

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF THE HEALTH INSURANCE COMMISSIONER  
233 RICHMOND STREET  
PROVIDENCE, RHODE ISLAND 02903

*In re:* Blue Cross & Blue Shield of  
Rhode Island—Class DIR  
(Filed November 19, 2010)

RH-2011-01

RECOMMENDATION OF THE HEARING OFFICER

*Summary*

On November 19, 2010 Blue Cross and Blue Shield of Rhode Island (“Blue Cross”) requested approval from the Office of the Health Insurance Commissioner (“OHIC”) for an average increase of 8.1% in its premium rates for the Direct Pay line of products to be effective April 1, 2011. The Attorney General (the “AG”) raised four objections to the requested rate increase: (1) Blue Cross used trend factors that are too high, resulting in inflated projected claims costs, (2) Blue Cross includes improper administrative costs, including costs related to its new building and IT costs, (3) Blue Cross included an inappropriate contribution to reserves, and (4) BC included tax and assessment costs in contravention of last year’s order by the Commissioner. As a result, the AG argues that an average rate increase of 0.4%, rather than 8.1% is justified. In addition, as a result of public comment received at the hearing, the Hearing Officer raised the issue of excessive age-in rate increases. As filed, Blue Cross’ rate structure imposes a hidden 76% rate increase on Pool I members when they reach age 65. It also imposes a 98% rate increase on Pool II members when they reach age 65.

At the hearing, Blue Cross revised its Direct Pay budget and conceded 0.2% on budget issues. This reduced the average rate increase sought by Blue Cross to 7.9%.

Based on the evidence presented at the hearing, applicable statutes and regulations, relevant case law, and prior Direct Pay decisions, I make two recommendations. First, the proposed rate increase should be reduced to .34% based on the following:

1. Blue Cross failed to provide adequate support in the record for its trend factors;
2. Blue Cross failed to provide adequate evidence to support the accuracy, reasonableness, or appropriateness of its budget;
3. Blue Cross has not been allowed to include a contribution to reserves in its Direct Pay rates and Blue Cross has not provided any compelling reason to alter that policy;
4. Blue Cross' recovery of its IT costs through a .34% increase is reasonable; and
5. Blue Cross should not pass along state assessments and state premium taxes to its Direct Pay customers because it failed to satisfy the conditions imposed by the Commissioner for properly apportioning state assessments and not has not demonstrated that including the premium taxes would not adversely affect the affordability of Direct Pay.

Second, I recommend that the Commissioner eliminate the unjustified and hidden rate increase for those subscribers who age-in to the 65+ rating bracket by removing that bracket from the Direct Pay rate table. Until Blue Cross can develop a more suitable and fair step increase for Direct Pay members who turn 65, Blue Cross should be required to charge all members who are 65 or older the same rate they were charged when they were in the 60 to 64 bracket.

#### **I. THE FILING**

On November 19, 2010, Blue Cross filed a request for approval of rate increases for its Direct Pay products to be effective April 1, 2011 (the "Filing").<sup>1</sup> The Blue Cross Direct Pay products provide health insurance coverage for persons and families not eligible for employer-based or state or federal health insurance programs.<sup>2</sup> Enrollment is on a non-group basis either

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<sup>1</sup> Blue Cross Exhibit ("BC Ex.") 1 at 1.

<sup>2</sup> BC Ex. 4 at 3.

through direct application to Blue Cross or through conversion from prior group (i.e., employer-based) coverage. There are about 14,500 members in the Direct Pay class.<sup>3</sup>

Two rating pools are used for Direct Pay.<sup>4</sup> One rating pool, Pool I, is the guaranteed issue pool. Pool I varies rates by family status and age. The other pool, Pool II, applies rates based on the age, gender and family status. In order to qualify for Pool II, an applicant must pass a medical screen. An annual open enrollment period is conducted for Pool I, while enrollment in Pool II is available continuously throughout the year for those who pass the screen. Pool I members<sup>5</sup> generally are expected to require a higher level of medical services, thus Pool I rates are higher than those for Pool II. In order to maintain lower rates for the Pool I population, Pool I rates are subsidized in part by Pool II premiums. Rates for members 65 and older are the same regardless of pool.<sup>6</sup>

Blue Cross offers five Direct Pay products, which vary by deductible level and Health Savings Account eligibility.<sup>7</sup> Only a few benefit changes have been made this year.<sup>8</sup> Blue Cross has also proposed to change its rate structure for Pool I by using five-year age steps and

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<sup>3</sup> Id. This is approximate membership as of September 2010.

<sup>4</sup> Forty-seven percent of Direct Pay members are in Pool I and fifty-three percent are in Pool II. BC Ex. 4 at 5.

<sup>5</sup> “Subscribers” and “members” are distinct terms. Subscribers are the members who purchase the health insurance contract (i.e., this is the number of Direct Pay contracts) and members are all those covered by the contract (i.e., the subscriber and all dependents).

<sup>6</sup> BC Ex. 1 at 5.

<sup>7</sup> BC Ex. 1 at 2-3. Blue Cross offers HealthMate Coast-to-Coast Direct 500/1000, HealthMate Coast-to-Coast Direct 1000/2000, HealthMate Coast-to-Coast Direct 2000/4000, HealthMate for HSA Direct Plan 3000/6000, and HealthMate for HSA Direct Plan 5000/10000. These plans are largely similar to plans previously offered.

<sup>8</sup> Benefit changes include elimination of cost-sharing for certain preventive services and extension of dependant coverage up to age 26. These changes were made to comply with the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. L. 119 (2010). In addition, coverage changes were made to comply with federal mental health parity regulations, 75 Fed. Reg. 5410 (Feb. 2, 2010). Finally, changes were made to Blue Cross’ drug formulary. BC. Ex. 1 at 1-2.

increasing the maximum rate differential for subscribers under age 65 from 1.1 to 1.25. Blue Cross says that these rate structure changes will improve the financial equity between younger and older Pool I subscribers and lessen the rate shock to Direct Pay subscribers in 2014 when federal law requires the removal of health status as a rating variable.<sup>9</sup>

The Filing proposes premium rates effective April 1, 2011 with an overall rate increase of about 8.1%, although as noted above, Blue Cross reduced this to 7.9% at the hearing.<sup>10</sup> The proposed rate increase for Pool II subscribers is uniform. In other words, the proposed rate increase would have the same effect within all age brackets<sup>11</sup> and gender/family configurations. In contrast to the uniformity of the proposed Pool II increases, the Pool I proposed increases vary considerably, from a low of 0.1% for Pool I subscribers under 25, to about 12% for those in the 60-64 and 65+ age brackets.<sup>12</sup> As noted above, Blue Cross' proposed change to the rate slope of Pool I to expand the spread between the rates for those under 25 and those in the 60-64 bracket. The proposed rates in the 60-64 bracket would be about 25% higher than those in the under 25 bracket.<sup>13</sup> The Pool I rates in the 65+ bracket, however, would be about 96% higher than the rates in under 25 bracket.<sup>14</sup>

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<sup>9</sup> BC Ex. 1 at 3.

<sup>10</sup> Transcript Vol. I ("Tr. I") at 22.

<sup>11</sup> The within bracket rates increase applies to those subscribers who remain in the same age bracket. If a subscriber "ages-in" to the next age bracket, the subscriber's rate will increase based on that fact as well.

<sup>12</sup> Attorney General Exhibit ("AG Ex.") C., Attachment AGBN-4. Note: These figures are based on the filed rate request of 8.1%.

<sup>13</sup> BC Ex. 1 at 3; Tr. I at 115-117.

<sup>14</sup> This is evident not only from the rate tables contained in BC Ex. 1, page 5, but also from the actuarial schedule used by Blue Cross. See, e.g., BC Ex. 2, Schedule 5, Column 1. The rate factor under Column 1 for "Under 25" is .554, while the rate factor for "65+" is 1.084. The latter is about 96% greater than the former.

## II. THE HEARING

### *A. Jurisdiction*

The Office of the Health Insurance Commissioner has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

### *B. Hearing Officer*

On December 10, 2010 the Health Insurance Commissioner entered an Order appointing the undersigned Hearing Officer.

