more cardiac revascularization procedures (579 per 100 000 population)—coronary artery bypass grafts, angioplasties, and stents—45% more than patients in Norway, the country with the next highest number (Table).[3,4] The United States has the fourth highest per capita consumption of pharmaceuticals.[6] US patients utilize many more "new drugs"—those on the market 5 years or fewer—than patients in other countries.[6] For instance, ezetimibe, which decreases low-density lipoprotein cholesterol level and was approved in October 2002, is not recommended by major guidelines[7] as first-line therapy. Nevertheless, the use of ezetimibe in the United States is about 5 times higher than it is in Canada, constituting more than 15% of prescriptions for lipid-lowering agents.[8] Greater use of new, more expensive pharmaceuticals, as well as higher prices both for older and newer drugs, helps explain why the United States spent $752 per capita (2005) on drugs, whereas France, with the next highest expenditure, spent $559 and Japan just $425.[3,4,6]

The Ingredients of the Perfect Health Care Storm

At least 7 factors drive overuse, 4 related to physicians and 3 related to patients. First, there is the matter of physician cul-

Author Affiliations: Department of Bioethics, The Clinical Center, National Institutes of Health, Bethesda, Maryland (Dr Emanuel), and Department of Economics, Stanford University, Stanford, California (Dr Fuchs).
Corresponding Author: Ezekiel J. Emanuel, MD, PhD, Department of Bioethics, Bldg 10, Room 1C118, National Institutes of Health, Bethesda, MD 20892-1156 (eemanuel@nih.gov).

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ture Medical school education and postgraduate training emphasize thoroughness When evaluating a patient, students, interns, and residents are trained to identify and praised for and graded on enumerating all possible diagnoses and tests that would confirm or exclude them The thought is that the more thorough the evaluation, the more intelligent the student or house officer Trainees who ignore the improbable "zebra" diagnoses are not deemed insightful In medical training, meticulousness, not effectiveness, is rewarded

This mentality carries over into practice. Peer recognition goes to the most thorough and aggressive physicians The prudent physician is not deemed particularly competent, but rather inadequate. This culture is further reinforced by a unique understanding of professional obligations, specifically, the Hippocratic Oath's admonition to "use my power to help the sick to the best of my ability and judgment" as an imperative to do everything for the patient regardless of cost or effect on others

Second, fee-for-service payment misaligns incentives, it creates a big incentive for overutilization. Although most physicians are not income maximizers, they know that it is better to be paid to do something, and the higher the payment the better Paying for doing more adds a strong financial motivation to what is often a slim clinical rationale for an intervention. Furthermore, the current system's bias toward paying significantly more for procedures rather than for evaluation and management reduces physicians' inclination to watch, wait, and communicate and increases their propensity to order a test.

This financial incentive for physicians to order and perform more expensive procedures is compounded by marketing Physicians face a paradoxic situation They are flooded with information; each month there are hundreds of publications on cancer alone. Simultaneously, there is a paucity of data comparing different treatments and interventions It is time consuming and difficult for physicians to judiciously incorporate new data into their practices This creates a powerful role for physician-directed pharmaceutical marketing, which expends more than $7 billion annually—about $10 000 per physician [9] Companies can selectively highlight favorable studies from the mass of research, confident that there are few comparative effectiveness data for physicians to put the marketers' desired conclusions into a proper context

Medical malpractice laws and the resultant defensive medicine also contribute to overutilization There is controversy about whether malpractice litigation and concomitant real cost of premiums are increasing or decreasing There is no doubt, however, about the increase in physicians' concern about malpractice suits and their inclination to do more

Then there is the patient side US patients prefer high technology over high touch. As the energy crisis highlights, Americans tend to embrace technologic fixes for problems. US culture emphasizes the new and the fancy; old and plain is equated with deprivation.[2] In the medical sphere, this cultural value informs a patient perception that doing more tests and receiving more treatments and interventions is receiving better care This helps to explain inappropriate prescribing of antibiotics for viral infections

A sixth contributor is direct-to-consumer marketing Pharmaceutical companies spend more than an estimated $4 billion annually advertising prescription drugs, with the concluding advice of "talk to your doctor about "[9] These ads drive patients' requests for new and more costly medications

In normal markets, demand is modulated by cost But third-party payment for patients attenuates this control Although patients experience deductibles, co-payments, and other out-of-pocket expenses, health insurance and gov-

Table. International Comparisons of Health Care Costs, Quality, and Outcomes[a]

Indicator[b]	United States	Norway	Switzerland	France	Japan	OECD Average
Health care expenditures per capita (2005), US $	6401	4364	4177	3374	2249	2560
Infant mortality, per 1000 births (2005)	6 8	3 1	4 2	3 6	2.8	5 4
Cancer mortality, per 100 000 population (2004)	203	201	186	244	208	227
Ischemic heart disease mortality, per 100 000 male patients (2004)	170 3	120 7	95 2	64 2	42 0	141.6
Life expectancy at age 65, female patients (2005), years	20 0	20 1	21 0	21 4	23 2	19 6
Hospital discharges, per 1000 population (2005)	121	173	157	268	106	163
Annual physician office visits per capita (2004)	3.8	NA	3 4	6 6	13 8	6 8
Physician salaries, specialists/general practitioners, US $	230 000/161 000	77 000/ NA	130 000/116 000	149 000/92 000	NA	113 000/83 000
Pharmaceutical spending per capita (2005), US $	752	375	424	559	425	383
Use of new pharmaceuticals (No of drugs released in last 5 y relative to US per capita) (2005)	100	NA	NA	65	40	NA
Coronary revascularization procedures (bypass, percutaneous transluminal coronary angioplasty, stenting) per 100 000 population	579	320	134	196	NA	245
Cesarean deliveries, % of births (2004)	29	15	26	18	NA	28

Abbreviations. NA, not available, OECD, Organisation for Economic Co-operation and Development.
[a] All dollar figures adjusted for US dollar purchasing power parity
[b] Sources. OECD,[3] Congressional Research Service,[4] and Danzon and Furukawa[5]

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ernment programs significantly shield patients' decisions from the true costs of health care.

Alone, each of these factors would induce some overutilization When they coincide, however, they amplify and reinforce each other to create a perfect storm of "more"· more referrals to specialists, expensive tests, procedures, and treatments For instance, patients' desires for "peace of mind," physicians' training to be thorough, and worries about malpractice suits coalesce to induce more testing and treatments When physicians make money on interventions and patients pay little for them, cost becomes largely irrelevant. The relative cost-unconscious environment augments the incentive for drug, device, and other manufacturers to develop more new expensive tests and treatments, even when they provide small marginal benefits to patients.

Policy Implications of the Perfect Storm

Some elements in the perfect storm are difficult or impossible to change; some, arguably, should not change. Changing Americans' affinity for new technology is somewhere between difficult, impossible, and undesirable.[2]

Calls for changing physician training and culture are perennial and usually ignored. However, the progression in end-of-life care mentality from "do everything" to more palliative care shows that change in physician norms and practices is possible. The escalation in health care costs poses a great challenge to the leaders of US medicine to recognize the gravity of the situation and to move toward more socially sustainable, cost-effective care Rapid reforms of medical education and training, even when widely acknowledged as essential, are uncommon

Another potential policy change is to curb aggressive marketing to physicians and consumers. After recent problems with new, heavily promoted pharmaceuticals, there is increasing pressure to reduce or eliminate direct-to-consumer advertising Simultaneously, there are credible calls for restricting the access of "pharmaceutical" representatives to physicians [10] Although laudable, such changes alone are unlikely to have a large effect on overutilization. Similarly, changes in malpractice law could help: Some experts estimate defensive medicine adds 5% to 9% to health care expenditures,[11] but reform would affect only some defensive practices

Realistically, the most effective policy change would be to alter how insurance pays for medical services One step is for more value-based co-payments, modeled on current tiered pharmaceutical benefits, that link the amount patients pay to effectiveness and cost of alternatives [12] For instance, men with early stage prostate cancer who choose radiation therapy might have no co-payment for 3-dimensional conformal radiation but might have to cover the marginal cost if they want more expensive intensity-modulated radiation therapy. Value-based co-payments would promote high-value interventions and discourage use of marginal medicine It would help if patients were financially sensitive to the cost of care, but not if out-of-pocket costs inhibit use of needed services, resulting in higher costs later This is not an all-or-nothing rationing scheme, but rather an ethical way to have patients experience costs but not at the expense of important outcomes.[12]

Finally, private and public payers for health care must work on developing better financial incentives for physicians and hospitals to provide more cost-effective care Many more experiments are needed with pay for performance, bundled payments, partial capitation, value-based payment, or other payment methods that promote prudent use of resources Such experiments with different ways of paying for health care services must be combined with careful monitoring of utilization, cost, and quality.

Conclusion

The United States has created the perfect storm for overutilization of health care. Costs cannot be controlled unless overutilization is substantially reduced Many physician and patient factors—ingrained values, physician culture, advertising, payment—drive and synergistically intensify overutilization The best hope for reining in costs is to devise financial incentives for physicians and patients that result in greater health care value.

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REFERENCES

1. American College of Physicians. Achieving a high performance health care system with universal access what the United States can learn from other countries *Ann Intern Med*. 2008,148(1) 55-75
2. Emanuel EJ What cannot be said on television about health care *JAMA* 2007, 297(19) 2131-2133
3. Organisation for Economic Co-operation and Development. Health at a glance 2007 OECD indicators. http //oberon sourceoecd org/vl=1643589/cl=22/nw =1/rpsv/health2007/index htm. Accessed May 30, 2008
4. Congressional Research Service US health care spending comparison with other OECD countries September 17, 2007 http //assets opencrs com/rpts /RL34175_20070917 pdf Accessed May 30, 2008
5. Angrisano C, Farrell D, Kocher B, Laboissiere M, Parker S. *Accounting for the Cost of Health Care in the United States* San Francisco, CA. McKinsey Global Institute, 2007 http //www mckinsey com/mgi/rp/healthcare/accounting-_cost_healthcare asp. Accessed May 30, 2008
6. Danzon PM, Furukawa MF International prices and availability of pharmaceuticals in 2005 *Health Aff (Millwood)*. 2008;27(1) 221-233
7. Grundy SM, Cleeman JI, Merz CN, et al. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines [published correction appears in Circulation 2004,110 763] *Circulation* 2004, 110(2) 227-239
8. Jackevicius CA, Tu JV, Ross JS, Ko DT, Krumholz HM Use of ezetimibe in the United States and Canada *N Engl J Med* 2008,358(17) 1819-1828
9. General Accountability Office *Prescription Drugs. Improvements Needed in FDA's Oversight of Direct-to-Consumer Advertising* Washington, DC US Government Printing Office, 2006. http //www.gao gov/htext/d0754 html Accessed May 30, 2008
10. Association of American Medical Colleges. Report of the AAMC Task Force *on Industry Funding of Medical Education to the AAMC Executive Council* Washington, DC AAMC, 2008 http //www aamc.org/research/coi/industryfunding pdf. Accessed May 30, 2008
11. Kessler D, McClellan M Do doctors practice defensive medicine? *Q J Econ* 1996,111 353-390
12. Denny CC, Emanuel EJ, Pearson SD Why well-insured patients should demand value-based insurance benefits *JAMA*. 2007,297(22) 2515-2518

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Honorable Senators and Representatives

My name is Eva Csejtey, an Intern at the American Friends Service Committee – Connecticut.

I am here today to testify on Bill # 6600, "An Act Concerning the Establishment of the SustiNet Plan".

