OFFICE OF THE ATTORNEY GENERAL
CONNECTICUT

WILLIAM TONG
ATTORNEY GENERAL

August 24, 2026

By Email

Commissioner Josh Hershman
Connecticut Insurance Department
280 Trumbull Street
7th Floor
Hartford, Connecticut 06103
cid.ratefilings@ct.gov

Re: *2027 Health Insurance Rate Request Filings*

Dear Commissioner Hershman:

Thank you for the opportunity to comment on the proposed 2027 rate increases submitted to the Connecticut Insurance Department by individual and small group insurers Anthem Blue Cross and Blue Shield, ConnectiCare and United Healthcare. These insurers are, once again, requesting rate increases that exceed other inflationary and general economic growth measures. To put it bluntly: never-ending insurance rate increases reflect a broken system that does not deliver affordable healthcare for the struggling citizens of Connecticut. Once again, these increases and plan design changes project another year of consumers getting less for more, particularly when one takes into account the volume of consumer complaints received by my Office over the past year, and the ongoing questions about whether certain insurance plans are fulfilling their existing obligations to comply with mental health parity laws.[1]

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, corporatized and enjoy ever-growing market share and bargaining power.

Once again, this year the unit cost of healthcare services and higher utilization projections underlie the primary bases for the requests – trend. In prior years I have encouraged greater scrutiny of the failure of the managed care contracting process to rein in unit cost increases and whether the experience certified in their actuarial analyses is truly credible.

[1] *See* e.g., connecticut-nonquantitative-treatment-limitation-annual-report.pdf

As to the ever-rising unit costs, I ask again this year: Why does the cost of the same procedure vary so much from hospital to hospital? With patient out of pocket costs as high as they have ever been, those costs are not merely absorbed by faceless insurers or employers – they are borne by individuals and families who are least able to pay inflated costs. And I would once again urge the Department to drill down on what insurers are doing to ensure that hospital reimbursement rates more closely reflect the actual costs of providing services.

Decades ago, carriers zealously guarded 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. I reach this conclusion based on the uptick of consumer complaints about upcoding. Consumers are paying significant out of pocket costs and –believe me – they notice when the have to pay a substantial deductible charge for a service they did not ask for and did not receive. It is not uncommon for my Office to hear from patients when they notice they were charged for an emergency department visit after receiving care at an urgent care center or billed at an acuity level reflecting a life-threatening condition that did not match their non-life threatening symptoms.

Further, while it is common for insurers to blame consumers for driving utilization by seeking the care they pay for in their monthly premiums, nowhere in these filings do the companies discuss their efforts to recoup payments made to providers, whether due to error, fraud, overpayments, subrogation to other payers or otherwise, even as providers frequently complain to the Office of the Attorney General about the aggressiveness with which the insurers pursue these recoveries.

My office is charged with the responsibility for prosecuting fraud in the Medicaid system, where we have recovered millions of dollars for that program. While the Office of the Attorney General does not have the same authority or purview into private insurance claims, I would expect the regulated plans to apply a similar level of oversight and obtain similar recoveries. However, nowhere in these filings do we see any public reporting of these recoveries and whether such recoveries operate to reduce the claims experience upon which these rates are based.

Pharmaceutical benefit manager (PBM) rebating and the impact on premium is similarly opaque in the current filings. In the end, the projections upon which these requests are made cannot be justified if their foundational experience lacks accounting for these critical offsets. Further, the trend assumptions likewise lack documented support such as actual provider contracting data demonstrating the history of unit cost increases.

We should all expect that carriers use every reasonable effort to offset excessive claims and insurance fraud and that they freely report such information to the public when asking for rate increases. Carriers should also provide specific and aggregate contractual increases in support of their unit cost trend projections. Therefore, I again ask whether the reported experience reflects inflated utilization

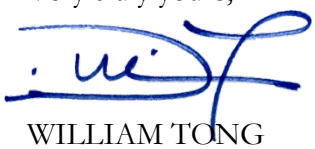
values driven by excessive provider billing. And again, I would suggest that if the experience does not reflect inflated values resulting from errors, upcoded or fraudulent claims, without offsets for health plan recoveries, the experience reported is not credible.

I would be remiss not to also point out that ConnectiCare's migration of its claims and payment systems to the Molina Healthcare platform was not handled well - my office received numerous complaints from consumers who could not verify enrollment, submit claims or obtain necessary authorizations for care. Likewise, providers were thwarted from filing claims and obtaining necessary prior authorizations. It is deeply concerning that the carrier requesting the highest increases should have provided some of the worst customer service during that transition and should have been so ill prepared for that transition many months after its acquisition was approved by the Connecticut Insurance Department. These failures did not live up to Molina's lofty promises for continuity and seamless transition made in advance of the acquisition.