### *C. Notice of the Hearing*

The parties agreed to a hearing date and notice of the filing and the hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, on January 5, 2011.<sup>15</sup>

### *D. Prefiled Testimony, Exhibits, and Witnesses*

The Blue Cross Exhibits 1 through 11 and AG Exhibits A through W were entered into the record without objection. Blue Cross Exhibits 4 and 8 consisted of pre-filed testimony of John Lynch and Augustine Manocchia. Attorney General Exhibit A consisted of pre-filed testimony of Barbara Niehus. There were no OHIC exhibits.<sup>16</sup>

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<sup>15</sup> BC Ex. 11.

<sup>16</sup> Charts used by the Hearing Officer to assist with cross-examination of actuarial witnesses have been included in the record over the objections of both parties. The charts are not exhibits but were included in the record in order to ensure a complete record.

The following witnesses provided live testimony at the hearing:

Blue Cross

| <i>Name</i>         | <i>Subject of Testimony</i>               |
|---------------------|---|
| John Lynch          | actuarial support for the rates requested |
| David Fogerty       | administrative costs                      |
| Augustine Manocchia | affordability issues                      |

The AG

| <i>Name</i>    | <i>Subject of Testimony</i>             |
|----------------|---|
| Barbara Niehus | actuarial support for the AG's position |

*E. Public Comment*

Public comment was received in the form of emails, letters and testimony at the hearing. Approximately thirty-nine emails and letters were received by OHIC and nine persons provided comment during the hearing. No comments supported the proposed rate increase. While a variety of issues were raised in the comments, a few issues are worthy of explicit mention. First, a number of commenters complained about the late notice provided them by Blue Cross regarding the hearing and opportunity to comment on the Filing. These commenters told similar stories about a Blue Cross letter dated January 11, 2011 that indicated that written comments on the proposed rate increase had to be submitted by January 21, 2011. The commenters explained that the letter arrived a week or more after January 11<sup>th</sup>, and sometimes after the deadline for submitting comments.<sup>17</sup>

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<sup>17</sup> For example, a letter to OHIC from A. Hersh complained that Blue Cross' notice letter, dated January 11, 2011 did not arrive until January 26, 2011. He also noted that the letter indicated that written comments had to be submitted by January 21, 2011. An email from Fred Jorgensen complained this his letter dated January 11, 2011 did not arrive until January 19, 2011. George M. Goodwin and Dr. William Haffner-Jones made similar written complaints. See written comments submitted to OHIC. Edward Broadley made the same complaint at the hearing. Tr. 1 at 12.

The number and consistency of these complaints suggests that there was a problem with Blue Cross' notice for the hearing and that some, or perhaps even many, Direct Pay subscribers may have received notice either immediately before or just after the deadline for comment. It is possible that this suppressed

A number of public commenters indicated that they were unemployed, underemployed, or suffering ill-effects of the economic downturn. As a result, these commenters indicated that paying for a rate increase would be a hardship.<sup>18</sup>

One commenter complained about his substantial rate increase, explained that Blue Cross' rates would increase solely because he got older and noted that this increase is on top of the proposed rate increase.<sup>19</sup>

### III. STANDARD OF REVIEW

The rates requested by Blue Cross must be "consistent with the proper conduct of the applicant's business and with the interest of the public . . . ."<sup>20</sup> In 2004 the Rhode Island General Assembly established the meaning of "proper conduct of the applicant's business" with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*<sup>21</sup> They decreed that Blue Cross' mission includes providing "affordable and accessible health insurance to insureds"<sup>22</sup> and "affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals."<sup>23</sup> The Board of Directors was specifically charged with

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the number of comments received. In its post hearing brief, Blue Cross asserts, "As easy as it is these days to fire off e-mails, a miniscule percentage of Direct Pay subscribers submitted comments criticizing the proposed rate increases." Blue Cross' Post Hearing Brief ("BC Brief") at 3. Apparently Blue Cross did not consider the fact that the late notices may have contributed to the low number of comments received by OHIC.

<sup>18</sup> See comments of George and Margaret Curti, Mary Preston, Steve Regnault, Larry and Pauline Coutu, Melanie Ducharme, Gerry McDavitt, Daine Crowley, Georgia Dennen, Bruce Buckler. Written comments submitted to OHIC; Transcript, January 21, 2011, at 9-12.

<sup>19</sup> Tr. I at 6.

<sup>20</sup> R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

<sup>21</sup> See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd*, *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

<sup>22</sup> R.I. Gen. Laws § 27-19.2-3(1).

<sup>23</sup> R.I. Gen. Laws § 27-19.2-3(5).

“ensuring that the corporation effectively carries out the charitable mission for which it was incorporated . . . .” Under the new law, Blue Cross must also “employ pricing strategies that enhance the affordability of health care coverage . . . .”<sup>24</sup> These newly enacted legislative directives make clear that the “proper conduct of the applicant’s business” is no longer left solely to the management’s discretion unless that discretion is exercised to provide “affordable” and “accessible” health insurance.<sup>25</sup>

In addition, the 2004 legislation empowered the OHIC to review Blue Cross’ administrative costs and determine the reasonableness of such costs.<sup>26</sup> Blue Cross, therefore, has the burden of providing detailed information and justification for all administrative expenses in its rate filings if it is to satisfy the requirements of R.I. Gen. Laws § 42-14.5-3.

The General Assembly also mandated that the OHIC discharge its powers and duties to:

- (a) Guard the solvency of health insurers;
- (b) Protect the interests of consumers;
- (c) Encourage fair treatment of health care providers;
- (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.<sup>27</sup>

Accordingly, the Commissioner’s decision in this matter must take these factors into account.

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<sup>24</sup> R.I. Gen. Laws § 27-19.2-10(3).

<sup>25</sup> *Id.*

<sup>26</sup> R.I. Gen. Laws § 42-14.5-3(b) (“[T]he commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs.”).

<sup>27</sup> R.I. Gen. Laws § 42-14.5-2. See also OHIC Regulation 2.

The Commissioner may approve, disapprove, or modify the rates proposed by Blue Cross.<sup>28</sup>

#### IV. DISCUSSION

##### *A. Trend Factors*

The AG argues that in three instances Blue Cross selected trend lines that were unsupported by the evidence. According to the AG, this resulted in an unnecessary increase of two percentage points in the rates proposed by Blue Cross. The three trends disputed by the AG are Pool I hospital outpatient, Pool I surgical/medical, and Pool II hospital inpatient.

##### *1. Blue Cross' development of trends*

When developing its proposed Direct Pay rates, Blue Cross relies on a number of variables. One of those variables is the “utilization/mix” trend. This trend is based on price-adjusted historical allowed claims per member per month in four separate categories: Hospital Inpatient, Hospital Outpatient, Surgical/Medical, and Prescription. Each trend category is measured for each pool, so there are a total of eight trend figures.<sup>29</sup>

When developing its trends, Blue Cross looks at the 25 most recent incurred claims data points. Each point is the average of one year of price-adjusted historical allowed claims per member per month. Thus, the twenty-five points incorporate three years' worth of data. Once the data points are compiled, Blue Cross develops a trend line using a statistical method called linear least squares. Linear least squares quantifies the average change in values over time and produces a trend line that best fits the data. According to Blue Cross, while an estimated freehand trend line could be drawn, the linear least squares method produces a line that best fits

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<sup>28</sup> R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

<sup>29</sup> BC Ex. 4 at 36-47.

the data.<sup>30</sup> The trend line is developed using, at minimum, the most recent 13 data points, but can include up to the full 25 points. The trend line ultimately used by Blue Cross is the one that produces the best fit as determined by a measure called r-squared.<sup>31</sup> A trend line with an r-squared value of .7 or greater “is generally considered statistically acceptable” to Blue Cross,<sup>32</sup> “provided that the best fit is actuarially acceptable.”<sup>33</sup> “[A] noncredible experience base, an erratic or biased pattern of data points, a low-r-squared value, or otherwise unreasonable result, may provide reasons to utilize actuarial judgment in trend determination.”<sup>34</sup> In other words, Blue Cross states that it might substitute its judgment for a trend line with a high r-squared value for a variety of reasons, including those just listed.

## *2. Pool I hospital outpatient*

Blue Cross obtained the best fit trend line for the Pool I hospital outpatient data points using the 24 data points. The trend line produced an r-squared value of .93 and a trend of -7.57%.<sup>35</sup> Despite the fact that the trend line was based on three years worth of data (24 points, each based on 12 months worth of data) and produced an r-squared value that was not only above the minimum .7 value established by Blue Cross, but was very high (meaning the line was a very good fit to the data), Blue rejected the negative trend. Instead, Blue Cross applied a trend of 0.0%.<sup>36</sup> Blue Cross reasoned that the negative trend cannot “reasonably be expected to

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<sup>30</sup> Id. at 36-7.