You have heard today on the importance of passing Bill 6600 which provides healthcare for every one who chooses SustiNet. You have been informed on the rising ten percent yearly health care costs that consume over one third of the state budget. You are aware each day more Connecticut residents are losing their employment which affects health care benefits. You have heard testimonies of the decline of quality health care while costs have increased. You are knowledgeable of insurance exclusions that refuse medical treatment for predetermined diseases such as diabetes, a growing and treatable disease. And your sensitivity to Connecticut residents who are dying because of the lack of quality health care is appreciated.

However, you may not have heard from testimonies that the lack of affordable health care does influence major life decisions. Twenty-seven years ago, my decision to marry was connected to my need for health care. I was identified by insurance companies as a medical risk because of my age and was unable to afford an individual plan. Not much has changed since the 1980's except for escalating health care expenses and the decline of real spendable earnings. With the SustiNet Plan, Connecticut residents would be guaranteed quality health care and make life decisions based on their desires and not their health care needs.

Let me provide an example of current public plans and their inadequacies which have been addressed by SustiNet. A colleague of mine explained his frustration due to the lack of immediate coverage, back log of appointments, minimal physician availability, required travel distance, and lack of concern for patient circumstances. I have an example using fictitious names: Jill's 2 year old son, Jesus has seizures and is referred to a specialist by his pediatrician. Jill leaves early to the appointment an hour away. On the way, Jesus vomits in the car and Jill stops to buy items to clean up the mess and clean clothes for Jesus. Jill arrives fifteen minutes late and is told rudely she would have to reschedule the appointment two weeks away despite her circumstances. This story is only one of many. SustiNet would eliminate these problems with better reimbursement rates, local physicians, improved communication and reimbursement for case management.

On behalf of the American Friends Service Committee, I implore you to address the health needs of Connecticut residents to live a healthy lifestyle and promote economic justice. Connecticut residents are counting on you to provide healthcare4every1 and start saving lives today. And I challenge the Honorable Senators and Representatives of Connecticut to *lead* the nation on health care reform.

I appreciate the opportunity to speak and would be happy to answer any questions.

HEALTH CARE PROPOSALS: WHAT GRADE DO YOU GIVE THEM?

Questions and Comments **Public Hearing March, 2009**

Larry Deutsch, MD, MPH
Hartford City Council, Minority Leader and Chair, Committee on Health and Human Services; University of Connecticut Department of Pediatrics; Children's Health Network; State of Connecticut Tobacco and Health Trust Fund Board of Trustees

Points (give 0 to 10)

1. Is it a ***universal*** plan which includes each and every person in the State? 0 10

2. Is it a universal plan which emphasizes ***primary care and prevention***? 0 10

3. Is it a universal plan which is ***comprehensive in its benefits*** and mandates, ***identical*** for all individuals without preexisting conditions, provisos, opt-ins, opt-outs, discriminating co-pays? Does it recognize health ***disparities*** and actively remedy inequities in health services and outcomes? 0 10

4. As coverage becomes universal, does it anticipate needs for a ***well trained diverse health workforce*** for adequate service ***capacity*** and expertise in all areas within the State, with real ***access*** for all and compensating in shortage areas? Are all providers given incentives or required to participate in care without discrimination based on status or payment source? 0 10

5. Is there equitable and sustainable system financing such that health is encoded as a ***human right***, and that the burden of sickness and payment is distributed throughout society in ***a just and progressive*** manner? Are there savings of simplicity and efficiency to eliminate profit and bureaucratic waste with redistribution of savings into community services? 0 10

6. Is there established a strong ***local and statewide public health structure*** for universal ***quality*** standards to anticipate general and special conditions for disease prevention and health promotion, diminishing need for political, court, and legislative wrangling in special cases? 0 10

7. Does it recognize there is more needed for good health than just medical services – ***social determinants of health*** include ***housing, nutrition, and education***? 0 10

8. Are ***oral (dental) and behavioral health services*** granted full and adequately-compensated status along with medical services? 0 10

9. Are ***communities funded and empowered*** to govern and adjust health services for their populations? 0 10

10. Are ***health care workers*** at all levels adequately compensated and empowered to evaluate and adjust their working conditions? 0 10

Total points (out of 100) (A = 100, B = 90, C = 80, D = 70, F = <60) _____

Answers: what can be done to get a perfect grade?

1. Legislation entitles all individuals in State, regardless of income, employment, immigration status.

2. Legislation adjusts program spending and fees through state health authority, public health department, and regulations to emphasize primary and preventive care, including local family and community health centers.

3. State regulations, through 'insurance' or health department authorize one uniform sufficient benefit package and set of quality care and service standards for all.

4. Legislature funds training and guideline programs for balanced health workforce; incentives for practice in shortage areas; requirement for servicing population without exclusive panels or discrimination in patient lists as condition of state licensure and practice.

5. Legislature funds health services capturing current federal, state, employer, and employee payments and out-of-pocket costs, adopts progressive tax structure or surcharge, and employs Medicare-like single-payer mechanism with fair provider compensation and quality mechanisms.

6. Legislature strengthens local and state health departments, evidence-based guidelines, and modern electronic records for quality and continuity of care and public health data collection and action.

7. Legislature eliminates homelessness, funds neighborhood improvement and exercise opportunities, ensures sound nutritional adequacy and advice.

8. Current departments of state government are authorized to study and remedy deficiencies in oral and behavioral health funding and distribution.

9. State legislature establishes and funds district or community-based health boards to involve and empower local consumers and health workers.

10. The legislature guarantees that the health workforce, including all levels of training, skill, and organization, is recognized with fair compensation and benefits, with its experience included with consumers in planning and delivering local services and maintaining standards of access and quality.

"Oral Health for All"

COHI
Connecticut Oral Health Initiative

Legislative Testimony
House Bill 6600 – An Act Concerning the Establishment of the SustiNet Plan

Madeline McClave, Interim Executive Director
Connecticut Oral Health Initiative (COHI)

Good afternoon. My name is Madeline McClave. I am the Interim Executive Director of the Connecticut Oral Health Initiative or COHI. Thank you for the opportunity to speak to the Public Health, Insurance and Real Estate, and Human Services' Committees today about House Bill 6600, An Act Concerning the Establishment of the SustiNet Plan. On behalf of our board of directors and other constituents, I am here to encourage you to support this bill because it will increase access to comprehensive, affordable, portable and efficient healthcare including dental services. SustiNet would benefit huge numbers of Connecticut residents as well as small nonprofits such as COHI in making health insurance more affordable and health, dental and mental health services accessible.

We ask that you make sure that oral health care continues to be included in the definition of healthcare coverage in this Plan through your work going forward. There are three compelling reasons to do so:

1) The links between oral health and other serious health problems
2) The cost-effectiveness of ensuring residents get early, regular, preventive dental care
3) The inaccessibility of oral health care for so many Connecticut residents

The integration of dental care into any state health care plan is extremely important to the oral health as well as the general health and well being of Connecticut residents. This is because of the links between oral health and a growing list of many serious and systemic health problems. These include diabetes, heart disease, stroke, cancer, systemic infection and pre-term births. Research increasingly supports what professionals have long contended: we cannot separate oral health from overall health. COHI urges you - who will craft any future state health care plans - not to ignore this science. In 2000, former U.S. Surgeon General C. Everett "Chick" Koop, coined the phrase "You're not healthy without good oral health." This is something that most of us who have adequate dental insurance coverage and get regular, preventive oral health care don't have to think about. Research shows that the mouth is truly a window into what's going on in the rest of the body.

In addition, while the recent settlement of the *Carr v. Wilson-Coker* lawsuit has led to some significant improvements in access to dental care within the HUSKY Plan, the well-documented deficiencies of all the Medicaid programs with regard to dental care underscore the need for including oral health care into any new state healthcare plan. In addition, because Medicare does not cover dental, adult coverage is vitally important. Most safety net dental clinics around the state have very long waiting periods for appointments or do not accept appointments at all so that patients must wait long hours and simply hope to be seen. The increasing number of emergency dental cases creates a huge challenge for these programs. Several have closed their doors to new patients to try to cope with the demand.

Through SustiNet, the State of Connecticut could finally address the real and sustained crisis that children, pregnant women, older adults and others face every day in trying to access dental care. By

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ensuring access to early, regular and preventive dental care through a new plan, the state would prevent significant pain and suffering as well as the huge medical and other costs incurred across the health system now due to lack of access for so many resident. The benefits would be huge.

According to a 2001 report of the U.S. Surgeon General, oral health problems are responsible for more missed school days than any other type of health problem. Three out of 100 children miss school because of dental pain. You may be surprised to learn that tooth decay is five times more common than asthma and is the single most common chronic disease among children. When oral health problems are not addressed, the pain and suffering often becomes so severe that patients end up making costly visits to hospital emergency rooms that are already overburdened. In fact, 'dental problems' are cited as one of the main reasons that children visit many emergency rooms during the day. Usually, there are no dentists available and treatment is for symptoms only. Patients sometimes must be hospitalized for acute infections, and are at increased risk of disease in permanent teeth, extensive pain and poor nutrition. They may even require oral surgery due to lack of early and regular dental care.

Thanks to the efforts of the General Assembly to ensure the settlement of *Carr v. Wilson-Coker* and the subsequent launching of the new dental 'carve out' program on September 1, 2008, there has been a significant increase in HUSKY provider enrollment, especially among pediatric dentists, and access in many parts of the state. However, some areas of Connecticut still do not have a good network of dental providers for this population and adult rates remain so low that they pose a barrier to providers' accepting these patients. Some New England states that have passed legislation for expanded or universal healthcare in the past few years neglected to include oral health coverage. Many officials and other experts who were involved in crafting and implementing these programs say that they wish they had included dental care in these plans. COHI urges your three Committees to learn from these states and support a plan such as SustiNet that recognizes the mouth to have parity with the rest of the body.

We ask that you respond to the clear data that shows the importance of early and regular dental care and the continuing lack of access, especially among the working poor who are uninsured, and those 21 and older across the Medicaid programs. Moving ahead with SustiNet and including oral health care in overall health coverage by the state will go a long way in fixing this problem. We hope that you will pay serious attention to the growing body of research that shows how vital oral health is to general health, the extremely high incidence of dental disease among poor children and adults, and the high cost/benefit ratio of providing early, regular dental care to prevent more extreme problems that cause pain, suffering, increased emergency department visits and hospitalizations, and missed school and work days.

Thank you very much for the opportunity to speak with you today. Please do not hesitate to contact COHI (246-2644 or madelinem@ctoralhealth.org) if you have questions or need additional information.

The Connecticut Oral Health Initiative works to raise awareness and improve public policy to support its mission 'Oral Health for All'. Founded in 1992, COHI has been an independent nonprofit since 2003. It brings together individuals, dental professionals and organizations that believe in 'Oral Health for All.'

