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CONNECTICUT

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By Email
Commissioner Andrew N. Mais
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Re: *2026 Health Insurance Rate Request Filings*

Dear Commissioner Mais:

Thank you for the opportunity to comment on the proposed 2026 rate increases submitted to the Connecticut Insurance Department by individual and small group insurers Anthem Blue Cross and Blue Shield, ConnectiCare and United/Oxford. These insurers are, as in nearly all of the last ten years, requesting rate increases that exceed other inflationary and general economic growth measures. It does not appear that consumers are getting more value for their hard-earned premium dollar. On the contrary, cost sharing continues to increase and grow more complex, provider networks constantly change, and availability of behavioral health services is an ongoing concern.

I commend the Insurance Department for its emphasis this year not just on the actuarial underpinnings of insurance rates, but on the major underlying cost drivers of those rates, including ever-rising prescription drug costs and reimbursement to large health systems who are increasingly sophisticated, consolidated and corporatized.

This year, as in prior years, managed care companies have failed to bring premiums and their underlying cost drivers in line with other products and services that consumers purchase. At the heart of these increases, according to the filings and actuarial memoranda submitted with each filing, are unit cost and utilization trend. The former of these two measures, unit cost trend or the actual cost of covered care and services, continues to be widely recognized as a primary driver for premium increases in Connecticut and other states.

While unit cost trend is certainly of great importance and deserving of the highest scrutiny, I would suggest that there is another often-overlooked issue that affects cost and which is not held in check by insurers in this state or others – provider upcoding. Insurers base their annual rate request on a foundation of "credible experience." This credible experience is certified by the company's

actuary and largely accepted as accurate and factual. We never seem to ask, however, whether the credible experience reflects inflated claims payments by the carriers and thus is not so credible after all. Twenty-five years ago, carriers routinely applied scrutiny and checks against inflated coding. At times they were accused by providers of applying arbitrary down coding and bundling measures. Flash forward to the present and the pendulum has swung to the opposite extreme, where carriers seem to refrain from any scrutiny of codes.

My office receives a growing number of complaints about inflated coding. I offer three examples, but there are many others:

1) A patient presents at a hospital emergency department with no life-threatening symptoms and the hospital bills a 99284 CPT code reflecting a level of care that is a 4 out of 5 measure of medical severity.
2) A patient visits an urgent care center located on a commercial street and the hospital bills with an emergency department revenue code.
3) A patient attends her annual physical and is questioned by the physician about an injury she sustained while in the care of another physician years ago and the physician bills an office visit in addition to the 100% covered preventive service on the basis that the question about the fully resolved condition from years ago constitutes a significant additional service to the physical.

In each of these examples, consumers were told by their insurers that they cannot alter or investigate the claims submitted by providers and that it is up to the patient to convince the provider to submit different or lower-level codes. This lack of scrutiny results in higher consumer out of pocket deductible payments and claim payments, the latter of which are the elemental building blocks of so-called credible experience.

Conclusion

As in prior years, I remain concerned about growing costs associated with hospital-based services, prescription drugs and whether the filings reflect double counting, where particular adjustments overlap with trend. And, as in prior years I implore managed care companies to protect their members and Connecticut consumers by negotiating lower allowed fees based on the actual cost of services and the Office of Health Strategy Connecticut Healthcare Cost Growth Benchmark. As I have also stated previously, it is abundantly clear that insurers are perversely disincentivized from driving down unit costs through negotiation of lower fees. I would add to my prior reflection that they are likewise strongly disincentivized from applying close scrutiny to the codes used in provider claims.

Pursuant to Connecticut law, in order for these rates to be approved, the Connecticut Insurance Department must determine that these requested rates are not "excessive, inadequate, or

unfairly discriminatory." Conn. Gen. Stat. sec. 38a-481(b). The burden of proof falls on the insurers to justify their rates—to provide transparent, factually-supported actuarial analysis. It is time for scrutiny to be applied not only to the projections that insurers make in their filings, but to the foundational experience upon which those projections are based. **Experience cannot be credible if it is inflated by upcoding.**

Thank you again for the opportunity to comment on the annual health insurance rate filings. I encourage the Insurance Department to thoroughly scrutinize these applications and reduce any and all components of the requested increases that are not actuarily justified.

Very truly yours,

WILLIAM TONG

APPENDIX A

Questions for all Health Plans

1) We have inquired in the past about health plans' failure to negotiate lower unit costs. We haven't discussed how claim processing affects reported experience.

   a) Our office has received a growing number of complaints by consumers that health plans are simply accepting up-coded claims from hospital systems and providers without applying any scrutiny to the level of care reflected in the claims, and either passing higher costs to consumers in the form of deductibles or absorbing the higher costs themselves, which are presumably passed on to employers and consumers through premiums or other cost sharing.

   b) What, if any, measures is the health plan taking to ensure that claims accurately reflect services provided?

      i) Does the health plan presently "down code" claims when the codes do not match the level of care provided?

      ii) Does the health plan bundle claims, as was more common 25 years ago?

   c) What is the health plan doing to reduce exorbitant facility charges for services provided by hospital systems? For example, the Office of the Attorney General has received complaints from consumers who received services at urgent care facilities in Fairfield and Milford. The providers billed for these services using emergency department codes even though the services were not rendered in a hospital emergency department. In some cases, the health plan has refused to challenge the upcharges. Why would a health plan decline to challenge inflated claims in this type of scenario?

   d) What does the health plan's provider relations department do to help consumers ensure that providers are accurately coding the services they provide?

   e) Does the health plan audit to identify upcoding? If so,

      i) Does the health plan refund patients when they pay too much cost share?

      ii) Please provide an audit report to the Insurance Commissioner.

