**Testimony of Victoria Veltri**
**State Healthcare Advocate**
**Before the Insurance and Real Estate Committee**
**Re SB 9 & SB 413**
**February 24, 2015**

Good afternoon, Senator Crisco, Representative Megna, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Victoria Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I appreciate the opportunity to comment on two similar bills, SB 9, An Act Concerning The Rate Approval Process For Certain Health Insurance Policies and SB 413, An Act Requiring A Public Hearing For Certain Health Insurance Policies. These proposed bills each seek to codify the spirit and intent of 2011's SB 11, legislation that was previously passed by the General Assembly, but vetoed by the Governor. However, on August 1, 2012, the Insurance Commissioner and the Healthcare Advocate entered into a formal letter agreement affirming the spirit of SB 11, permitting OHA to request up to four public hearings per year for health insurance filings greater than 15%. Since that time, OHA has only requested one such hearing, at which the public was able to comment on the impact of the proposed increases, and ultimately resulting in a significant reduction in the authorized rate increase.

At their heart, these bills promote greater transparency in the rate review process and clarify the threshold for what may be considered a reasonable rate request. As the commercial marketplace continues to grow and consumer's share of healthcare costs continues to shift, it is more important than ever that consumers are informed of proposed changes to the premium amounts, have an appropriate forum in which to share their perspective and adequate notice of the options for being heard.

Although these bills set the threshold permitting a rate review at different levels, they each recognize and address these key areas. The requirement that that insurers notify members of proposed increases, including the percentage and dollar amount of the proposed increase, any factors impacting the increase such as age rating classifications, and the disclosure that they may submit public comment to the Insurance Department concerning the proposed increases.

This increased transparency and enhanced consumer notice bolsters consumer's ability to participate in the rate review process in a practical way, and codifies OHA's role and consumer advocate as set forth in 2011's letter agreement with the Insurance Department. It also establishes consistent parameters for the review process by setting expectations of what constitutes a reasonable increase. The U.S. Department of Health and Human Services supports this concept, noting that any rate request in excess of 10% must be reviewed by regulators for a determination of whether such an increase is reasonable. Connecticut currently has no standard for this measure, and either of the proposed levels set by SB 9 and SB 413 would be adequate to achieve the goals of consistency and transparency.

One key distinction between these bills concerns the forum for such a review of a rate increase. SB 9 states that for proposed increases in excess of 10% and at the request of OHA or the Attorney General, the Insurance Department shall hold a **symposium** to review the filing. However, for any filings in excess of 12%, SB 413 would instead permit a **hearing**, which is consistent with the 2011 letter agreement entered into by the Insurance Commissioner and the Healthcare Advocate, and incorporates the rules and structure of the Uniform Administrative Procedures Act into the process.

Although these bills go a long way in promoting increased transparency and consumer participation in the rate review process, more can be done. Current law requires that filings list the aggregate premium rate increase, but this may not be an accurate representation of the impact on consumers. For example, a plan may present an aggregate filing of 14.8% representing two plans – one with a 2% rate increase for one plan that only covers 1,000 lives and a 15% rate increase for a plan with 50,000 lives. This would not meet a 15% threshold for review, but does dramatically impact members in the larger plan. Instead, rate filings should include a weighted rate increase, with clear presentation of the impact on each plan, so as to present a more accurate picture of the impact on individual members. In addition, the public comment period should include ample opportunity for consumers to comment and views others comment prior to the hearing, as well as additional time for review and comment when any material change to a rate filing has been submitted. Only then can the process be truly representative and transparent.

The Insurance Department currently is empowered to conduct hearings of any filings it deems to be excessive, unjustified or discriminatory, so this concept falls within its existing statutory scope of authority.

Thank you very much for your foresight and dedication to this timely and critical issue.
If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.