001471

Matthew Katz

AMA AMERICAN MEDICAL ASSOCIATION

Therapeutic Insights

Gaining Control of Asthma in Children

In cooperation with the Connecticut State Medical Society

Release Date: June, 2008

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Ronald Ferdman, MD, *Author, Planning Committee*
Assistant Professor of Clinical Pediatrics
USC Keck School of Medicine
Division of Clinical Immunology and Allergy
Children's Hospital Los Angeles
Los Angeles, CA
Speaker's Bureau: GlaxoSmithKline

Allan Luskin, MD, *Reviewer*
Clinical Associate Professor of Medicine
University of Wisconsin School of Medicine & Public Health, Madison
Director, Center for Respiratory Health
Dean Medical Center
Madison, WI
President, Healthy Airways, Vice President, SRxA, Consultant sanofi-aventis, Merck, Teva, Astra-Zeneca, Pharmaxis, Genentech, Novartis, Aerocrine

Todd A. Mahr, MD, *Reviewer (American Academy of Pediatrics)*
Clinical Professor of Pediatrics
University of Wisconsin School of Medicine & Public Health, Madison
Director, Pediatric Allergy & Clinical Immunology
Gundersen Lutheran Medical Center
LaCrosse, WI
Speaker's Bureau, Research Honorarium, Advisory Board GlaxoSmithKline, Astra Zeneca, Alcon, Speaker's Bureau and Honorarium Teva, Schering Plough, sanofi-aventis, Sepacour, Speaker's Bureau, Advisory Board, Honorarium Genentech, Novartis

Susan Nedza, MD, MBA, FACEP, *Independent Reviewer*
Vice President, Clinical Quality & Patient Safety
American Medical Association
Adjunct Associate Professor, Department of Emergency Medicine
Northwestern University Feinberg School of Medicine
Chicago, IL
Nothing to disclose

AMA Staff

R. Mark Evans, PhD, *Editor/Planning Committee*
Nothing to disclose

Patti J. Fitzgerald, *Managing Editor/Planning Committee*
Nothing to disclose

Laura Schmidt, *Project Manager/Planning Committee*
Nothing to disclose

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Expiration Date: June 30, 2009

Welcome to the AMA's quarterly online CME newsletter, Therapeutic Insights. This issue of the newsletter is intended for primary care physicians, pediatricians, and other physicians who treat children with asthma. Upon completion of this activity, participants should be able to

- *Apply the NAEPP EPR-3 guidelines for the diagnosis and management of asthma in children.*
- *Determine which young children with recurrent wheezing are likely to have asthma, and when daily controller medication should be initiated.*
- *Assess children with suboptimally controlled chronic asthma and determine what therapeutic options are available to regain control.*

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It is estimated that it will take approximately 1 hour to review this material and answer the self-assessment questions. Record your answers to the evaluation and self-assessment questions online or by completing the answer sheet at the end of this newsletter and faxing or mailing according to instructions

Statement of Educational Need

Many highly efficacious pharmacologic and nonpharmacologic therapies are available to treat asthma. Several national and international consensus asthma guidelines exist, and while they differ in regards to certain minor details, there is almost universal agreement in their recommendations for the use of medications and other treatment approaches.[1] Multiple studies have demonstrated that adherence to these guidelines results in improved patient outcomes,[2] improved quality of life[2] and decreased cost to the health care system.[3] Despite the widespread promulgation of these guidelines and the availability of effective medications, many patients with asthma continue to be poorly controlled.[4]

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This gap between the availability of effective treatment and poor disease control is especially wide in children. Children are disproportionately affected by asthma. Compared to adults >18 years of age, children with asthma have a higher rate of reported attacks, physician office visits, outpatient hospital visits, emergency department visits and hospitalizations.[5] Only in asthma mortality does the rate in adults surpass that of children <18 years old. Asthma impairs children physiologically (decreased lung function), functionally (sleep, exercise, school) and psychologically (depression, anxiety).[6] Its effects extend beyond the child to their parents and other family members.[7]

Figure 1 illustrates the treatment gap in children and adolescents diagnosed with asthma.

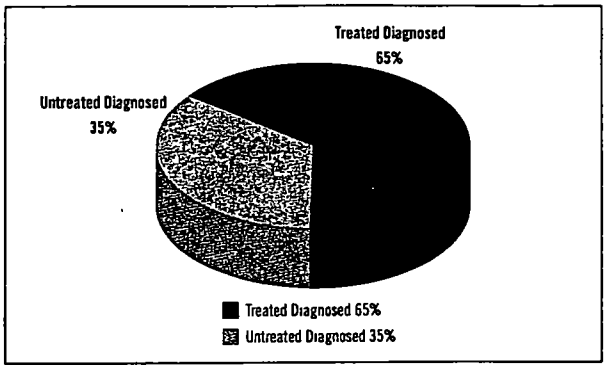


Figure 1. Patients (2 to 18 years of age) Diagnosed with Asthma: Treated vs Untreated

Source: IMS Health. Integrated Administrative Claims Data. Time period: 12 months ending March 2007.

Methods: The category of diagnosed/untreated is defined as patients with a diagnostic claim for asthma between April 2006 and March 2007 whose parents/guardians did not fill a prescription to treat their asthma in the last 12 months of the study period. Treated and untreated refers to pharmacologic management.

Introduction

In asthma, as is the case with many chronic diseases, effective treatments exist, but there is no cure. However, asthma is distinctly different from other chronic diseases in that asthma has no non-pulmonary long-term complications in most patients. While an increased risk of chronic obstructive lung disease due to airway remodeling exists,[8] this long-term complication is still unproven.[9] Lung function does decrease with time in long-standing asthma. While therapy has not been shown to reverse or stop this decline, with proper treatment, lung function can be reversed to near normal while on therapy, and acute morbidity and mortality can largely be prevented. The average life-span of people with asthma is not substantially different from non-asthmatics. Thus, there is continual opportunity for renewal in even the most poorly controlled individual.

The National Asthma Education and Prevention Program's (NAEPP) Expert Panel Report 3 (EPR-3)[10] released in August, 2007 provides updated asthma guidelines that for the first time, are fully evidence-based, reflecting a review of more than 15,000 studies. While the new guidelines share the same basic format and many of the features of prior NAEPP expert reports, several changes have been made with the intent of addressing deficiencies and improving/updating previous recommendations.

Significant changes include a new focus on monitoring asthma control to determine ongoing therapy. EPR-3 greatly expands the concept of asthma control as a measure used to determine the effectiveness of asthma therapy. Also new is the introduction of the concept of two distinct domains of severity and control—current impairment and future risk. Some of these principles are explored in more detail in this newsletter.

EPR-3 continues to recommend the step therapy approach to asthma management based on severity and control. However, EPR-3 has expanded the stepwise approach from 4 to 6 steps in order to simplify the actions at each step. In addition, the recommendations for step therapy have been modified to include newer medications, and more recent data regarding safety and efficacy of older medications. Unlike previous EPR guidelines, children have been divided into 2 age groups, 0-4 years and 5-11 years, while youths and adults ≥12 years remain a separate group. This newsletter will focus on the two youngest age groups.

EPR-3 contains sets of tables that may be used for initial assessment of asthma severity, assessment of ongoing control, and guidance with stepwise therapy, in each of the three age groups. These tables are quite detailed and provide substantial information. For the purposes of this newsletter, these tables have been condensed and simplified for the two younger age groups and are presented as a point of reference. The entire EPR-3 report and an executive summary that contains the tables in entirety can be obtained at: http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.

The EPR-3 continues to classify asthma medications into two types—short-term quick relief medications and long-term controller medications. The mainstay of the quick relief medications remains the inhaled short acting beta-agonists (SABAs). Inhaled anticholinergic medications may provide an additive effect to SABAs for treatment of acute exacerbations in the emergency department, but do not play a significant role in the outpatient treatment of most children. Short courses of oral corticosteroids are still the best treatment for significant exacerbations that fail to respond to frequent inhaled SABAs.

There are many choices available for long-term controller medications. Inhaled corticosteroids (ICSs) continue to be the most effective long-term controller medication for asthma, and are recommended as first line therapy in all ages. There are currently six different ICSs on the market in the US, with a seventh nearing release. Alternatives to ICSs in young children include the leukotriene receptor antagonist, montelukast, and the mast cell stabilizer, cromolyn sodium. Sustained-release theophylline is also an alternative choice for long-term control in children ≥5 years of age, but in general is rarely used due to the need to monitor serum levels. Inhaled long-acting beta-agonists (LABAs) (salmeterol and formoterol) are effective when used in combination with a daily ICS as "add-on" therapy for those patients not well controlled on low- or medium-dose ICSs. LABAs should never be used as monotherapy for long-term control of asthma. Leukotriene modifiers are an alternative for add-on therapy in young children. Omalizumab (anti-IgE) is another option for add-on therapy for selected children (≥12 years) with more severe allergic asthma that is suboptimally controlled on combination ICS and LABA therapy. Long-term daily or alternate-day use of oral corticosteroids is reserved for those children with the most severe asthma, and is usually a therapy of last resort.

Figure 2 provides a comparison of the relative use of these agents in children diagnosed with asthma. SABAs are the most commonly used agents (*ie*, > 80%) and oral corticosteroids and the controller medications, ICS and leukotrienes, are used in a third of children. ICS/LABA combination is used much less (*ie*, 15%), while other controller medications, LABAs, xanthines, mast cell stabilizers, and anti-IgE therapy are not commonly used.

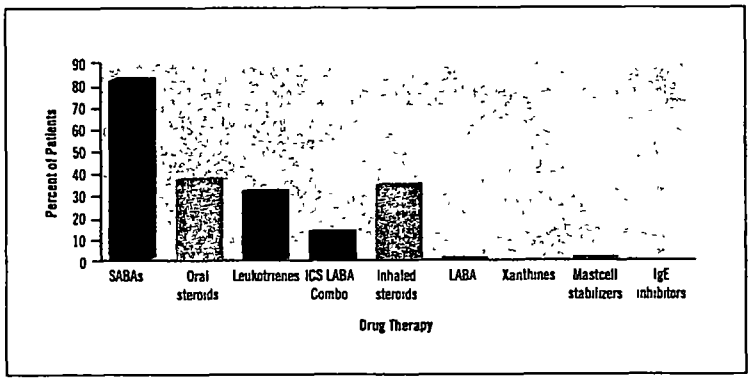


Figure 2. Patients (2 to 18 years of age) Diagnosed with Asthma—Treated with Pharmacologic Therapy

Source: IMS Health. Integrated Administrative Claims Data. Time period: 12 months ending March 2007.

Case 1

An 18-month-old boy presents with a persistent cough for 3 days. He first became ill 4 days earlier with clear rhinorrhea and decreased oral intake. Other family members had similar upper respiratory congestion A mild cough started the next day, and by that evening the cough had worsened to the point where his mother administered 2 puffs of albuterol via a metered dose inhaler (MDI), but this afforded only minimal improvement. The child coughed throughout the night and his mother gave him 1 teaspoon of albuterol syrup because the albuterol inhaler did not appear to help. The child was then brought to your office for evaluation.

Past medical history is significant for 3 similar episodes within the last 8 months. The first episode was precipitated by a viral respiratory infection and resulted in an emergency department (ED) visit during which he received 2 nebulized albuterol doses and a 3 day course of oral prednisolone. A chest radiograph at that ED visit was normal. The other 2 episodes responded to nebulized therapy in after-hour urgent care, and neither time was the boy treated with oral corticosteroids. One of these episodes was also preceded by a viral URI, but there was no reported respiratory infections associated with the third episode and his mother thinks it started after visiting a relative who owns a cat. Other notable history is for mild atopic dermatitis that responded to hydrocortisone 1% cream, but has improved dramatically in the last 6 months, coincident with removal of eggs from his diet. Birth history is unremarkable. His mother smokes, but only outside of the house, and there are no pets. Review of family history reveals that his mother had asthma as a child and there are cousins with both allergic rhinitis and asthma.

Exam shows a well appearing child with normal vital signs except for mild tachypnea. Growth parameters were symmetrical around the 75th percentile. Lung exam revealed scattered expiratory wheezing and some mild suprasternal retractions. There was a clear nasal discharge. The remainder of his exam was normal.