<sup>31</sup> Id. at 38.

<sup>32</sup> Id.

<sup>33</sup> Id.

<sup>34</sup> Id.

<sup>35</sup> Id. at 41.

<sup>36</sup> Id. at 41-42

continue.”<sup>37</sup> Blue Cross stated that its recent commercial group business outpatient trend, 4.04%, is a reasonable proxy for both Pool I and Pool II outpatient trend. Blue Cross then stated. “Due to the indicated dichotomy, based on valid r-squares, between Basic (Pool I) and Preferred (Pool II), we have selected to reduce the Commercial Groups indicated trend by about 4%, resulting in a neutral selected Basic (pool I) outpatient utilization/mix trend of 0.00%”<sup>38</sup> Thus, Blue Cross appears to disregard the best fit trend line based on two factors. First, Blue Cross makes a judgment that the negative trend cannot continue. Blue Cross gives no reason for this assertion other than to say that that it cannot “reasonably be expected to continue.” Second, Blue Cross asserts that its commercial outpatient trend is a “reasonable proxy” for the combined Pool I and Pool II outpatient trends. Recent group outpatient trend is approximately 4%. But, there is a significant split between the Pool I and Pool II outpatient trends. The Pool II outpatient best fit trend line, using all 25 data points, indicates a trend of 11.8%. The r-squared for that line is .96.<sup>39</sup> However, Blue Cross suggests that this is not reasonable either. Since the Pool I outpatient data produces a negative trend of -7.57% and the Pool II outpatient data produces a positive trend of 11.8%, Blue Cross opted to apply its group trend of 4% by allocating it between these two groups: 0% for Pool I and 8% for Pool II. Presumably Pool I got the lower figure because its trend has been going down, while Pool II got the higher figure because its trend is going up. In short, the outpatient component of the Pool I and Pool II rates got Blue Cross’ recent commercial trend, but with a with a 4 point reduction for Pool I, with those 4 points, in turn, applied to Pool II.

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<sup>37</sup> Id. at 41.

<sup>38</sup> Id. at 41-42.

<sup>39</sup> Id. at 45.

The AG argues that Blue Cross fails to recognize that the Direct Pay pool has attracted healthier lives and therefore it is reasonable to expect the downward outpatient trend to continue.<sup>40</sup> The AG also points to Blue Cross' affordability initiatives as reducing observed trends. Finally, the AG notes that Direct Pay cost trends for both Pool I and Pool II for the six month period ending October 31, 2010 were more favorable than Blue Cross' pricing assumptions.<sup>41</sup> For these reasons, the AG suggests that a trend of -5.0% is more appropriate.

As a result of these diverging opinions and data, we have:

1. The best fit line, resulting from 3 year's worth of data specific to Pool I outpatient claims, with an r-squared of .93, producing a trend of -7.57%;
2. Blue Cross' proposed trend of 0.0%, based purely on the commercial outpatient trend of 4% being applied to both pools, with a -4% adjustment to Pool I, which was in turn loaded into Pool II's outpatient trend, to produce a trend of 8% in that pool;
3. The AG's recommendation of -5%, which, the AG notes partially recognizes the downward trend observed in Pool I's outpatient data; and
4. The recent partial year data contained in AG Exhibit D, for the period 4/10 to 9/10, which reflects a trend of 1.0571, or 5.7%.

For the following reasons, I find none of the testimony on this issue particularly persuasive. First, Blue Cross disregards the best fit trend line because it does not believe that it is reasonable to assume that the negative trend will continue. At the hearing, Blue Cross noted that it is very skeptical of negative trends. Blue Cross concedes that it is not impossible that this negative trend could continue, but it notes that historically overall trends have been up.<sup>42</sup> In general, I do not dispute this assertion. But Direct Pay rates should not be developed based on

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<sup>40</sup> AG Ex. A at 7.

<sup>41</sup> AG Ex. A at 7. Unless I am misreading it, AG Exhibit D appear to contain data for the period ending in September 2010, not October 2011.

<sup>42</sup> Tr. I at 83.

generalizations from the larger health care economy. However, even if we were all in agreement that it is not reasonable to expect this downward trend to continue, the question then becomes, “When is it going to end?” Blue Cross, without further explanation apparently believes that the steady, two-year, downward Pool I outpatient trend has ended. Blue Cross appears to base this conclusion on its recent commercial outpatient trend of 4%. This raises a second concern. It appears that the Pool I (and Pool II) outpatient trend is based largely on Blue Cross’ recent commercial outpatient trend. Yet, there is no explanation or description of that trend in the record. There is no indication of how it was calculated, whether it has been approved by OHIC, what data was included in its calculation, whether it is reasonable, or if it really is a reasonable proxy for Direct Pay trends. It is simply described as “Recent Commercial Group outpatient trend factors.” As a legal and factual matter, this is an insufficient basis upon which to project rates. Blue Cross bears the burden of demonstrating that its proposed rates “are consistent with the proper conduct of its business and with the interest of the public.”<sup>43</sup> The inpatient trend is a critical component of the rates Blue Cross seeks. Therefore, Blue Cross cannot simply proffer a trend figure based on unexamined, unexplained, and unsubstantiated “Recent Commercial Group outpatient trend factors” and expect to meet its burden. Blue Cross must provide some support, some explanation, some reason, some evidence to justify its reliance on the commercial trends it references.

Likewise, I cannot find support for the AG’s alternative figures in the record. The AG also rejects the best fit trend line and instead puts forth an outpatient trend figure of -5%. I cannot tell what that figure is based on. If, as the AG apparently believes, the downward trend in Pool I outpatient claims is going to continue, why not use the best fit trend line? The AG does

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<sup>43</sup> R.I Gen. Laws §§ 27-19-6(c) and 27-20-6(c).

not say. Nor does the AG explain where the -5% figure comes from. The AG asserts that the health of Direct Pay subscribers can affect the outpatient trend, but that effect is never quantified or even estimated. Finally, the AG notes that recent cost trend data suggests trends more favorable than those projected by Blue Cross. Upon examination of that recent cost trend data two things are clear. First, this data is only partial year data, which may mean that it is not fully reliable. Second, while the AG's assertion that the partial year trends are more favorable than those proposed by Blue Cross may be true, it is only true in the aggregate. In fact, the partial year data referenced by the AG shows a Pool I outpatient trend of 5.71%,<sup>44</sup> a trend more than 10 points higher than the trend the AG argues should be used. The partial year data does not support the AG's suggestion of a negative Pool I outpatient trend.

Finally, I am left with the various other potential trend figures referenced by the parties and contained in the record: (1) -7.57% (the best fit line), (2) 4.04% (the recent commercial group trend), and (3) 5.71% (recent partial year Pool I outpatient trend). Even if I were to assume that all of these figures were properly developed and accurate, I am not an actuary and have no way of knowing which, if any, of these figures should be selected. Indeed, all three figures were rejected, either explicitly or implicitly, by at least one of the actuaries at the hearing.

Since I do not find either actuary's choice of an outpatient trend figure to be reliable or supported by the evidence, and I find no basis in the record to chose any of the other potential outpatient trend figures referenced in the record, I cannot recommend any Pool I outpatient trend figure to the Commissioner.

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<sup>44</sup> AG Exhibit D, page 2, last column, bottom row, contains data for the period ending in September 2010. The Pool I outpatient trend figure is 1.0571, or 5.71%.

### *3. Pool I surgical/medical*

Blue Cross obtained the best fit trend line for the Pool I surgical/medical data points using all 25 data points. The trend line used produced an r-squared value of .17 and calculated a trend of -0.67%.<sup>45</sup> The r-squared value does not meet the minimum .7 value established by Blue Cross. As a result, Blue Cross rejected the best fit trend line and instead applied a trend of 2.0%.<sup>46</sup> As was the case with its development of the Pool I outpatient trend, Blue Cross looked to its group business. Blue Cross' actuary testified:

Recent Commercial Group Surgical/Medical trend factors imply an annual trend of 4.04% for utilization mix. Although the Class DIR data does not fully meet our credibility standards, we do not want to wholly discard it. Therefore we have elected to use a 2.00% trend factor which is a mitigation of Commercial Group's 4.04% annual trend.<sup>47</sup>

This approach suffers from the same infirmities as the approach used by Blue Cross to develop its Pool I outpatient trend. There is no explanation or description of "Recent Commercial Group Surgical/Medical trend factors" in the record. There is no indication of how those factors were calculated, whether those factors have been approved by OHIC, what data was included in the calculation of those factors, whether those factors are reasonable, or whether they are a reasonable proxy for Direct Pay. They are only referenced as "Recent Commercial Group Surgical/Medical trend factors."<sup>48</sup> For all the reasons noted above with respect to the Pool I outpatient factors, this is an insufficient basis upon which to project rates and does not satisfy Blue Cross' statutory burden of demonstrating that its proposed rates are consistent with the

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<sup>45</sup> BC Ex. 4 at 42.