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. Scrutiny needs 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. The Department should not simply accept medical cost projections but should require companies to submit proof of cost trends in the form of provider contract data. It should also recognize that **experience cannot be credible if it is inflated by upcoding or not adjusted by post-claim recoveries.**

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

Very truly yours,



WILLIAM TONG

APPENDIX A

Anthem – Individual On and Off exchange (12.8 % Increase)

1. Please clearly identify the non-benefit expenses presented in the Anthem actuarial memorandum and explain their impact on premiums.

2. Anthem includes a 3.1% morbidity adjustment but does not supply supporting studies, models or risk scores for the projection.
    a. What independent evidence does Anthem have to support morbidity deterioration in the Connecticut individual market in 2027?

3. What is the "Quality improvement Expense," $4.55 PMPM, delineated in the Federal MLR Estimated Calculation and why is it not included in general administrative expenses?

4. Explain why Anthem's filing omits information about:
    a. Fraud recoveries
    b. Overpayment recoveries
    c. Subrogation recoveries

5. How much did Anthem recover in 2025?

6. Does Anthem offset its reported experience with these recoveries?

7. Anthem projects an 11.6% trend but does not delineate the unit cost and utilization components of that projection.
    a. What component of the trend is attributable to unit cost?
        i. Why has Anthem not delineated the percentage of unit cost attributable to pharmacy increases?
    b. What component of the trend is attributable to utilization?
    c. Why is overall trend higher than last year's 10.3% trend?
    d. Why is Anthem's trend higher than ConnectiCare' s despite having similar networks?

8. Has Anthem undertaken approaches to reduce unit costs for covered services, and have these approaches achieved lower unit costs? Please explain.
    a. Which provider systems are driving the projected unit cost increases and are contributing contract renewals falling within the 2027 coverage year?

b. Why has Anthem not provided contracting data supporting the projected unit cost increases?

9. Why does Anthem project it will have to pay a risk adjustment in 2027 necessitating a 2.2% premium adjustment?

10. What independent sources did Anthem use to assess the demographic makeup of its 2027 membership?

11. 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 costs? How are they reflected in the trend projection?

12. Pharmacy rebates information is not sufficiently reported. Please provide additional detail, including PBM contracts or rebate schedules, historical reconciliation of rebates, or any trend analysis projecting future rebate expectations.

13. Anthem includes a 9.55% administrative load but does not breakdown these costs into components such as salaries, commissions, etc. or provide a historical explanation for variations in these costs over time.

14. Anthem includes "other adjustments" such as grace period, induced demand and benefit expenses without demonstrating how these adjustments were calculated or how they have trended relative to prior years.

15. Does the Office of Health Strategy Healthcare Cost Growth Benchmark or other industry-accepted benchmark play a role in Anthem's rate negotiations with providers or other efforts to reduce costs? If not, why not?

APPENDIX B

Anthem Small Group (17.4 % increase)

1. Please clearly identify the non-benefit expenses presented in the Anthem actuarial memorandum and explain their impact on premiums.

2. Has Anthem undertaken approaches to reduce unit costs for covered services, and have these approaches achieved lower unit costs? Please explain.

    a. Which provider systems are driving the projected unit cost increases and are contributing contract renewals falling within the 2027 coverage year?

    b. Why has Anthem not provided contracting data supporting the projected unit cost increases?

3. Anthem projects an 11.7% trend, compared with 9.3% last year, but does not delineate the unit cost and utilization components of that projection.
    a. What component of the trend is attributable to unit cost?
        i. Why has Anthem not delineated the percentage of unit cost attributable to pharmacy increases?
    b. What component of the trend is attributable to utilization?
    c. Why is overall trend higher than last year's 9.3% trend?

4. What is the "Quality improvement Expense," $4.42 PMPM, delineated in the Federal MLR Estimated Calculation and why is it not included in general administrative expenses?

5. Why does Anthem expect changes in market morbidity while its competitor UHC does not?

6. Explain why Anthem's filing omits information about:
    a. Fraud recoveries
    b. Overpayment recoveries
    c. Subrogation recoveries

7. How much did Anthem recover in 2025?

8. Does Anthem offset its reported experience with these recoveries?

9. Does the OHS Healthcare Cost Growth Benchmark or other industry-accepted benchmark play a role in Anthem's rate negotiations with providers or other efforts to reduce costs? If not, why not?