Asthma in Young Children

Recurrent wheezing in young children is a frequent dilemma for primary care physicians. Wheezing is an extremely common symptom in this group, and roughly half of all children will have at least one episode in their first year of life.[11] While most of these children will not go on to develop asthma, the majority of children who do have asthma presented with their first episode of wheezing very early in life. Approximately 80% of children with asthma begin wheezing before 5 years of age, and 50% will have their first episode by their first birthdays.[12] Identifying the portion of wheezing young children who have asthma has important prognostic and therapeutic implications.

Not only is wheezing common, its consequences in young children are substantial. The estimated rate of emergency department visits for asthma (168.3/10,000 population) is higher in children 0-4 years of age than any other age group. Of all children 0-4 years old with asthma, the annual rate of emergency department visits is 25.9/100 persons with asthma, which again is higher than for any other age group (range 5.4-10.9 per 100 persons with asthma for all other age groups). Rates of hospitalization for asthma are 2-5 times higher in children 0-4 compared to other age groups.[5] The estimated annual costs of direct asthma care for all children less than 5 years of age are similar to the costs of all children 5-17 years, but an overwhelming proportion is for hospitalizations, accounting for 75% of total costs in the younger group compared to only 35% of costs in the older group.[13] Lung function at 1 year of age in children who will go on to develop asthma is indistinguishable from those children with recurrent wheezing who do not develop asthma.[14] However, by 6 years of age, lung function in asthmatic children is decreased compared to non-asthmatics, and this decrement in lung function persists and even increases with age.[15]

These data show that not only do children with asthma present at a young age, they are in fact disproportionately affected in terms of symptoms, health care costs and lung function, making early identification essential. Early initiation of asthma medications has been shown to significantly improve symptoms even in young children. Unfortunately, studies to date have been unable to demonstrate that asthma medications prevent loss of lung function in children.[16]

When a physician is confronted with a child as described in Case 1, several questions arise.

- ***How Likely is this Child to Wheeze Again in the Future?***

Obviously, not all children who have a single episode of wheezing have asthma; however, a large proportion of young children with recurrent wheezing will demonstrate this symptom for several years. Both the pattern ("phenotype", see below) and the differential diagnosis should be considered when evaluating recurrent wheezing in young children. In a multi-year longitudinal study of over 1200 infants, three phenotypes of wheezing have been described: transient early wheezing, nonatopic wheezing and atopic wheezing.[17,18]

Transient wheezing is the most common phenotype, accounting for almost 60% of wheezing cases, and occurring in males more than females. These children have recurrent wheezing in their first year of life, and symptoms usually resolve by 3-5 years of age. These children have low lung function before the wheezing starts, but lung function is normal by 6 years of age.[14] The major risk factor is maternal smoking during pregnancy.[19] Other risk factors include exposure to recurrent viral infections (either directly by day care attendance, or indirectly from an older sibling in school), and possibly gastro-esophageal reflux.[20] There is no association with personal or family history of atopic diseases.

Nonatopic wheezing also starts early, usually at less than 3 years of age, and accounts for 20% of wheezing cases; there is no sex predilection. Wheezing usually improves by 6 years of age and is mostly resolved by 13 years of age.[14,18] A major risk factor is premature birth and a preceding lower respiratory tract infection, especially respiratory syncytial virus (RSV).[14,21] These children are more likely to come from socioeconomically disadvantaged backgrounds. Lung function is mostly normal, the major exception being in those who develop lower respiratory infections with RSV before 3 years of age. In this subgroup, lung function is lower than normal after the RSV infection and they may have increased airway hyperresponsiveness, but these revert to normal by puberty.[21] There is no association with personal or family history of atopic diseases.

Atopic wheezing is the "classic" asthma phenotype, and is attributable to the remaining 20% of those children who wheeze. Atopic wheezing is more common in males, presents early, in the second or third year of life, but often under 1 year of age. The major risk factor is a personal or family history of atopic diseases and allergic sensitizations.[14,18] Wheezing tends to continue at least into adolescence. Lung function is normal prior to onset of wheezing, but by 6 years of age, there is reduced lung function compared to age-matched children with no history of wheezing.[14,18] This reduced lung function persists for life in most patients.[15]

Differential Diagnosis of Wheezing: Distinct from these different phenotypes, the differential diagnosis for recurrent wheezing must also be considered. These include conditions that exacerbate existing wheezing, or can be the sole cause, including: gastroesophageal reflux or aspiration from swallowing dysfunction; aspirated foreign bodies; laryngeal webs; tracheal stenosis; external bronchial airway compression from anomalous vascular rings/slings, congenital or acquired lung cysts, mediastinal masses or cardiomegaly; tracheoesophageal fistulas; cystic fibrosis; and heart disease among others.[10] The medical history and physical exam should specifically address the clinical features associated with these various conditions.

Returning to the child in Case 1, his initial history and exam do not suggest any underlying diagnosis on the differential of recurrent wheezing. A normal chest radiograph makes conditions such as lung masses, congenital lung and heart disease unlikely. He is growing and thriving and shows no sign of underlying systemic disease that would warrant a further work-up. Lastly, he responds as expected to short-acting bronchodilators and oral corticosteroids and has periods of good health in-between episodes. He has features that could be consistent with any of the 3 different phenotypes of wheezing, including many that fit the atopic wheezing, or asthma, phenotype. So what are the necessary clinical criteria to determine if a child likely will have asthma?

Table 1. Composite Asthma Predictive Index*

- History of ≥4 episodes of wheezing lasting >1 day, at least 1 confirmed by a physician
  AND
- ≥1 major criteria **OR** ≥ 2 minor criteria

Major Criteria

- Parent with physician-diagnosed asthma
- Patient with physician-diagnosed eczema
- IgE-mediated allergy[b] to ≥1 aeroallergen[c]

Minor Criteria

- Wheezing apart from colds
- Eosinophilia (≥4%)
- Patient with physician-diagnosed allergic rhinitis[d]
- IgE-mediated allergy[b] to milk or eggs or peanuts[c]

* Table a composite of recommendation from references[10,22,23]

a Original index used *loose index* as "ever wheeze", and *stringent index* as "frequent wheeze", defined as parental rating of ≥3 for frequency of wheezing using a scale from 1 (very rarely) to 5 (on most days)

b As determined by allergy skin test or blood RAST Aeroallergens were house dust mites, cockroach, molds, and grass/weed/tree pollens

c. Included in only modified index, not original index.

d Included in only original index, not modified index.

- ***Does this Child Have Asthma?***

The original asthma predictive index (API) was developed based on the Tucson Children's Respiratory Study of wheezing.[22] API was intended to provide a clinically useful set of criteria to help predict which young children with wheezing will be likely to have asthma symptoms beyond 6 years of age. This index was subsequently modified to include allergy test results.[23] In children with a negative index, 95% stopped wheezing before 6 years of age. Conversely, children had a 76% risk of persistent wheezing beyond 6 years of age if a stringent index (frequent wheezing) was positive, and 59% had asthma if a loose index (ever had wheezing) was used. **Table 1** is a composite of the original and modified APIs.

Using the composite API, this child meets two major criteria (parent with asthma and personal history of eczema). He also meets one minor criteria (wheezing apart from colds). While not proven, he may meet additional criteria, namely allergic sensitization to an aeroallergen (wheezing after exposure to a cat) and to eggs (eczema improved after eggs removed from diet). As part of his evaluation, it would be entirely reasonable to perform allergy testing to confirm these and other possible allergies. With a positive API and in the absence of any signs of other underlying conditions, it is very likely that this child has asthma.

- ***Should this Child be Started on Daily Controller Medications?***

While all clinical features indicate that this child likely has asthma, there is no way to be absolutely certain, and it may not be possible to definitively make the diagnosis until several years in the future. This raises an important point: *it is not necessary to definitively make the diagnosis of asthma in a young child in order to start appropriate asthma therapy*. Physicians too often hesitate to prescribe asthma controller medications because a child is "too young" to make the diagnosis. A clear distinction needs to be made between "persistence of asthma" symptoms and "persistent asthma". Persistence of asthma refers to the long-term duration of asthma symptoms. This can be assessed by determining the child's asthma phenotype (transient, nonatopic, atopic) and their API, which will help identify children who may stop wheezing early, or persist for many years. On the other hand, the EPR-3 continues to use the same step classification of asthma severity as in previous versions (*ie*, intermittent asthma versus mild, moderate, and severe persistent asthma **(Tables 2-4)**. Children with intermittent asthma do not require daily controller medications, while those with persistent asthma symptoms require various magnitudes of daily controller medications depending on the severity of their persistent asthma. Long-term duration and severity of symptoms are independent features. Children can have intermittent asthma for years, if not their entire lives. Conversely, even if a child's symptoms resolve at an early age (*eg*, 3 years of age) that child can have severe persistent asthma during that time, and suffer the same morbidity as a child who will wheeze to a later age. In addition, children with intermittent asthma may nevertheless have severe flares that require intensive and sometimes prolonged therapy. *The decision to start a controller medication should be based on the current severity of the child's asthma, not on the likelihood that the symptoms will resolve at an early age*

The EPR-3 defines persistent asthma in a child 0-4 years of age as having symptoms that meet any one of these criteria: asthma symptoms or short-acting beta-agonist needed two or more days a week, one or more nighttime awakenings per month, any interference with normal activity or two or more exacerbations requiring steroids in 6 months or satisfying the API index **(Table 1)**. Based on these criteria, the child presented in Case 1 should initiate daily controller medications. According to the guidelines, Step 2 therapy would be indicated **(Table 2)**; a low-dose inhaled corticosteroid is indicated **(Table 4)**

Table 2: Classifying Initial Asthma Severity and Recommendations for Level of Initiation of Stepwise Asthma Therapy in Children 0-4 Years of Age and 5-11 Years of Age

Components of Severity	Classifying Asthma Severity and Initiating Therapy in Children							
	Intermittent		Persistent					
			Mild		Moderate		Severe	
	Ages 0-4	Ages 5-11	Ages 0-4	Ages 5-11	Ages 0-4	Ages 5-11	Ages 0-4	Ages 5-11
Impairment: Symptoms	≤2 days / week		>2 days / week but not daily		Daily		Throughout the day	
Impairment: Nighttime awakenings	0	≤2x / month	1-2x / month	>2x / month	3-4x / month	>1x / week but not nightly	>1x / week	Often >7x / week
Impairment: Short-acting β_2-agonist use for symptom control	≤2 days / week		>2 days / week but not daily		Daily		Several times a day	
Impairment: Interference with normal activity	None		Minor limitation		Some limitation		Extremely limited	
Impairment: Lung Function • FEV_1 (predicted) or peak flow (personal best) • FEV_1 /FVC	N/A	Normal FEV_1 / Between exacerbations >80% >85%	N/A	>80% >80%	N/A	60-80% 75-80%	N/A	<60% <75%
Risk: Exacerbations requiring oral systemic corticosteroids (consider severity and interval since last exacerbation)	0-1x / year (see notes)		≥2 exacerbations in 6 mo requiring oral systemic corticosteroids, OR ≥4 wheezing episodes / 1 year lasting >1 day and risk factors for persistent asthma	≥2x / year (see notes) Relative annual risk may be related to FEV_1				
Recommended Step for Initiating Therapy	Step 1 (for both age groups)		Step 2 (for both age groups)		Step 3 and consider short course of oral systemic corticosteroids	Step 3 medium-dose ICS option and consider short course of oral systemic corticosteroids	Step 3 and consider short course of oral systemic corticosteroids	Step 3 medium-dose ICS option OR Step 4 and consider short course of oral systemic corticosteroids

In 2-6 weeks, depending on severity, evaluate level of asthma control that is achieved
- Children 0-4 years old If no clear benefit is observed in 4-6 weeks, stop treatment and consider alternative diagnoses or adjusting therapy
- Children 5-11 years old Adjust therapy accordingly

Modified from EPR-3[10]

- ***How Should this Child's Acute Asthma be Treated?***

While an emphasis in the treatment guidelines is the identification of children with persistent asthma and initiating daily controller therapy, even appropriately treated children will have acute asthma flares. The child in Case 1 is having a relatively mild exacerbation, but nevertheless there are several key points to remember when treating acute flares.