<sup>46</sup> Id. at 41-42

<sup>47</sup> Id. at 43.

<sup>48</sup> Id.

proper conduct of its business and in the interest of the public. Blue Cross must provide *something* to justify the reliance on the commercial trends.

Furthermore, Blue Cross provides no explanation of why it chose to “mitigate” the Commercial Group’s 4.04% by reducing it by 2.04%. Blue Cross did indicate that it did not want to wholly discard the Pool I Surgical/Medical trend, but that statement alone does not explain how they arrived at a trend of 2.0%. Perhaps Blue Cross arrived at a 2.0% trend because that number is roughly the average of the Commercial Group trend (4.04%) and the observed Pool I Surgical/Medical trend (0.67%).<sup>49</sup> Perhaps there is another reason. The record is silent on this point.

The AG argues that the best fit trend line value of .67% should be used. First, the AG complains that Blue Cross inappropriately gave partial weight to its commercial group trend.<sup>50</sup> Yet, the AG does not explain why it was inappropriate. The AG then states, “In the case of the Pool I Surgical/Medical trend factor, I believe that Blue Cross’ calculated value of 0.67% is more appropriate to use in the calculation of rates that should be approved for Class DIR than Blue Cross’ arbitrary choice of 2%.”<sup>51</sup> However, in its prefiled testimony, the AG neither explains why 0.67% is more appropriate than 2/0% nor discusses the fact that the AG relies on the fitted line in this case despite the fact that it produced a very low r-squared value. During the hearing, however, the AG explained that the data points for Pool I Surgical/Medical remained

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<sup>49</sup> The actual average of these two figures is 2.355.

<sup>50</sup> AG Ex. A at 8.

<sup>51</sup> Id.

within a relative narrow range of \$160 to \$175 and that the trend was “eyeballed” and found to be close to flat, thus, it seemed reasonable to use the fitted line.<sup>52</sup>

The problem I have with this testimony is that it is inconsistent with the AG’s approach to the Pool I hospital outpatient trend. The AG’s rationale for accepting the trend line in this case (narrow range of data points, data points hewed close to the fitted line) can be equally applied to the trend line in the case of Pool I Hospital Inpatient (narrow range of data points, data points hewed close to the fitted line). However, the AG rejected the fitted trend line for Pool I hospital outpatient and chose a different figure.

Both actuaries have mentioned that judgment plays a role in ratemaking. There can be no doubt that health insurance ratemaking is an inexact, technical, and highly complicated process. Actuarial judgments based on a thorough knowledge of the field and experience in the industry must be applied. But, when judgment is to be applied, it must be applied in a consistent manner. The failure to do so, as in this case, raises doubts about that judgment. The fact that the AG appears to take different positions based on similar circumstances does not leave me with any confidence that I can substitute the AG’s judgment for Blue Cross’ with respect to this trend. Accordingly, I cannot recommend any Pool I Surgical/Medical trend figure to the Commissioner.

#### *4. Pool II hospital inpatient*

Blue Cross obtained the best fit trend line for the Pool II hospital inpatient data using 13 data points. The trend line used produced an r-squared value of .64 and calculated a trend of -16.44%.<sup>53</sup> The r-squared value does not meet the minimum .7 value established by Blue Cross. As a result, Blue Cross rejected the best fit trend line and instead, Blue Cross applied a trend of

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<sup>52</sup> Transcript Vol. II (“Tr. II”) at 31-33.

<sup>53</sup> BC Ex. 4 at 44.

0.0%.<sup>54</sup> Again, Blue Cross relied on its commercial group trend to develop its trend for Direct Pay. Blue Cross stated that it believes that its group inpatient trend is a “reasonable proxy” for Direct Pay inpatient trend. For all the reasons noted above with respect to the Pool I outpatient trend factors and Pool I surgical/medical trend factors, reliance on untested, unknown (to the Hearing Officer), and poorly described trends is an insufficient basis upon which to project rates and does not satisfy Blue Cross’ statutory burden of demonstrating that its proposed rates are consistent with the proper conduct of its business and in the interest of the public.

The AG objects to Blue Cross’ calculation of this trend on two grounds: (1) Blue Cross gave partial weight to its commercial group results and (2) some weight should have been given to the calculated trend.<sup>55</sup> The AG suggests a trend of -3%. There is no explanation as to why this is an appropriate alternative trend or how the number -3% was chosen. Furthermore, Blue Cross’ Pool I Inpatient trend was calculated the exact same way as its Pool II Inpatient trend. Both rejected the fitted trend line and both relied on commercial group inpatient trend data.<sup>56</sup> The AG does not object to the use of commercial group data for the Pool I inpatient trend, but does object when that data was used for the Pool II inpatient trend. This inconsistency casts doubts on the AG’s analysis.

For the reasons stated previously, I cannot recommend any Pool II Hospital Inpatient trend figure to the Commissioner.

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<sup>54</sup> Id. at 44-45

<sup>55</sup> AG Ex. A at 8.

<sup>56</sup> Compare BC Ex. 4 at 40 (Pool I Hospital Inpatient trend) with BC Ex. 4 at 44-45 (Pool II Hospital Inpatient trend).

### *5. Trends not challenged by the AG*

As noted above, the projected Pool I Inpatient and the Pool II Outpatient trends used by Blue Cross also rely on group commercial trends. As previously noted, no explanation or description has been provided for these trends. There is no indication of how those trends were calculated and there is nothing in the record to support their use. There is no evidence that those trends are reasonable or accurate. Use of these trends is an insufficient basis upon which to project rates and does not satisfy Blue Cross' statutory burden of demonstrating that its proposed rates are consistent with the proper conduct of its business and in the interest of the public. I cannot recommend any Pool I Inpatient and the Pool II Outpatient trends to the Commissioner.

#### *B. Facilities Expenses/Budget*

The AG challenges some of the costs of the new building. Costs for the new building have been increasing.<sup>57</sup> Actual Direct Pay costs attributable to the building have increased nearly \$115,000 from 2008 to 2009.<sup>58</sup> The building costs are projected to increase by to \$323,324 in 2012.<sup>59</sup> Furthermore, building cost estimates for particular years have consistently increased in consecutive Direct Pay filings. For example, in the 2008 Direct Pay filing, Blue Cross budgeted \$180,827 for the new building for 2010. In its 2009 Direct Pay filing Blue Cross budgeted \$296,081 for the new building in 2010. In this year's filing, Blue Cross projects \$306,680.<sup>60</sup> Yet, Blue Cross offers no explanation for these amounts, why these increases were projected or why the costs of the building increased so dramatically over time. Indeed, Blue Cross offered no prefiled direct testimony in support of any part of its budget, any only offered its witness, Mr.

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<sup>57</sup> Tr. I at 176.

<sup>58</sup> AG Ex. C, Attachment AGBN-2. The specific amount is \$114,719 (increasing from \$179,223 in 2008 to \$293,942 in 2009).

<sup>59</sup> Id.

Fogerty, to provide limited general testimony about the budget and to answer questions from the AG and the Hearing Officer.

The AG argues that Direct Pay subscribers should not bear the additional costs of the new building and that Blue Cross' expense should be reduced by \$100,000 to reflect the increased expenses.<sup>61</sup> In its post hearing brief, Blue Cross objects to this figure as arbitrary.<sup>62</sup> There is no evidence in the record to support Blue Cross' assertion. Indeed, there is scant evidence from Blue Cross on the budget at all. The main evidence for the budget is found in BC Exhibits 5, 6 and 7. Exhibits 5 and 6 simply list budget numbers compiled by Blue Cross. There is nothing in these documents or in any prefiled direct testimony to support these figures or even suggest that they are appropriate or accurate. There is no explanation as to how these documents were prepared. Exhibit 7 is a narrative that breaks down expenses allocated to Direct Pay. Again, there is nothing in the record to suggest that these figures are accurate or appropriate and there is no explanation as to how they were prepared.