APPENDIX B

Questions for Anthem – Individual On and Off Exchange

1) Please identify the non-benefit expenses presented in the Anthem actuarial memoranda and explain their impact on premium.

2) Why does Anthem include a 3.7 % morbidity impact for expiring enhanced subsidies if the department's bulletin HC-801-25 requires plans to assume that the subsidies continue during the calendar year 2026?

3) Anthem projects a 10.3% trend.

    a) What component of the trend is attributable to unit cost?

    b) What component of the trend is attributable to utilization?

4) Anthem asserts that various legislative restrictions will impact its ability to contain costs. Specifically, what are those changes and how are those changes projected to increase cost, and further how are they reflected in the trend projection?

5) Has Anthem considered directly passing pharmacy rebates onto its members?

    a) Would Anthem's pharmacy benefit manager (PBM) favor this approach?

6) Anthem dismisses the OHS Healthcare Costs Growth Benchmark as inapplicable to healthcare premium setting and rates. Why? Does Anthem use the Benchmark for any part of its provider contract negotiations or to otherwise drive costs down?

7) Anthem mentions that membership is continuing to disenroll from Medicaid due to post pandemic eligibility changes. Is this still a legitimate factor considering that Medicaid pandemic continuous enrollment ended in March of 2023?

8) Explain the impact of Covered Connecticut adjustments and whether those adjustments have significantly lowered premium projections.

9) If federal cost share funding reductions occur, other than potentially increasing adverse selection, won't those reductions also lower induced demand for medical services and therefore lower utilization? Why or why not?

APPENDIX C

Questions for Anthem Small Group

1) Anthem's Actuarial Memorandum states "NY HCRA surcharges and provider settlements are included in this adjustment."

    a) What are these adjustments and why are they applicable to the Connecticut market?

2) Anthem projects a 9.3% trend.

    a) What component of the trend is attributable to unit cost?

    b) What component of the trend is attributable to utilization?

APPENDIX D

Questions for ConnectiCare Benefits, Inc. – Individual On-Exchange

1) ConnectiCare calculates a 6.6% increase due to benefit updates. Please identify the particular benefit updates and their projected impacts.

2) ConnectiCare's average request for individual on-exchange plans for 2026 is 21.7%--its second highest rate request since 2015. Has ConnectiCare's merger with Molina affected its rate request for plan year 2026?

3) How does the high request relate to the plan's reported trend of 7.6%, which is lower than that of competitors?

4) Why does ConnectiCare exclude capitation payments from its trend analysis?

    a) How often does ConnectiCare use capitation in its contracts with health systems?

5) Is the 2.5% of premium listed on the profit and risk load the actual profit margin?

6) Why is the risk adjustment administrative fee increase not included in the general administrative cost increase?

7) Does the OHS Healthcare Cost Growth Benchmark play a role in ConnectiCare's rate negotiations with providers or other efforts to reduce costs? If not, why not?

APPENDIX E

Questions for United/Oxford Small Group Off Exchange

1) Oxford's trend has increased from 8.2% last year to 9.5% this year.

    a) Why have utilization and unit costs increased so much from last year?

2) Oxford states that it uses a proprietary United Healthcare national pricing methodology to adjust utilization frequency and unit cost projections by service category.

    a) How is the use of this nationwide experience adjustment consistent with the declaration that Oxford bases its current increase on credible experience in the Connecticut market? Shouldn't all projections be based on the credible Connecticut market experience?

3) What is Oxford doing to hold down medical costs and utilization frequency? Oxford cites both as drivers of the increased trend projection.

4) When Oxford refers to deductible leveraging, it suggests that because medical service costs go up while deductibles remain stable that the deductible has progressively less downward pressure on utilization. Why would this be so, if incomes have not risen to the same extent as medical costs? Wouldn't a person's income and budget drive the disincentive to utilize services more than the relative difference between the deductible and the unit cost of the service?

5) Oxford and other plans have historically cited cost shifting from public plans to commercial plans.

    a) If true, why do health plans accept that shift rather than negotiating with providers on a cost basis?

6) Oxford references new technology as a cost driver.

    a) Does Oxford assess new technologies to determine whether they have a positive impact on outcomes and thus potentially lower cost?

7) Oxford cites administrative expenses to make health care more affordable.

    a) Why are these administrative processes, which are designed to make health care more affordable, not lowering cost rather than adding to it?

b) Does Oxford have examples of successful administrative processes that have lowered costs?

8) In the benefit categories section, under professional fees, Oxford states that for hospital-based services professionals charges are included in facility fees.

   a) Given that when insures pay separate facility and professional fees, costs for services are substantially higher, why doesn't Oxford negotiate single rates with hospitals under circumstances where hospitals employ all of the providers and staff in hospital outpatient offices?

9) Oxford references a mid-year trend adjustment of an additional .68%.

   a) Why is this necessary if the primary trend projection is meant to encompass the full 2026 coverage year?

10) Does the OHS Healthcare Cost Growth Benchmark play a role in Oxford's rate negotiations with providers or other efforts to reduce costs? If not, why not?