Table 3. Assessing Asthma Control and Recommendations for Adjusting Asthma Therapy in Children 0-4 Years of Age and 5-11 Years of Age

Components of Severity	Assessing Asthma Control and Adjusting Therapy in Children					
	Well Controlled		Not Well Controlled		Very Poorly Controlled	
	Ages 0-4	Ages 5-11	Ages 0-4	Ages 5-11	Ages 0-4	Ages 5-11
Symptoms	≤2 days / week but not more than once on each day		>2 days / week or multiple times on ≤2 days / week		Throughout the day	
Nighttime awakenings	≤1x / month		>1x / month	>2x / month	>1x / week	≥2x / week
Short-acting β_2-agonist use for symptom control (not prevention of EIB)	≤2 days / week		>2 days / week		Several times a day	
Interference with normal activity	None		Some limitation		Extremely limited	
Lung Function • FEV_1 (predicted) or peak flow (personal best) • FEV_1 /FVC	N/A	>80% >85%	N/A	60-80% 75-80%	N/A	<60% <75%
Exacerbations requiring oral systemic corticosteroid	0-1x / year		2-3x / year	≥2x / year	>3x / year	≥2x / year
Reduction in lung growth	N/A	Requires long-term follow-up	N/A	Requires long-term follow-up	N/A	Requires long-term follow-up
Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.					
Recommended Action for Treatment	• Maintain current step • Regular follow-up every 1-6 months • Consider step down if well controlled for at least 3 months		Step up 1 step	Step up at least 1 step	• Consider short course of oral systemic corticosteroids • Step up 1-2 steps	

Modified from EPR-3[10]

Even children with intermittent asthma have the potential to develop serious and even life-threatening asthma attacks.

In general, the severity of acute attacks is related to the severity of underlying asthma, as well as recent asthma control and exacerbations.[10] However, the severity of past exacerbations does not necessarily predict the severity of future ones, and even children with relatively minor asthma may have unexpectedly severe asthma attacks.[24] Among children who die from asthma, approximately 30%-50% have what was classified as mild asthma, and would not have been classified as high risk for fatal asthma.[24,25] One study characterized the severity of 10% of children who died of asthma as "trivial" prior to their fatal attacks.[25] So for any child who is having an asthma flare, the potential that the flare could be severe must be considered and therapy must always be initiated promptly.

Inhaled SABAs are the treatment of choice for acute asthma symptoms.
The cornerstone of therapy for acute attacks is administration of inhaled SABAs. Case 1 raises several points regarding the use of SABAs. First is the use of oral (albuterol syrup in this case) vs. an inhaled SABA (albuterol MDI). There is no debate that inhalation is the most efficacious route of administration for SABAs, due to their more rapid onset of action and time to peak action, greater bronchodilatory effect and reduced adverse effect profile. The inhaled form can also be administered more frequently than the oral syrup in case of emergencies. However, on a practical basis in young children, albuterol syrup requires no special skill to administer and is used frequently in clinical practice. It is not reasonable to expect that inhaled SABA be prescribed to every young child who wheezes even once. There are no guideline recommendations for changing from oral preparations to inhalation.[26] As a general guide, in children who have just started to wheeze, an inhaled SABA should be prescribed (a) for recurrent wheezing—usually by the second or third episode; (b) for any severe episode, especially those requiring oral corticosteroids, ED visits or hospitalization; (c) if oral albuterol is only partially effective or if it is associated with disturbing adverse effects. Once a child is diagnosed with asthma or has well established recurrent wheezing, it is no longer appropriate to use oral albuterol syrup for acute relief of symptoms.[26]

If inhaled SABA is more efficacious than oral administration why did the mother in Case 1 switch from albuterol MDI to oral albuterol syrup? For any inhaled medication to be effective, it must be delivered adequately to the lungs. Almost certainly, if a child seemingly has a greater response from oral SABA than inhaled SABA, this is an indication that the inhaled medication is not being administered correctly. One piece of critical information that was not included in the case was whether or not the MDI was used correctly. All children <5 years of age who are unable to demonstrate proper MDI technique should be prescribed a valved holding chamber (VHC or "spacer") to use in conjunction with any MDIs. There is no age that is "too young" to prescribe an MDI and VHC, and most VHCs are available with different size masks to accommodate a child of any age. Many children over 5 years old will also need a VHC.[27] VHCs may enhance delivery of medications to the lung, and also decrease oropharyngeal deposition. Therefore, they can be used in conjunction with inhaled corticosteroid MDIs in all ages to minimize oropharyngeal adverse effects, even if the patient reliably demonstrates proper MDI technique. It should be noted that although it is common practice, the administration of most MDIs with VHC is an off-label use. More study is needed to determine the effect of VHCs with the newer hydrofluoroalkane (HFA) MDIs. Proper MDI and VHC technique should be part of the initial instructions when MDIs are first prescribed, and then periodically reviewed at future visits.[10]

Many studies, including those in very young children and in acutely ill children, have examined the efficacy of inhaled SABA delivered via an MDI and VHC compared to nebulization. Almost without exception it has been shown that inhaled SABA administered with an MDI and VHC is at least equivalent to, and sometimes superior to nebulized SABA in terms of efficacy, adverse effects, time, costs and patient satisfaction.[28] However, these studies run counter to the general perception of most primary care physicians that nebulized SABA is superior to MDI and VHC. A SABA delivered via MDI and VHC should give equivalent results to nebulized SABA, only *if MDI and VHC technique is correct*. Repeated studies have demonstrated that patient inhaler technique is often poor, and even after instruction, many patients continue to have poor technique or their technique deteriorates over time.[29] Nebulization is an easier skill to perform and is much more forgiving of short lapses of non-cooperation by the child. Even a few moments of a child resisting an MDI and VHC will result in substantially less medication being delivered to the lung. The newer, more efficient nebulizers can deliver a dose of medication in a few minutes; thus, the apparent superiority of nebulized SABA can often be attributed to poor inhaler technique. Once again, there are no strict guidelines as to when nebulized SABA should be prescribed to a child. As a general rule, it would be advisable for any child with recurrent wheezing who is under 5 years of age to be prescribed an aerosol compressor. While in general, inhalers are the preferred mode of delivery for inhaled asthma medications, selected children under 12 who have persistent asthma not well controlled with inhalers alone could also benefit from having access to a nebulized SABA at home, especially during severe flares. If a child initially prescribed MDI therapy does not improve promptly, consideration should be made for changing to nebulized therapy.

Acute attacks respond most readily to therapy that is initiated early.
In general, there are two ways to utilize inhaled SABAs: 1) give a dose after onset of an asthma symptom to quickly relieve that symptom; and 2) give a dose just prior to a known asthma trigger, such as in exercise-induced asthma, where an inhaled SABA is given 15-20 minutes prior to physical activity. Exercise, however, is not the only trigger for which SABAs can be administered preventatively. In young children, by far the most common trigger for acute asthma is viral respiratory infections, as is described in Case 1. The EPR-3 guidelines recommend that treatment be initiated with an inhaled SABA at the onset of a viral infection, before lower respiratory symptoms start. The SABA can be administered every 4-5 hours for at least the first day, and extended for a longer period if needed. While it is impossible to prevent a child from contracting a cold, early administration of inhaled SABAs may lessen or even prevent the cold from triggering a significant asthma attack. In Case 1, SABA therapy could have been initiated 2 or even 3 days earlier, and would likely have prevented this now more serious exacerbation. Additionally, if a particular child has a previous history of severe attacks with URIs, starting a short course of an oral corticosteroid at the onset of the URI is an additional option.[10]

Distinguishing Between Asthma Severity and Asthma Control
Once the diagnosis of asthma has been established, determination of its severity is important in order to guide appropriate therapy.

Case 2a
An 8-year-old boy with asthma presents to your office for evaluation.

Over the last 4 months he has had 13 ED visits and 3 hospitalizations, including one in the intensive care unit, for asthma.

During these 4 months he required his inhaled SABA at least 4-6 times during the day and woke up an average of 2 times per night to use his SABA. He becomes short of breath on minimal exertion and has missed 30 of the last 80 days of school.

Case 2b
An 8-year-old boy with asthma presents to your office for evaluation.

Over the last 4 months he has not been hospitalized and has not required any ED visits or urgent care office visits for his asthma.

During these 4 months he required his inhaled SABA about 1-2 times per month, usually with very strenuous exercise, but otherwise has no exercise limitations. He has no nighttime disturbances and has not missed any summer school due to his asthma.

These two cases portray two supposedly very different 8-year-old boys at the two ends of the spectrum: Case 2a with severe disturbance from asthma and Case 2b with negligible asthma.

Case 2 – Additional History
The patient in Case 2a and Case 2b is the same 8-year-old boy. Case 2a presented during the winter season, and his only medication at the time was inhaled SABA, prn. Case 2b is the same child, but he presented during the end of the summer season.

One of the new aspects of the EPR-3 guidelines is a closer look at the concept of asthma "severity" and its role in guiding therapy. The severity of asthma symptoms varies over time and in this case, seasonally. It may change more slowly over the years as a child grows up. It may also change quickly over a few days, such as during a viral URI. What is the "overall" severity of this child's asthma? Since the severity of the boy's asthma in Case 2 changed so dramatically during the year, it becomes essentially impossible to assign one level of asthma severity to this child, as is the case in most children Therefore, asthma severity cannot be the only criteria used to guide asthma therapy.

Case 2 – Additional History
Case 2a is how the patient presents to you initially, when his only treatment is inhaled SABA prn. Due to the severity of his symptoms, you prescribed a daily high-dose inhaled corticosteroid, daily inhaled LABA, a daily leukotriene antagonist and a short course of oral corticosteroids. The boy in Case 2b represents the child who returns for a re-evaluation after having taken all these asthma medications for the last 4 months.

The EPR-3 distinguishes between asthma "severity" and asthma "control". Using symptom severity alone, Case 2a would obviously be labeled as "severe" asthma. However, again using symptom severity alone, would we label Case 2b as "mild" asthma? How could a child who requires 4 daily controller medications, including oral corticosteroids, have "mild" asthma? The answer is that Case 2b is not a case of mild asthma, but rather a child with *severe asthma that is well controlled.*

The EPR-3 defines "severity" as the intrinsic intensity of the disease process, as measured by the degree of current impairment and the assessment of future risk or by defining the least amount of medication needed to achieve control of symptoms. There are two ways to measure asthma severity. It is most easily and directly measured in a patient who has not yet started daily long-term control therapy. In Case 2a, this child has several symptoms—daily SABA need, nightly sleep disturbance and severe exercise limitation—that would place him at the level of severe persistent asthma. Alternatively, severity can be measured by the level of step care (*ie*, the amount of medication required to achieve adequate control). In Case 2b, the child requires step 6 medications (**Table 4**), the highest level, to maintain asthma control. Characterizing asthma severity is important to guidethe initial therapeutic choice.

"Control" is defined as the degree to which the manifestations of asthma are minimized by therapeutic intervention and the goals of therapy are met. As opposed to severity, which is used to determine initial therapy, control is used to determine ongoing therapy. If control during any interval is poor, therapy should be increased. If control is good, therapy can be continued, or even decreased. Essentially, assessment of severity is only done upon initial presentation. Thereafter, the level of asthma control should be used to determine if changes are necessary to improve the patient's control (**Figure 3**).