At the hearing, Mr. Fogerty testified that that he prepared those exhibits, that the budget figures were updated to reflect a reduction after the Filing was made, and that aggregate Direct Pay expense have gone down.<sup>63</sup> He also provided some general testimony about employee benefit expenses, absolute expenses for the building going up, the IT system, whether Direct Pay members benefit from the IT system, and the recovery of costs related to the IT system.<sup>64</sup> He did

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<sup>60</sup> Id.; BC Ex. 5.

<sup>61</sup> AG Ex. A at 10; AG Ex. C, Attachment AGBN-2; Tr. II at 57-59.

<sup>62</sup> BC Brief at 10.

<sup>63</sup> Tr. I at 172-74.

<sup>64</sup> Id. at 174-96.

not, however, explain the budget, how its figures were arrived at, how Exhibits 5, 6 and 7 were created, what they mean, or even that the budget was appropriate or accurate.

I agree with Blue Cross that the AG's assertion that there are \$100,000 of excessive costs related to the new building is arbitrary. There is no explanation as to how that number was calculated in the AG's prefiled testimony and no further explanation about the basis for this number from the AG's expert during the hearing. Indeed, the AG's exhibit on this point simply lists projected and actual budget numbers for the building from various filings and then states, "Estimated 'extra cost' = \$100,000" with no other explanation.<sup>65</sup> I am at a loss to understand how this number was arrived at. However, this does not solve Blue Cross' fundamental problem. Blue Cross offers no justification for its budget. Indeed, there is no evidence that the numbers are even accurate. This is a serious problem. Blue Cross bears the burden of demonstrating that its proposed rates "are consistent with the proper conduct of its business and with the interest of the public."<sup>66</sup> The budget is a component of the rates Blue Cross seeks. Therefore, Blue Cross cannot simply put forth a list of budget figures unsupported by any evidence and expect to meet its burden. Blue Cross must provide some support, some explanation, some reason, some evidence to justify the inclusion of the budget figures in the rates it seeks.

A list of budget items and the kind of general testimony about the budget provided by Mr. Fogarty do not meet this requirement. It is true that Mr. Fogarty testified that costs budgeted to Direct Pay are going down,<sup>67</sup> but a decrease in overall costs does not justify all components of

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<sup>65</sup> AG Ex. C, Attachment AGBN-2.

<sup>66</sup> R.I Gen. Laws §§ 27-19-6(c) and 27-20-6(c).

<sup>67</sup> Tr. I at 173. Blue Cross also suggests that it benefits from increased efficiencies by housing its operations in one building, but Blue Cross does not quantify the value of those efficiencies. Furthermore, Blue Cross concedes that any such efficiencies could have been realized if Blue Cross had moved to any location where its employees were housed in a single building. Tr. I at 176-77.

the budget and does not mean that the prior, higher costs were appropriate to begin with.<sup>68</sup>

Without evidence that supports a finding that the budget is consistent with the proper conduct of Blue Cross' business or that it is in the public's interest, I cannot recommend that any portion of the budget, apart from the Blue TransIT system and the state assessments and premium taxes which are discussed separately below, be included in any new rates for Direct Pay subscribers.

The increasing building costs raised by the AG provide a prime example of the problem with this budget and the lack of evidence to support it. There is no dispute that Blue Cross' building costs are rising dramatically and have been going up for the last 4 to 5 years. Yet, I have no way of knowing whether those increased costs are justified or not and it is unclear what the proper costs for the building should be. There is nothing in the record to support the reasonableness of those costs. Thus, it is impossible for me to recommend how much, if any, of those costs should be included in the proposed rates. The same reasoning applies equally to the remainder of Blue Cross' budget.

### *C. Blue TransIT Expenses*

As a part of its proposed rate increase, Blue Cross seeks a .34% increase to cover expenditures for its new IT system. Blue Cross has included this component in its Direct Pay rate filings since 2007.<sup>69</sup> The funds collected from this particular increase do not directly pay for the system. Instead, the system is financed through Blue Cross' reserves. Blue Cross has included the .34% increase as part of the Filing in order to recover a portion of those expenditures. A similar component (although slightly higher) is included in increases across other Blue Cross lines of business.

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<sup>68</sup> Tr. II at 59-60 (In response to my question on this point, Ms. Niehus stated "it doesn't say that everything is as efficient as it can be . . .")

Currently the new IT system project is \$98 million over budget. The bulk of the increases are due to cost overruns and changes to the scope of the project.<sup>70</sup> The AG suggests that the .34% should be disallowed because the project has been poorly managed and Direct Pay subscribers should not be forced to pay for the system until Blue Cross demonstrates better management of the project.<sup>71</sup> Blue Cross counters that Direct Pay members benefit from the new system and therefore should help pay for the system.

I see no reason why Blue Cross should not be allowed to recover this cost. There is nothing in the record to suggest that the .34% increase sought by Blue Cross in this year's filing would not have been requested had there been no cost overruns. The recovery of the costs of this project was originally projected to take about fifteen years.<sup>72</sup> We are still in that original fifteen-year period. Blue Cross has extended its recovery timeline due to the cost overruns,<sup>73</sup> it has not attempted to recover its costs through a larger rate increase. Furthermore, despite the AG's assertions of mismanagement, there is no evidence in the record that the cost overruns and increases in project scope were unwarranted, unreasonable, inappropriate, or in any way the result of mismanagement. Of course, that is not to say that the nearly \$100 million cost increase was justified either. There is simply no evidence in the record one way or the other. Given the fact that there is no evidence of mismanagement and it is likely that Blue Cross would have requested the .34% increase even if there had not been cost overruns, it is not unreasonable for Blue Cross to request .34% in this Filing.

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<sup>69</sup> Tr. II at 65-66

<sup>70</sup> Tr. I at 183-84.

<sup>71</sup> AG Ex. A at 10-11.

<sup>72</sup> Tr. I at 194.

<sup>73</sup> Id. at 184-85.

With respect to the IT system, one thing is clear from the record. There is no guarantee that the costs of the IT system will not further escalate in the future.<sup>74</sup> Thus, there is real potential for this component of the annual filing to be further extended by Blue Cross beyond the twenty years it now projects. This annual .34% increase should not become a blank check for Blue Cross to finance additional cost overruns and increases in scope. Blue Cross has a less than successful record when it comes to installing new IT systems.<sup>75</sup> With cost overruns nearing \$100 million dollars for this IT project and the possibility for the costs to increase further, Blue Cross must be mindful of the fact that at some point it may not be allowed to recover the costs of the system from Direct Pay subscribers. Thus, holding down further cost increases associated with this project should be a priority for Blue Cross.

#### *D. State Assessments and Premium Taxes*

As a part of last year's Direct Pay decision, the Commissioner determined that Blue Cross should not pass along certain premium tax costs and state assessments to Direct Pay subscribers. Specifically, the Commissioner noted that the costs of certain state assessments for medical services are billed to Direct Pay subscribers not on the basis of the historical consumption of those services by Direct Pay members, but instead are allocated to the Direct Pay class proportionately as a percentage of Blue Cross' total premium.<sup>76</sup>

The Commissioner found that this method risked allocating to Direct Pay subscribers "medical costs . . . greater than the costs they actually incurred." As a result, the Commissioner ordered Blue Cross to "develop a more accurate method of allocating these costs to Direct Pay

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<sup>74</sup> Tr. I at 185.

<sup>75</sup> Id. at 186-87.

<sup>76</sup> *In re Blue Cross & Blue Shield of Rhode Island Subscription Rates for Class DIR*, No. RH-2010-01 (Order entered Feb. 8, 2010) [hereinafter 2010 Direct Pay Decision] at 8 (unnumbered).

subscribers.” He went on to note, “Until it does so, these costs should not be allocated to Direct Pay products.” Blue Cross has not developed a more accurate method of allocating those costs.