APPENDIX C

ConnectiCare Benefits, Inc. – Individual On-Exchange (22.7 % increase)

1. Explain why ConnectiCare's filing omits information about:
    a. Fraud recoveries
    b. Overpayment recoveries
    c. Subrogation recoveries

2. How much did ConnectiCare recover in 2025?

3. Does ConnectiCare offset its reported experience with these recoveries?

4. What efforts has ConnectiCare undertaken to counter provider upcoding?

5. Why is ConnectiCare's 10.7% average corporate administrative cost so much higher than Anthem's 9.55% administrative cost?
    a. What is the "Quality Expense" component of administrative cost and what evidence does ConnectiCare have that the expenditure improves the health care quality of its members?

6. Has ConnectiCare undertaken approaches to reduce unit costs for covered services, and have these approaches achieved lower unit costs? Please explain.
    a. Which provider systems are driving the projected unit cost increases and are contract renewals falling within the 2027 coverage year?
    b. Where is the provider contracting data supporting the projected unit cost increases?
    c. Has ConnectiCare provided the department with justification for its 13.5% pharmacy cost trend?

7. What portion of ConnectiCare's administrative expenses and 3.45% profit margin will be allocated to its parent company, Molina?

8. ConnectiCare projects a 1.077% increase for "other adjustments" without evidence supporting these adjustments. Please provide that evidence.

9. ConnectiCare's average request for individual on-exchange plans for 2027 is 22.7%, which is higher even than its unprecedented 21.7% request last year. Has ConnectiCare's merger with Molina affected its rate request for plan year 2027?

10. Why is ConnectiCare seeking a profit margin that is so much higher than last year's request – 3.45% vs. 1.97%?

11. ConnectiCare projects a 5.5 % unit cost trend but does not support the projection with provider contract data. Please provide that data.
    a. Can ConnectiCare point to any large provider contracts that guarantee the projected unit cost price increases?

12. Why does ConnectiCare assume that its covered population will be sicker, higher acuity and generally more expensive than Anthem's?

13. Why does ConnectiCare apply a 1% capitation adjustment if capitation allows it to shift risk to providers?

14. Does the OHS Healthcare Cost Growth Benchmark or other industry-accepted benchmark play a role in ConnectiCare's rate negotiations with providers or other efforts to reduce costs? If not, why not?

APPENDIX D

United Health Care (UHC) Small Group Off Exchange (18.9% average rate increase)

1. Why has UHC eliminated Oxford products and how will this impact its market share in 2027?

2. UHC reports 1,424 covered lives in its filing.
    a. Does this include former Oxford members?
    b. If so, does the reported credible experience include the claim experience of members transferring from Oxford?

3. Explain why does UHC's filing omits information about:
    a. Fraud recoveries
    b. Overpayment recoveries
    c. Subrogation recoveries

4. How much did UHC recover in 2025?

5. Does UHC offset its reported experience with these recoveries?

6. UHC's trend has increased from 9.5% (United/Oxford) last year to 12% this year.
    a. Why have utilization and unit costs increased so much since last year?
    b. Does UHC consider utilization trend to be a factor driven entirely by consumer choice?

7. UHC states that it uses a proprietary national pricing methodology to adjust utilization frequency and unit cost projections by service category. Did UHC use a manual rate experience, and if so, why did it not use Oxford experience?
    a. How is the use of this nationwide experience adjustment consistent with the declaration that it bases its current increase on credible experience in the Connecticut market? Shouldn't all projections be based on the credible Connecticut market experience?

8. What approaches has UHC undertaken to reduce unit costs for covered services, and have these approaches achieved lower unit costs?
    a. Which provider systems are driving the projected unit cost increases and are contract renewals falling within the 2027 coverage year?

   b. Please provide the provider contracting data supporting the projected unit cost increases.

9. UHC Assumes a 1% impact from deductible leveraging. Please provide empirical support for that assumption.

10. UHC has not fully justified its administrative cost projection
    a. The filing does not demonstrate administrative cost trends or efficiency adjustments or offsets.

11. UHC and other plans have historically cited cost shifting from public plans to commercial plans – so that commercial rates effectively subsidize lower public plan rates.
    a. Why do health plans accept that shift rather than negotiating with providers on a cost basis?

12. UHC references new technology as a cost driver
    a. Does UHC assess new technologies to determine whether they have a positive impact on outcomes and thus potentially lower cost?

13. UHC cites administrative expenses designed to make health care more affordable.
    a. What are these administrative processes, which are designed to make health care more affordable, and where are the calculations showing the net cost savings of these administrative processes?