Table 4. Preferred Stepwise Therapy for Asthma in Children 0-4 Years Old and 5-11 Years Old

Intermittent Asthma	Persistent Asthma: Daily Medication. Consult with asthma specialist if step 3 (0-4 yrs old) or step 4 (5-11 yrs old) care or higher is required. Consider at step 2 or 3					
Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	
Preferred: SABA PRN	*Preferred:* Low-dose ICS	*Preferred:* 0-4 yrs old: Medium-dose ICS. 5-11 yrs old: Medium-dose ICS OR Low-dose ICS + LABA or LTRA	*Preferred:* 0-4 yrs old: Medium-dose ICS + LABA or LTRA. 5-11 yrs old: Medium-dose ICS + LABA	*Preferred:* 0-4 yrs old: High-dose ICS + LABA or LTRA. 5-11 yrs old: High-dose ICS + LABA	*Preferred:* 0-4 yrs old: High-dose ICS + LABA or LTRA + Oral steroid. 5-11 yrs old: High-dose ICS + LABA + Oral steroid	Step up if needed (first, check adherence, environmental control, and comorbid conditions). Assess control. Step down if possible (and asthma is well controlled at least 3 months)

Each Step: Patient education, environmental control, and management of comorbidities
Steps 2-4 Consider subcutaneous allergen immunotherapy for patients who have allergic asthma in patients ≥5 years old

Quick-Relief Medication for All Patients
- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms. up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- With viral respiratory symptoms SABA q 4-6 hours up to 24 hours (longer with physician consult) Consider short course of oral systemic corticosteroids if exacerbation is severe or patient has a history of previous severe exacerbations

SABA. short-acting beta agonists, LABA. long-acting beta agonists, ICS. inhaled corticosteroids, LTRA. leukotriene antagonist.
Note: for simplification and clarity, non-preferred alternative therapies are not included in this table Please refer to the full EPR-3 for additional details
Modified from EPR-3[10]

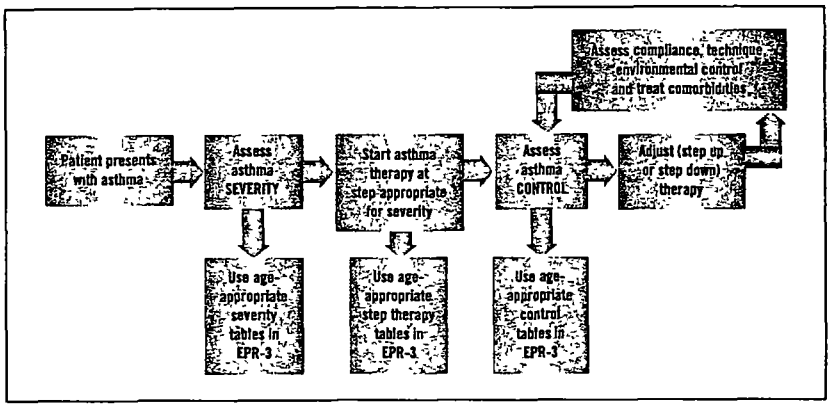


Figure 3. Simplified Schema for Asthma Therapy

Derived from EPR-3[10]

Impairment and Risk

A new feature of the EPR-3 is the introduction of the concept of two domains, "impairment" and "risk", that pertain to both severity and control. Impairment is defined as the frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced. Risk is the likelihood of either asthma exacerbations, progressive decline in lung function (or, in children, reduced lung growth), or risk of adverse effects from medication.

Case 3a

A 4-year-old girl has a past history of 3 ED visits and one short hospitalization for asthma 6 months ago.

For the last 2 months, she requires her inhaled SABA about 2-3 times a week, has nocturnal asthma symptoms about once a week and some minor exercise limitations. Her only current medication is inhaled SABA prn.

Case 3b

A 4-year-old girl has never had any ED visits, hospitalizations or urgent care visits for her asthma.

For the last 2 months she requires her inhaled SABA about 2-3 times a week, has nocturnal asthma symptoms about once a week and some minor exercise limitations. Her only current medication is inhaled SABA prn.

Both of these patients are not optimally controlled as indicated by their frequent need for both daytime and nighttime inhaled SABA and some exercise limitations. One could argue that since both of these children currently have the same degree of symptoms that they require the same therapy. However, while the children in Case 3a and 3b do have the same degree of symptoms (*ie*, the same impairment), due to her past history of ED visits and a hospitalization, the patient in Case 3a could be considered to be at more risk of experiencing another serious asthma exacerbation. Therefore, since the assessment of asthma control includes both current impairment (the same in Case 3a and 3b) and risk (more in Case 3a), it could be argued that the patient in Case 3a does in fact require a higher step level of therapy than the patient in Case 3b, despite equal current symptoms. Thus, if two patients present with similar current impairment, but one has a past history indicating higher risk for future exacerbations, that patient should be treated more aggressively in an attempt to prevent future attacks.

Case 3 – Additional History

The child in Case 3a is not prescribed any new medications and is instructed to continue her inhaled SABA prn. The child in Case 3b is prescribed a medium-dose ICS daily in addition to inhaled SABA prn. For the next month, both children's asthma remains well-controlled.

Which child is now at higher risk? There are many risks to consider, including not only those associated with poorly controlled and acute exacerbations of asthma, but also the risks of adverse reactions to treatment and decreased lung growth from asthma. As discussed above, her past history of serious asthma exacerbations, as well as her ongoing symptoms puts the child in Case 3a at risk for future attacks. Since she remains on inhaled SABA as her only treatment with no long-term control medications, she remains at higher risk than the child in Case 3b for asthma flares. Her risk for future attacks could be mitigated by starting therapy with a long-term daily controller medication. In general, the risk of adverse reactions to most long-term daily controller medications, including ICSs, is minimal, especially if compared to the risks of uncontrolled asthma. Nevertheless, even the small risks of adverse medication effects can be further ameliorated by using the minimum doses required to maintain control and by maximizing alternative therapies—either using other classes of medications and, if appropriate, environmental allergen control and allergy immunotherapy. Which child is at greater risk for reduced lung function? Unfortunately, while therapy with ICS has been shown to be very effective in controlling asthma, it has not been shown to modify the underlying disease process and prevent the loss of lung function seen in some children with asthma.[16] Therefore, with current available therapy, both children are at equal risk of experiencing reduced lung development.

Maintaining Asthma Control – When is it Time to Step Down?

There is great emphasis placed on choosing the initial level of step therapy and then stepping up if adequate control of asthma is not achieved. Less attention is given to the appropriate manner in which to "step down" therapy.

Case 4

A 10-year-old boy experiences an asthma exacerbation that is not responding adequately to frequent administration of inhaled SABA at home. He is taken to a local ED where his symptoms improve with 2 nebulized albuterol treatments and oral prednisolone. He is discharged from the ED with 4 additional days of oral prednisolone and a sample of a low-dose ICS, which he takes for two weeks until the sample is empty. Three weeks later he is seen by his primary physician for another asthma exacerbation. This flare improves after administration of nebulized levalbuterol and another course of oral prednisolone. He is given a prescription for a medium-dose ICS to take for one month. Six weeks later he presents to an after hours urgent care facility with severe wheezing. Once again he responds to nebulized SABA and an intramuscular injection of a corticosteroid. He is given a prescription for daily montelukast, but the family does not fill it because the child is feeling better by the next day. You see him in your office 4 weeks later and he is wheezing again and has been taking his inhaled SABA 4-5 times daily for the last week.

This case illustrates an all too common scenario. In each of the three encounters for asthma exacerbations appropriate acute therapy was administered. In addition, each point of care is to be commended in that they prescribed a long-term controller medication upon discharge home. Since so many children lack access to sufficient wellness visits, and may rely on urgent care settings to treat their asthma, it is essential that long-term therapy be initiated at these acute visits.[30] Of note is that a different long-term controller regimen was prescribed at each location—low-dose ICS, medium-dose ICS and a leukotriene antagonist. While ICSs are the preferred initial treatment for persistent asthma, there is latitude in range of doses, and leukotriene antagonists are non-preferred but nevertheless an alternative option. Although each center prescribed long-term controller therapy, the child keeps returning with asthma attacks.

What was missing in this case was both proper patient education and follow-up care. An integral component of the EPR guidelines has always been patient education. New emphasis has been placed on a multifaceted approach to include education at all points of care (primary care physician, ED, urgent care center and pharmacy). The most effective education can occur when an active partnership is developed with the family and a trusted health care professional who has established open communication with the family and understands the family's concerns, cultural factors and communication needs. Each of this patient's acute care visits represented missed opportunities for education. While the correct medications were prescribed at each visit, the family was not educated sufficiently to understand that these medications needed to be continued longer than just until the child's acute symptoms resolved. A written asthma action plan was not provided to the family. Appropriate follow-up care with the primary physician was not assured due to lack of communication between the two care settings or health professionals. Efforts are currently underway to measure the type and effectiveness of patient education and discharge instructions.

Case 4 – Additional History

The patient is prescribed combination low-dose ICS and an inhaled LABA to administer twice daily until the next office visit. The child returns 3 weeks later and the family reports that he is symptom free and has not required any immediate relief medication in 2 weeks. He has normal sleep and normal exercise and has not missed any days of school. Spirometry in your office is normal with all values near 100% of predicted for age. They ask if they can now stop his daily medications because his asthma is gone.

Initiating a daily long-term controller medication is not akin to a life sentence. There may be reluctance to start long-term controller medications due to the impression that the child will be "stuck" on these medications for too long a time.[31] Both patients and physicians may too hastily discontinue effective long-term controllers because they are wary of adverse medication effects.[32] While no medication is without potential adverse effects, the benefit of asthma medications far outweighs the risk of the asthma. **Figure 4** provides an overview of the prescription of all asthma medications at the state and national level. Families often do not fully understand that asthma is a chronic condition that is not curable. They should be educated that just because they are asymptomatic that does not mean that their asthma is "gone", as suggested by the case above.

A goal of asthma therapy is to find the minimum amount of medication that provides adequate asthma control. When a patient's asthma is poorly controlled, it is obvious that some step up in asthma therapy is indicated. Asthma therapy can be stepped up as quickly as needed to obtain control, and the speed of stepping up is only limited by the onset of action of the medications.

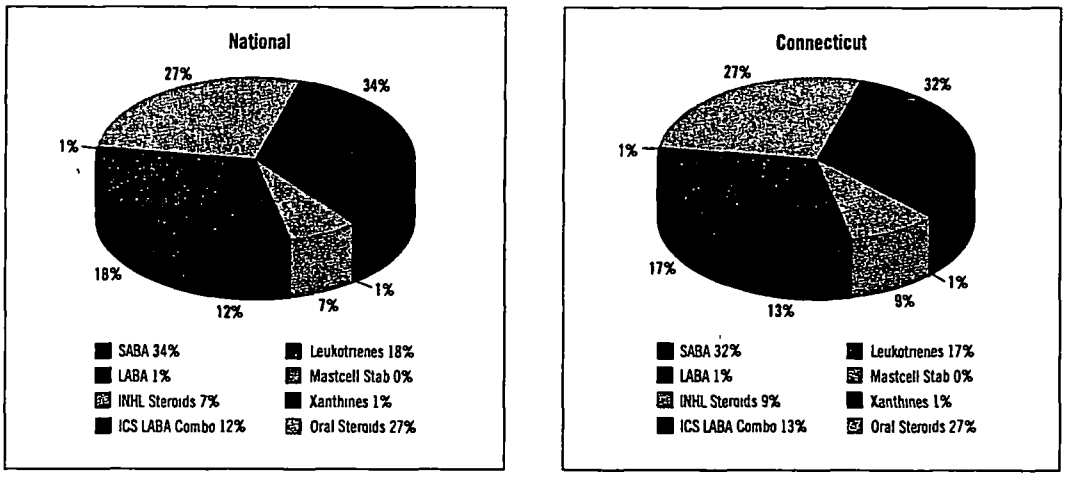


Figure 4. Proportion of Asthma Prescriptions Dispensed at Retail Pharmacies Nationally and in Connecticut.