In its filing, Blue Cross points out that Direct Pay members benefit from these services,<sup>77</sup> but it has not changed its allocation method. Instead, Blue Cross asserts in its post hearing brief that it is “perplexed” as to how to more accurately allocate these costs and attempts to deflect responsibility for coming up with an allocation method by pointing out that the Attorney General has not come up with an allocation method for Blue Cross.<sup>78</sup> It is not the Attorney General’s responsibility to devise an allocation method for Blue Cross. It is Blue Cross’ responsibility. Blue Cross was told to come up with a different allocation method in last year’s Order and Decision. It did not do so. Nevertheless Blue Cross insists that it be allowed to pass along these costs in the same manner it did last year,<sup>79</sup> arguing that its allocation is “fair” and “makes practical business sense.”<sup>80</sup>

Blue Cross proffered no evidence that it (1) ever attempted to devise an allocation method to comply with the Commissioner’s Order and Decision, (2) raised this issue with the Commissioner after last year’s Order and Decision, (3) tried to explain to the Commissioner any potential difficulties or problems associated with such an allocation, or (4) was actually “perplexed” by the requirement imposed by the Commissioner. Furthermore, there is nothing in the record to suggest that the Commissioner’s concerns regarding Blue Cross’ allocation method are unfounded. In the absence of any evidence in the record that (1) Blue Cross experienced

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<sup>77</sup> BC Ex. 4 at 16.

<sup>78</sup> BC Brief at 16 (“Apparently the Attorney General’s expert has no other suggestions as to what would be a ‘more accurate’ method.”).

<sup>79</sup> BC Ex. 2, Schedule 24; BC Ex. 4 at 55.

<sup>80</sup> BC ex. 4 at 15.

difficulty developing the new allocation method, (2) Blue Cross actually tried to develop such an allocation method, or (3) the Commissioner's concerns were misplaced, Blue Cross cannot reasonably expect that it will be allowed to simply revert to the very allocation method that the Commissioner deemed inappropriate last year. Blue Cross has had year to address this issue but has not done so.

In last year's Order and Decision, the Commissioner indicated that the assessments were disallowed in order to address the affordability requirements of R.I. Gen. Laws § 27-19.2-1 *et seq.*<sup>81</sup> Ultimately, this is an affordability issue for the Commissioner to resolve with Blue Cross. Blue Cross does not help its case by stubbornly forging ahead in the face of an explicit order by Commissioner.

With respect to the state's premium assessment, the Commissioner noted that:

As Blue Cross has the capacity to withhold certain internal assessments to Direct Pay Subscribers—such as for contributions to reserves—and this increase the product's affordability, it should do so for other internal assessments, specifically the State's Premium Assessment. The Premium Assessment adversely affects the affordability of the Direct Pay product. While it is a cost to Blue Cross, like a reserves assessment, it is not a cost incurred by Direct Pay subscribers for using or administering its products.<sup>82</sup>

The Commissioner has long held that affordability concerns, especially with respect to the kinds of internal assessments described here, must be weighed against the affordability of the Direct Pay line of products. For example, in the 2007 Direct Pay decision, Blue Cross' requested

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<sup>81</sup> 2010 Direct Pay Decision at 7 (unnumbered).

<sup>82</sup> *Id.* at 8-9 (unnumbered).

2% contribution to surplus, plus a .5% federal tax component were rejected.<sup>83</sup> The rationale for the rejection was discussed extensively. The reasons included:

- The Direct Pay class was found to be particularly vulnerable to the high costs of health care (e.g., Direct Pay subscribers directly bear all the costs of health insurance and that it also contains a greater component of older, sicker participants (in Pool I) than employer groups, thereby driving up the class' medical claims costs);
- Direct Pay members should be afforded reasonable aid in their efforts to purchase affordable health insurance, including: (1) efforts by Blue Cross to keep health care cost increases low, (2) elimination of unnecessary administrative expenses, (3) investment of plan surpluses in income-based subsidy programs and (4) in actuarial estimates that reflect a higher allocation of the risks to Blue Cross of the uncertainties inherent in the rate projection process.<sup>84</sup>

Blue Cross has not presented any evidence to suggest that the Commissioner's affordability concerns for Direct Pay subscribers are no longer relevant. Furthermore, as noted below, the Hearing Officer is recommending against the Blue Cross' proposed reserves contribution. Thus, based on last year's decision by the Commissioner, the lack of any evidence that Direct Pay is any more affordable than it was before, or that inclusion of the premium tax in the Direct Pay rates would make Direct Pay more affordable, I see no reason to re-adjust the affordability equation in favor of Blue Cross and against Direct Pay subscribers. As with the state assessments, this is ultimately an issue for the Commissioner to resolve with Blue Cross.

#### *E. Contribution to Reserves*

Blue Cross includes in the Filing a 1.00% increase in order to make a contribution to its reserves and an additional .25% to pay the taxes on that contribution.<sup>85</sup> As noted above, Blue Cross has not been allowed to include a reserve component for Direct Pay in the past few years

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<sup>83</sup> *In re Blue Cross & Blue Shield of Rhode Island—Class DIR*, No. HIC No. 06-RH-01 (Order entered Feb. 21, 2007) [hereinafter 2007 Direct Pay Decision] at 15.

<sup>84</sup> *Id.* at 22-24.

based on affordability reasons. Direct Pay subscribers do not receive the benefits of group coverage and are thus more vulnerable to the increasing costs of health insurance coverage. This year, however, Blue Cross argues that its declining reserves necessitate a contribution to reserves from Direct Pay. Its reserves are below the amount recommended by the Lewin Report, a reserve study commissioned by OHIC.<sup>86</sup> The AG counters with two arguments. First, the AG notes that Blue Cross' reserves are above the threshold required to avoid monitoring by OHIC and the Blue Cross Blue Shield Association.<sup>87</sup> Second, the AG argues that Blue Cross' premium deficiency ("PDR") reserve is too conservative.<sup>88</sup> An overstated PDR would make Blue Cross' reserves appear lower than shown on its financial reports.<sup>89</sup>

The issue here is one in which the financial needs of Blue Cross must be balanced against affordability concerns for Direct Pay subscribers. In the past, when Blue Cross reserves were considerably higher than they are now, determining that balance—in favor of no contribution to reserves—was a much easier task. Now, with Blue Cross reserves declining, that task becomes much more difficult.

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<sup>85</sup> BC Ex. 4 at 16-17, 58-60.

<sup>86</sup> BC Ex. 1 at 3.

<sup>87</sup> AG Ex. A at 12, Tr. II 14-15.

<sup>88</sup> A PDR is established when established premiums rates are not expected to cover incurred costs for the period covered by the rates. PDR funds are released over time to cover premium deficiency. AG Ex. A at 13. In this case, the AG argues that BC overstated its PDR for Direct Pay for the period from October 1, 2010 to March 31, 2011. During that period, Blue Cross held PDR amounts of \$2.5 million for Direct Pay, but only expected losses of \$706,000 for that same period. AG Ex. A at 13. Based on her analysis of Blue Cross' PDR, the AG's expert states that she has "concerns that the PDR on other lines of business may also be overstated." AG Ex. A at 14. If this is the case, she goes on, "then Blue Cross's [reserve] position would actually be more favorable than shown in its reported financials, supporting the Attorney General's recommendation that no contribution to reserves be made" in connection with this Filing. AG Ex. A at 14.

<sup>89</sup> AG Ex. A at 14.

I cannot accept the AG's suggestion that Blue Cross' PDR for all lines of business could be overstated. The AG only reviewed the PDR for Direct Pay and, based on what was there, expressed a concern that Blue Cross may be overstating its PDR for other lines of business. This is speculation, nothing more. I cannot presume that Blue Cross' overall PDR is overstated and that its reserve position is much more favorable than reported simply because of what has been observed with respect to the PDR for Direct Pay. Blue Cross' overall PDR may be overstated. I simply have no way of knowing if that is the case.

There are, however, other factors to consider when balancing Blue Cross' financial condition against the affordability concerns for Direct Pay subscribers. First, Blue Cross' financial problems, while significant, are not dire. There is no evidence to suggest that Blue Cross' financial condition is dire, only that its surplus level is down. When balanced against the financial impact of yet another rate increase to Direct Pay subscribers, who have seen rate increases every year since 2006, with one exception,<sup>90</sup> the balance must be struck in favor of subscribers. Second, Direct Pay makes up a miniscule portion of Blue Cross' overall business—between 3% and 4%.<sup>91</sup> Thus, the financial impact of denying the 1% contribution would also be miniscule in terms of Blue Cross' overall book of business. These factors do not make my recommendation against the reserve component easy. This is a judgment call—and a very close one. But on the whole, the affordability of the Direct Pay products must come before Blue Cross' present financial considerations. This is not to say that Blue Cross should never be allowed to include a reserves component in a proposed rate increase. Should Blue Cross' financial condition

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<sup>90</sup> BC Brief, last attachment, noting the following rate increases approved since 2006: 18.5% (2006), 4.0% (2007), 8.7% (2008), 0.0% (2009), 6.1% (2010). If simply averaged, these rate increases equal an average annual increase of nearly 7.5% over the last five years  $((0.185 + .04 + .087 + .00 + .061)/5 = .0746)$ .