Source: IMS Health. National Retail Prescription Data. Time period: 12 months ending January 2008.

In Case 4, however, the child's asthma is well-controlled and his lung function is normal while receiving treatment with a combination of ICS and inhaled LABA. Perhaps this child would be equally well-controlled on ICS therapy alone, perhaps at even a lower dose, or with leukotriene antagonist monotherapy. In contrast to a child who is symptomatic and obviously needs a step up in therapy, how can it be determined if it is safe to step down in a well-controlled, asymptomatic child who has normal lung function testing (if age allows)? If a child is well, the only way to know if they will remain equally well on a lower step of therapy is to step down and observe for worsening. Signs of deterioration would include increased use of as needed inhaled SABA, more frequent nocturnal symptoms, diminished exercise tolerance or decreased pulmonary function.

What is the criteria for determining when to step down therapy? The EPR-3 recommends that a step down in therapy can be considered after a minimum of 3 months of well-controlled asthma. During long periods of uncontrolled asthma or after a significant asthma exacerbation, lung inflammation is increased. Inflammation is directly related to airway hyper-responsiveness. Heightened airway hyperresponsiveness increases susceptibility to asthma triggers. In essence, one asthma exacerbation predisposes a patient to further exacerbations, even with mild triggers. When airway hyperresponsiveness lessens, exposure to these same minor triggers will have less of a deleterious effect. In patients who are continually being

exposed to triggers, as in the case of a child who is allergic to a household cat, their hyperresponsiveness may never lessen. In a child who had a viral-induced asthma exacerbation, the hyperresponsiveness will decrease slowly after the infection resolves. However, it may take several months for hyperresponsiveness to return to baseline, and during this time, the child will be at risk for additional flares. One study showed that after a viral upper respiratory infection, a quarter of atopic individuals did not return to baseline airway hyperresponsiveness by 9 months after resolution of the infection, and even non-atopic individuals took up to 3 months to return to normal.[33] Ideally, long-term anti-inflammatory medication should be administered until airway hyperresponsiveness returns to baseline. Since it is not clinically practical to measure airway hyperresponsiveness, it is necessary to wait for at least 3 months of well-controlled asthma before stepping down therapy.

Several other factors should be taken into consideration before stepping down. Waiting longer than 3 months is recommended if a child has severe asthma or recently had a severe exacerbation. If the child is just entering into the season of the year when traditionally his/her asthma is worse, it may be prudent to wait until after the season is over. If an important event and/or family vacation is planned in the near future, stepping down can wait until the event has passed. The start of the school year is often associated with increased viral infections, exercise and emotional stress, so stepping down should be done with caution at this time to avoid missing days of school due to asthma flares. Similarly, asthma therapy can be stepped up in anticipation of upcoming changes. Due to his prior history of such poorly controlled asthma and frequent acute flare, the current long-term controller regimen for the child in Case 4 should be continued at least 3, and preferably 6 months, before a step down in therapy is advised.

Summary

There have been substantive updates to the EPR guidelines which are intended to improve the care of patients with asthma. While all the changes were not addressed in this newsletter, the cases illustrate selected important features of the guidelines. Young children 0-4 years of age are disproportionately affected by asthma, and it is essential to identify those at high risk for developing recurrent wheezing and starting appropriate therapy as soon as possible to prevent ongoing morbidity. Rapid and aggressive therapy of acute asthma exacerbations are necessary in all children despite the severity of their underlying asthma. There is a distinction between asthma severity—used to initiate treatment, and asthma control—used to modify ongoing treatment. Emphasis is on achieving asthma control, and once achieved, maintaining control.

Self-Assessment Questions

You may receive your CME certificate online by going to www.ama-assn.org/go/therapeuticinsights and completing the self-assessment and program evaluation. Alternatively, you may use the answer sheet provided with the AMA Therapeutic Insights *newsletter to record your answers, and either fax to 312-464-4849 or mail to*

Healthcare Education Products
Therapeutic Insights—Asthma in Children
American Medical Association
515 N State Street
Chicago, IL 60610

If completing online, you will be able to print your CME certificate
If faxing or mailing, you will receive your CME certificate in 3-4 weeks
Please select the single best answer for each question

1. Which of the following is CORRECT regarding recurrent wheezing and asthma in children 0-4 years of age?
   a. Since asthma can not be diagnosed earlier than the age of 5 years, the new EPR-3 guidelines contain recommendations only for children 5-18 years old.
   b. Children with recurrent wheezing should not be prescribed daily controller medications until the diagnosis of asthma is made with certainty.
   c. The majority of children with asthma begin wheezing after 4 years of age.
   d. A disproportionate share of asthma health care costs go toward hospitalizations in children 0-4 compared to older children with asthma.
   e Children who develop recurrent wheezing before the age of 3 years will generally outgrow the wheezing by the time they are 6 years old.

2. Which of the following is CORRECT regarding acute asthma in young children?
   a. Children with mild asthma severity may have life-threatening or even fatal asthma exacerbations.
   b. Albuterol syrup is an equivalent alternative to inhaled albuterol in children too young to use a metered dose inhaler.
   c. Use of oral glucocorticoids during viral infections is contraindicated due to the chance of interfering with the normal immune response to the infection.
   d. Only nebulized SABA should be used for children less than 2 years old.
   e During viral respiratory infections, coughing should be treated with inhaled SABA only if wheezing is present concurrently.

3 All of the following are criteria that predict asthma, according to the asthma predictive index (API) EXCEPT:
   a. History of at least 4 separate episodes of wheezing, each lasting over a day.
   b. Wheezing that responds to a short course of an oral corticosteroid.
   c. History of physician-diagnosed asthma in mother
   d History of physician-diagnosed atopic dermatitis in child
   e. Eosinophilia >4%

4 Which of the following is CORRECT regarding asthma severity versus asthma control?
   a. Asthma severity can change throughout the year and as children grow, and therefore should be assessed at each visit.
   b. Asthma control can be achieved by decreasing asthma severity.
   c. Asthma severity is assessed to guide initial therapy.
   d. "Risk" is a domain under only asthma severity, while "impairment' refers only to asthma control.
   e. Asthma severity can be decreased by use of an inhaled corticosteroid.

5. Which of the following is CORRECT regarding "stepping down' asthma therapy?
   a. Every effort should be made to step back as soon asthma control is achieved.
   b. Once a child is started on an inhaled corticosteroid, he/she should remain on at least a low dose inhaled corticosteroid for the foreseeable future.
   c. The shorter the half-life of a drug, the more quickly it can be stepped back.
   d. In most cases, a minimum of 3 months of well-controlled asthma should be achieved before stepping down therapy.
   e. Growing children with asthma should never be 'stepped back", instead, their medication doses should increase as they grow.

Program Evaluation

1. The program improved my ability to apply the NAEPP EPR-3 guidelines to the diagnosis and management of asthma in children.
2. The program was helpful in determining which young children with recurrent wheezing are likely to have asthma, and when daily controller medication should be initiated.
3. The program content improved my ability to assess children with suboptimally controlled chronic asthma and determine what therapeutic options are available to regain control.
4. The case-based format of this program was an effective way of applying the clinical guidelines.
5. The program was free of commercial bias.
6. Based on the information in this AMA Therapeutic Insights newsletter, what likely changes do you anticipate making in your management of children with asthma.

Self-Assessment Responses

(Please circle your response, one response per question)

Q.1	a	b	c	d	e
Q.2	a	b	c	d	e
Q.3	a	b	c	d	e
Q.4	a	b	c	d	e
Q.5	a	b	c	d	e

Evaluation Responses *(Please circle)*

	Strongly Agree		*Agree*		*Strongly Disagree*
Q.1	1	2	3	4	5
Q.2	1	2	3	4	5
Q.3	1	2	3	4	5
Q.4	1	2	3	4	5
Q.5	1	2	3	4	5

Q.6 _____

_____

_____

Additional Comments_____

_____

_____

_____

_____

Name:_____

Address:_____

_____

_____

City/State/Zip_____

Phone:_____ Fax:_____

E-mail address:_____

*M.E.#_____

*The Medical Education (ME) number is an 11-digit number assigned to every physician in the US by the AMA for identification and recording of basic information. If you are an AMA member, this number is found on your AMA membership card. If you do not have your ME number, you can obtain this number by calling the AMA at 1-800-262-3211. If this is not possible, please identify your date of birth, medical school, and year of graduation so that AMA staff can look up your ME number and accurately record credits

Date of Birth:_____
Mo/day/year

Medical School:_____

Yr. Graduation:_____

Hours of participation claimed (not to exceed 1):_____

Signature _____

Date:_____

When completed, please fax to 312.464.4849 or mail to:

American Medical Association
Healthcare Education Products & Standards
Therapeutic Insights: Asthma in Children
515 North State Street
Chicago, IL 60610

References

1. Bacharier LB, Boner A, Carlsen KH, et al. Diagnosis and treatment of asthma in childhood: a PRACTALL consensus report. *Allergy* Jan 2008,63(1) 5-34

2. Patel B, Sheridan P, Detjen P, et al Success of a comprehensive school-based asthma intervention on clinical markers and resource utilization for inner-city children with asthma in Chicago: the Mobile C.A R.E. Foundation's asthma management program. *J Asthma* Mar 2007;44(2).113-118.

3 Kelly CS, Morrow AL, Shults J, Nakas N, Strope GL, Adelman RD. Outcomes evaluation of a comprehensive intervention program for asthmatic children enrolled in medicaid. *Pediatrics* May 2000, 105(5):1029-1035.

4. Warman KL, Silver EJ, Stein RE. Asthma symptoms, morbidity, and antiinflammatory use in inner-city children. *Pediatrics* Aug 2001;108(2):277-282.

5. *MMWR - National Surveillance for Asthma - United States, 1980-2004* Atlanta: Department of Health and Human Services Centers for Disease Control and Prevention; Oct. 19 2007. 56 No. SS-8.

6 McQuaid EL, Kopel SJ, Nassau JH. Behavioral adjustment in children with asthma. a meta-analysis. *J Dev Behav Pediatr* Dec 2001;22(6).430-439.

7. Frankel K, Wamboldt MZ. Chronic childhood illness and maternal mental health--why should we care? *J Asthma* 1998,35(8):621-630.

8. Silva GE, Sherrill DL, Guerra S, Barbee RA. Asthma as a risk factor for COPD in a longitudinal study. *Chest*. Jul 2004,126(1).59-65.

9. McFadden ER, Jr. Natural history of chronic asthma and its long-term effects on pulmonary function. *J Allergy Clin Immunol* Feb 2000;105(2 Pt 2):S535-539.

10. *Expert Panel Report 3 (EPR3) Guidelines for the Diagnosis and Management of Asthma Report 2007*: National Heart, Lung, and Blood Institute (NHLBI); August 28 2007. No. 08-4051.

11. Tager IB, Hanrahan JP, Tosteson TD, et al. Lung function, pre- and post-natal smoke exposure, and wheezing in the first year of life. *Am Rev Respir Dis* Apr 1993;147(4):811-817.