<sup>91</sup> Tr. II at 68.

worsen in the future, the balance could very well tilt in Blue Cross' favor. In this Filing, however, it does not.

*F. Excessive Age-In Increases for Members Who Turn 65*

During the public comment portion of the hearing, a member of the public, Sam Katzovicz, brought to the Hearing Officer's attention a hidden problem with Blue Cross' rate structure—an excessive “age-in” problem. After complaining about a large increase in his rate, Mr. Katzovicz remarked:

I think the gist of my statement is probably pretty clear. As I talked to Ms. Niehus, whatever rate increase you allow Blue Cross and Blue Shield, there is a built-in increase by changing in the age because the pricing of Blue Cross/Blue Shield is built on age groups. So, if you leave everything alone, just the time, and the shift of the groups to the higher age will introduce increased rates just by that definition.

So whatever rate you allow, it's increased by that shift in age. That's just kind of my comment.<sup>92</sup>

Based on Mr. Katzovicz's comments, the Hearing Officer looked into the jump in rates due to the movement of a subscriber to the next age bracket.<sup>93</sup> The Hearing Officer noticed that Pool I subscribers moving from last year's 60-64 bracket to this year's proposed 65+ bracket would be subject to a 76% increase.<sup>94</sup> The rate increase is even worse for a Pool I subscriber who moves from the 60-64 bracket to the 65+ bracket. As noted earlier, Blue Cross charges all subscribers 65 and older are the same rate regardless of pool.<sup>95</sup> Thus, a Pool II subscriber moving from last year's 60-64 bracket to this year's proposed 65+ bracket would be subject to a 98%

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<sup>92</sup> Tr. I at 6.

<sup>93</sup> Tr. I at 123.

<sup>94</sup> See AG. Ex. C, Attachment AGBN-4. For example, an individual 64 year old Pool I subscriber in the HealthMate 500 plan paid \$710.44 per month last year. If the rates proposed by Blue Cross were to take effect without any changes to the age-in rating structure, that subscriber will pay \$1,252.50 a month next year. This is a 76% increase  $((1,252.50-710.44)/710.44 = .76)$ .

<sup>95</sup> BC Ex. 1 at 5.

increase.<sup>96</sup> When the Hearing Officer raised this issue with Blue Cross, Blue Cross' actuary indicated that he did not take this jump into consideration when developing the rate table.<sup>97</sup> According to Blue Cross, the rate slope for this Filing was increased in order to better balance fiscal equity and social equity. If the more expensive subscribers (mainly those who are older) are charged a higher rate (one that is more in line with their actual costs), plan rates become more appealing to younger, healthier subscribers, who then are more likely to purchase insurance and get into the pool.<sup>98</sup> As Mr. Lynch notes, the rate slope is a value judgment. There are always trade-offs when exercising this sort of judgment, and not very good ones.<sup>99</sup> I do not disagree with this general proposition and I do not disagree with Blue Cross' efforts to try to balance fiscal equity and social equity, even if I disagree with the specific method by which they do so. The problem I have with this particular rate structure is a narrow one: it imposes a rate increase of 76% on some members and a 98% rate increase on others simply because they turn 65. There is justification in the record for a rate slope in general. But there is no justification provided for the huge jump in rates for those who celebrate their 65<sup>th</sup> birthday. There is no evidence that 65 year olds are 76% more expensive than Pool I members who are 64. Likewise, there is no evidence that 65 year olds are 98% more expensive than Pool II members who are 64.

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<sup>96</sup> See AG. Ex. C, Attachment AGBN-4. For example, an individual 64 year old Pool II subscriber in the HealthMate 500 plan paid \$632.09 per month last year. If the rates proposed by Blue Cross were to take effect without any changes to the age-in rating structure, that subscriber will pay \$1,252.50 a month next year. This is a 98% increase  $((1,252.50-632.09)/632.09 = .98)$ .

<sup>97</sup> Tr. I at 123.

<sup>98</sup> Id. at 124-26.

<sup>99</sup> Id. at 125-26.

When asked if these rate increases from 64 to 65 constitute “rate shock,” the AG’s actuary said yes.<sup>100</sup> The AG’s actuary then noted that there are not many people that fall into this category, and suggested that “it may make sense to adjust that 65 plus category and maybe even just set it equal to the 60 to 64 category because there will never be a whole lot of people there which would solve that particular problem without jeopardizing the entire program.”<sup>101</sup> Indeed, Blue Cross conceded that, because not too many people would be affected, Blue Cross would not suffer a hardship if this problem were to be fixed by eliminating the 65+ rate category.<sup>102</sup> It is important to note that this problem will not go away even if the rate request is denied. Even if last year’s rates remain in place, the jump to the 65+ bracket alone will generate an increase of 57% percent from Pool I and 77% from Pool I.<sup>103</sup>

In its post hearing brief, Blue Cross takes issue with the Hearing Officer’s inquiries into this issue. Blue Cross argues that this rate structure was already approved, the AG did not raise the issue, Blue Cross did not suggest any changes to this rate structure, the AG did not challenge the rate slope, there was no discovery on this issue, and that it was raised *sua sponte* by the Hearing Officer “without prior notice to the parties.”<sup>104</sup> Based on these reasons, Blue Cross asserts that “it is not the role of the Hearing Officer to recommend a change in rating structure in

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<sup>100</sup> Tr. II at 20-21.

<sup>101</sup> Id. at 22-23. See also, Tr. II at 25 (“What I would say would be a solution that would be terribly disruptive, again, set the 65, age 65 plus category to be equal to the 60 to 64 without messing with a lot of other things. That would address your specific problem, I think, without seriously threatening the rest of the program.”)

<sup>102</sup> Tr. II at 89-90.

<sup>103</sup> See AG. Ex. C, Attachment AGBN-4. An individual 64 year old Pool I subscriber in the HealthMate 500 plan paid \$710.44 per month last year. If the rates remain the same, that subscriber will pay \$1,117.31 at 65. This is a 57% increase  $((1,117.31-710.44)/710.44 = .57)$ . An individual 64 year old Pool II subscriber in the HealthMate 500 plan paid \$632.09 per month last year. If the rates remain the same, that subscriber will pay \$1,117.31 at 65. This is a 77% increase  $((1,117.31-632.09)/632.09 = .77)$ .

<sup>104</sup> BC Brief at 23.

these circumstances.”<sup>105</sup> Blue Cross also quotes a lengthy passage from a Rhode Island Supreme Court case on the “appropriate” role of a Hearing Officer. Blue Cross appears to suggest that the Hearing Officer’s questions on this issue created a Due Process problem.<sup>106</sup> Blue Cross also suggests that, because it had no notice, it was prevented from providing additional testimony. It also states “[s]ince the age 65 issue was first brought up the Hearing Officer at the hearings, no clear record has been developed by the parties.”<sup>107</sup>

Contrary to Blue Cross’ assertion, the issue was not raised *sua sponte* by the Hearing Officer. As noted above, it was raised by a member of the public who came to give comment about his rate increase.<sup>108</sup> This comment prompted the Hearing Officer to question Blue Cross about the age-in step increase, the 64 to 65 step in particular, which produces an extremely high rate jump.<sup>109</sup> Blue Cross also ignores the fact that its own rate review statute expressly grants the Hearing Officer broad powers to make inquires of the parties, including the power to examine and cross-examine witnesses. The statute states that the Hearing Officer:

may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he or she deems relevant.<sup>110</sup>

The statute does not impose a notice requirement or limit the Hearing Officer to questions that have been provided to Blue Cross in advance of the hearing. As for an opportunity to provide

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<sup>105</sup> BC Brief at 23.

<sup>106</sup> Id.

<sup>107</sup> Id.

<sup>108</sup> Tr. I at 6.

<sup>109</sup> Tr. I at 123.