12. Yunginger JW, Reed CE, O'Connell EJ, Melton LJ, 3rd, O'Fallon WM, Silverstein MD. A community-based study of the epidemiology of asthma. Incidence rates, 1964-1983. *Am Rev Respir Dis* Oct 1992,146(4).888-894

13. Smith DH, Malone DC, Lawson KA, Okamoto LJ, Battista C, Saunders WB. A national estimate of the economic costs of asthma. *Am J Respir Crit Care Med*. Sep 1997;156(3 Pt 1) 787-793.

14 Martinez FD, Wright AL, Taussig LM, Holberg CJ, Halonen M, Morgan WJ. Asthma and wheezing in the first six years of life The Group Health Medical Associates. *N Engl J Med* Jan 19 1995, 332(3).133-138.

15. Lange P, Parner J, Vestbo J, Schnohr P, Jensen G. A 15-year follow-up study of ventilatory function in adults with asthma. *N Engl J Med* Oct 22 1998,339(17).1194-1200

16. Guilbert TW, Morgan WJ, Zeiger RS, et al Long-term inhaled corticosteroids in preschool children at high risk for asthma *N Engl J Med* May 11 2006,354(19).1985-1997.

17. Stein RT, Holberg CJ, Morgan WJ, et al Peak flow variability, methacholine responsiveness and atopy as markers for detecting different wheezing phenotypes in childhood. *Thorax*. Nov 1997, 52(11).946-952.

18. Taussig LM, Wright AL, Holberg CJ, Halonen M, Morgan WJ, Martinez FD. Tucson Children's Respiratory Study. 1980 to present. *J Allergy Clin Immunol*. Apr 2003,111(4).661-675.

19 Stein RT, Holberg CJ, Sherrill D, et al. Influence of parental smoking on respiratory symptoms during the first decade of life the Tucson Children's Respiratory Study. *Am J Epidemiol* Jun 1 1999,149(11).1030-1037

20. Celedon JC, Litonjua AA, Ryan L, Weiss ST, Gold DR. Bottle feeding in the bed or crib before sleep time and wheezing in early childhood. *Pediatrics*. Dec 2002,110(6).e77

21. Stein RT, Sherrill D, Morgan WJ, et al. Respiratory syncytial virus in early life and risk of wheeze and allergy by age 13 years. *Lancet* Aug 14 1999;354(9178):541-545

22. Castro-Rodriguez JA, Holberg CJ, Wright AL, Martinez FD. A clinical index to define risk of asthma in young children with recurrent wheezing. *Am J Respir Crit Care Med* Oct 2000; 162(4 Pt 1):1403-1406

23. Guilbert TW, Morgan WJ, Zeiger RS, et al Atopic characteristics of children with recurrent wheezing at high risk for the development of childhood asthma. *J Allergy Clin Immunol* Dec 2004;114(6). 1282-1287.

24. Hannaway PJ Demographic characteristics of patients experiencing near-fatal and fatal asthma. results of a regional survey of 400 asthma specialists. *Ann Allergy Asthma Immunol* Jun 2000,84(6): 587-593.

25. Robertson CF, Rubinfeld AR, Bowes G Pediatric asthma deaths in Victoria: the mild are at risk. *Pediatr Pulmonol* Jun 1992,13(2) 95-100.

26. Rastogi D, Shetty A, Neugebauer R, Hanjith A National Heart, Lung, and Blood Institute guidelines and asthma management practices among inner-city pediatric primary care providers. *Chest* Mar 2006,129(3) 619-623

27. Rubin BK, Fink JB. The delivery of inhaled medication to the young child *Pediatr Clin North Am* Jun 2003,50(3).717-731

28. Castro-Rodriguez JA, Rodrigo GJ Beta-agonists through metered-dose inhaler with valved holding chamber versus nebulizer for acute exacerbation of wheezing or asthma in children under 5 years of age a systematic review with meta-analysis. *J Pediatr* Aug 2004, 145(2) 172-177

29. Munzenberger PJ, Thomas R, Bahrainwala A. Retention by children of device technique for inhaled asthma drugs between visits *J Asthma* Nov 2007,44(9).769-773.

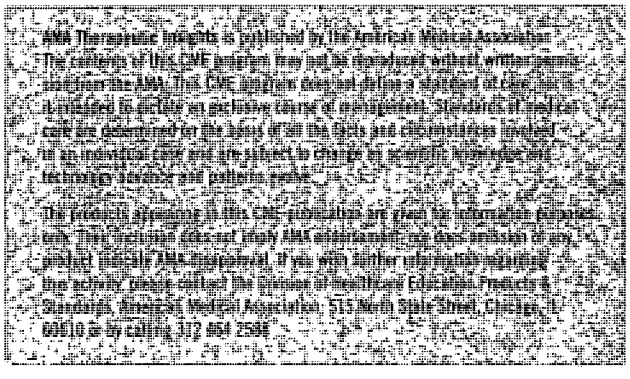
30. Lehman HK, Lillis KA, Shaha SH, Augustine M, Ballow M. Initiation of maintenance antiinflammatory medication in asthmatic children in a pediatric emergency department. *Pediatrics*. Dec 2006,118(6).2394-2401.

31 Handelman L, Rich M, Bridgemohan CF, Schneider L Understanding pediatric inner-city asthma. an explanatory model approach. *J Asthma* Apr 2004,41(2).167-177.

32. Cabana MD, Rand CS, Becher OJ, Rubin HR. Reasons for pediatrician nonadherence to asthma guidelines *Arch Pediatr Adolesc Med*. Sep 2001,155(9).1057-1062.

33. Xepapadaki P, Papadopoulos NG, Bossios A, Manoussakis E, Manousakas T, Saxoni-Papageorgiou P. Duration of postviral airway hyperresponsiveness in children with asthma. effect of atopy *J Allergy Clin Immunol* Aug 2005,116(2).299-304.

IMS Health Data Sources. National Retail Prescription data is sourced from the IMS Xponent family of products. Xponent™ is based on actual prescription activity within the retail, mail service, long-term care, specialty retail, and Puerto Rico markets Based on complex algorithms Xponent projects prescriptions generated across all prescription channels and payment types (cash, Medicaid and third-party) for more than 800,000 individual prescribers every month. IMS collects over 75% of the retail prescription data The Integrated Administrative Claims Data is fully HIPAA-compliant assuring anonymous data collection, and is used to provide the diagnostic and treatment information for this newsletter. This source is comprised of fully adjudicated medical and pharmaceutical claims for over 45 million unique anonymous patients from over 85 health plans across the US The database includes both inpatient and outpatient diagnoses and treatment. The database is representative of the national, commercially insured population on a variety of demographic measures including age, gender, and plan type.



ROBERT MADORE
DIRECTOR
REGION 9A UAW
111 SOUTH ROAD
FARMINGTON, CONNECTICUT 06032-2560
PHONE (860) 674-0143
FAX. (860) 674-1164
PRINTED IN U.S.A.

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® RON GETTELFINGER, President ELIZABETH BUNN, Secretary-Treasurer

March 2, 2009

To: Senator Harris, Representative Ritter and Members of the Public Health Committee

From: Robert Madore, Director

Re: RB 6600 AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN.

Good afternoon, my name is Beverley Brakeman and I am the Community Action Program Council Representative for UAW Region 9A. I am here on behalf of our Director Robert Madore to urge your passage of RB 6600 AAC The Establishment of the Sustinet Plan.

There is no reason for me to elaborate on the plan's merit as you have heard very detailed information and data to substantiate this proposal. However, there are several components of this proposal before you today that are particularly exciting:

1. **Pooling large numbers of people for healthcare**: Using the state employee plan as a pool to be grown in membership by those in Medicaid and saga ensures that costs can be kept down, risk can be spread and healthcare can be provided to more people.

2. **The medical home:** It is my estimation that the primary care provider model many of us currently have falls far short of the proposed medical home included in this bill. The medical home proposed in this bill include care coordination, 24 hour consultive services and patient education – all critically important ways in which to improve our current healthcare delivery system.

3. **Electronic medical records:** I don't have to tell any of you how this would streamline our healthcare system and help patients. It seems that every visit to a doctor, emergency room or specialist requires a recap of our medical history which could be avoided with an electronic medical record system as proposed in this bill.

4. **Financing Mechanism:** This plan has a financing mechanism that we believe is fiscally responsible and political feasible.

5. **Benefits:** The benefits included in the Sustinet plan are both preventive, address chronic illness and are comprehensive.

6. **Uninsured:** There are built in mechanisms for those who are uninsured to become insured.

ROBERT MADORE
DIRECTOR
REGION 9A UAW
111 SOUTH ROAD
FARMINGTON, CONNECTICUT 06032-2560
PHONE (860) 674-0143
FAX (860) 674-1164
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7. **Accountability:** There is a built in mechanism to measure Sustinet's effectiveness in providing quality healthcare coverage while controlling healthcare costs.

8. **Immigrants**. No one will be denied access to health coverage based on their immigration status.

All of that said, this is a big plan designed to address a big problem. Despite the economic times this is not the time for incrementalism and microcosmic thinking. It is the time to act now and act big and rather than be daunted by the challenges of this plan's implementation tap into your collective creativity to figure out how to get it done.

We must not allow ourselves to become like the system we oppose.
Bishop Desmond Tutu

Thank you.

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WILLIAM HANDELMAN: There's no question that we agree that the information technology is the critical linchpin in -- in the development of a Medical Home model, and we'll -- and we're going to -- to testify in support of the E-Health initiative, in strongly support of that.

We also realize we were strongly supportive of the SustiNet Bill, which includes a similar health containment and quality. By the way, I would prefer you to add the word "quality" to this, terms of this authority of this bill and if legislation goes for -- goes forward. So there's no question of that; okay? HB6600

The other part of the equation is, though, how you get a small practice to be able to utilize these services which aren't contained within the practice, within the Medical Home concept; i.e., the things we already talked about, nutrition services, social services, et cetera. I know that there's talk on the federal level of a shared -- of sharing those resources; in other words, for the government to -- to -- to fund a free-standing group which includes all those comprehensive services and then allow physicians to link into those services. And I think -- but all of those, I think, have to -- in the small practice setting, I think this is still a concept and not a -- a reality. And I think that, therefore, we can't jump ahead and -- and state that we should adopt this across the board when, in fact, it hasn't yet been proven to function in that -- in that setting and, in fact, in Connecticut that we do know the majority of practices are not one-to-eight physicians, over 50 percent of our practices are one-and-two physicians, particularly in primary care.

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agreement, what happens to make one, since it doesn't exist in writing?

KATHY GROFF: I had never had this experience before, and my feeling was since I sat down in a room with several administrators and this physician, that I had those people saying this was my physician of record. And that's all I have.

REP. RITTER: So to put it in my words, it would be a verbal commitment that someone is willing to be your physician of record --

KATHY GROFF: Correct.

REP. RITTER: -- is the content of the verbal agreement.

KATHY GROFF: Yes.

REP. RITTER: Okay. That's -- that's quite interesting to me, actually, and something I perhaps hadn't understood in this conversation before. And I just want to reemphasize my understanding of it. This is as a family practitioner; am I correct?

KATHY GROFF: Yes.

REP. RITTER: Are you aware of it among other types of specialties, among APRNs, that that might be different or interpreted differently or used differently or would, indeed, the only agreement that they're required to have be a verbal one unless they choose to -- unless they need to prescribe Schedule II and III drugs?

KATHY GROFF: That is the law for all APRNs of all the different kinds that there are.