<sup>110</sup> R.I. Gen Laws § 27-19-6(c).

testimony on the issue, Blue Cross was told that its actuary would be given an opportunity to respond to testimony by the AG's actuary on this issue,<sup>111</sup> and Blue Cross availed itself of that opportunity.<sup>112</sup> With respect to Blue Cross' assertion that "it is not the role of the Hearing Officer to recommend a change in rating structure," Blue Cross' rate hearing statute makes clear that the decision after the hearing "may approve, disapprove, *or modify* the rates proposed to be charged by the applicant."<sup>113</sup> The rates proposed to be charged include all components and structures that factor into those rates. Thus is it appropriate for a Hearing Officer to recommend such changes.

The case cited by Blue Cross, *Davis v. Wood*, 427 A.2d 332 (R.I. 1981), makes clear that questioning by a hearing officer is permitted, but that a hearing officer "must not attempt to establish proof to support the position of any party to the controversy. Once he does so, he becomes an advocate or participant, thus ceasing to function as an impartial trier of fact."<sup>114</sup> Blue Cross has offered no evidence that the Hearing Officer in this case tried to establish proof to support the position of a party in this matter. The only party other than Blue Cross is the AG, and Blue Cross asserts that the AG did not raise or press this issue.<sup>115</sup> Thus it is not possible that the Hearing Officer attempted "to establish proof to support the position of any party to the controversy."

Finally, as to Blue Cross' contention that the record is not clear on this issue, nothing could be farther from the truth. A member of the public complained about the age-in rates during the public comment portion of the hearing. This was captured on the record. A quick review of

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<sup>111</sup> Tr. II at 25.

<sup>112</sup> Id. at 87-91.

<sup>113</sup> R.I. Gen Laws § 27-19-6(c) (emphasis added).

<sup>114</sup> 427 A.2d at 337.

<sup>115</sup> BC Brief at 22-23.

an exhibit admitted into evidence<sup>116</sup> reveals the excessive rate increase by simply comparing last year's rate for a 64 year old with the proposed rate for a 65 year old. The Hearing Officer questioned both parties on this issue on the record. The actuaries for both parties were asked about this issue and both provided testimony on the record. Blue Cross was given "a second bite at the apple" when its actuary was given another chance to comment on the issue on the record and did so. Finally the parties were asked to address this issue in their post hearing brief and did so.

There is, however, another aspect of this issue that merits some discussion: the possible, and in my view, very probable, equal protection problem with this classification. The Fourteenth Amendment to the Constitution of the United States guarantees equal protection of laws without unreasonable distinctions.<sup>117</sup> This includes distinctions created by a state administrative agency, such as OHIC.<sup>118</sup> While the equal protection clause does not preclude creation of all classifications, it does require that such classifications be reasonably related to some legitimate state interest. Stated differently, a classification created by state action must be reasonable and not arbitrary. It must rest on some difference having a fair and substantial relation to the object of the regulation so that all similarly situated persons are treated alike. While it is true that the business of insurance inherently involves explicit and widely accepted discrimination among individuals based on a projection of an individual's risk, this fact does not relieve OHIC, as an

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<sup>116</sup> AG Ex. C, Attachment AGBN 4.

<sup>117</sup> In addition, the Equal Protection Clause of the Rhode Island Constitution provides, in part, that no person shall be denied equal protection of the laws. R.I. Const. art. 1, § 2.

<sup>118</sup> *Robinson v. Florida*, 378 U.S. 153, 156 (1964) ("state action, of the kind that falls within the proscription of the Equal Protection Clause of the Fourteenth Amendment, may be brought about through the State's administrative and regulatory agencies just as through its legislature"); *Front Royal & Warren County Indus. Park Corp. v. Town of Front Royal*, 135 F.3d 275, 289 (4<sup>th</sup> Cir. 1998) (The Equal

arm of the State, from considering whether the rating classifications it is asked to approve are based upon reasonable distinctions and bear some relation to a legitimate State interest.

In equal protection cases where the actions of a non-governmental entity are implicated, there must be some sort of state action. This is often a difficult standard to meet. Nevertheless, the courts have recognized that “conduct that is formally ‘private’ may become so entwined with governmental policies or so impregnated with a governmental character as to become subject to the constitutional limitations placed upon state action.”<sup>119</sup> The extent of that involvement can, however, be measured only by the “sifting [of] facts and weighing [of] circumstances.”<sup>120</sup> Nevertheless, two Supreme Court cases suggest that the level of State involvement in the present case may be enough to implicate the Equal Protection clause. In *Public Utilities Commission v. Pollack*,<sup>121</sup> the amplification of radio programs on streetcars and buses in the District of Columbia was challenged on first amendment grounds.<sup>122</sup> The Court found that the state was sufficiently involved with the practice partly because the Public Utilities Commission had investigated the effects of the music and concluded that the radio service did not interfere with passengers’ convenience, comfort, or safety.<sup>123</sup> In the present case, Blue Cross’ rates are not simply approved based on actuarial soundness, OHIC cannot approve Direct Pay rates unless they are actuarially justified, in the public interest, and consistent with proper conduct of Blue Cross’ business. OHIC must also ensure that Blue Cross has met its programmatic affordability

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Protection Clause limits all state action, prohibiting a state from denying a person equal protection through the enactment, administration, or enforcement of its laws and regulations).

<sup>119</sup> *Evans v. Newton*, 382 U.S. 296, 299 (1966).

<sup>120</sup> *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722 (1961).

<sup>121</sup> 343 U.S. 451 (1952).

<sup>122</sup> *Id.* at 463.

<sup>123</sup> *Id.* at 462.

requirements before a rate is approved. When one or more of these standards have not been met, OHIC has issued various orders to Blue Cross to take some action. For example, in the context of previous Direct Pay hearings, OHIC has conditioned the approval of Direct Pay rates on the continued operation of a premium assistance program, ordered Blue Cross to submit an annual affordability report, and required Blue Cross to increase its medical management efforts.<sup>124</sup> OHIC has required Blue Cross to remove certain components from its Direct Pay rates, including state assessments and premium taxes, based on the public interest and affordability.<sup>125</sup> OHIC has also determined the method and amount by which Blue Cross may recover costs of its IT system from Direct Pay subscribers.<sup>126</sup> Based on this high level of involvement, it is hard to see how Blue Cross' Direct Pay line has not become "entwined with governmental policies" and "impregnated with a governmental character."

In contrast, in *Jackson v. Metropolitan Edison Co.*,<sup>127</sup> the Court contrasted the state commission's activities in *Pollak* with the apparent lack of state interest in Metropolitan Edison's termination practices, and concluded that Metropolitan Edison's action did not constitute state action because the utility had acted strictly on its own initiative and had exercised a choice allowed by state law. "[W]here the Commission has not put its own weight on the side of the proposed practice by ordering it, [it] does not transmute a practice initiated by the utility and approved by the Commission into 'state action'."<sup>128</sup> Again, in the present case, OHIC quite

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<sup>124</sup> *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, HIC No. 05-RH-02 (Order entered Feb. 20, 2006) [hereinafter 2006 Direct Pay Decision].

<sup>125</sup> 2010 Direct Pay Decision.

<sup>126</sup> *In re Blue Cross & Blue Shield of Rhode Island—Class DIR*, No. OHIC-2008-01 (Order entered Feb. 18, 2008) [hereinafter 2008 Direct Pay Decision].

<sup>127</sup> 419 U.S. 345 (1974).

<sup>128</sup> *Jackson*, 419 U.S. at 357.

plainly places its weight behind the rates and practices that Blue Cross may use for its Direct Pay products. Thus, unlike the state agency in *Jackson*, this Office's authority over Blue Cross' Direct Pay rates are substantial.

Since potentially serious equal protection issues could be implicated once the State's imprimatur is placed on the rates sought by Blue Cross, it is incumbent upon OHIC to ensure that the minimal standards for equal protection in cases not involving a suspect classification, quasi-suspect classification, or fundamental right, or are met. In this case, those minimal standards have not been met with respect to the proposed classification that would impose a 76% or 98% increase on a Direct Pay member without a rational basis simply because that member turns 65. As such, the classification cannot and should not be approved. Furthermore, even if the rate increase sought by Blue Cross were to be denied in its entirety, the existing rate structure, approved by last years rate review process, would still impose a significant rate increase on individuals and couples who turn 65. This is an equally unacceptable classification.

Ultimately, this particular rate classification constitute "rate shock," is not in the interest of the public, and it is not directly supported by any actuarial evidence. These grounds alone are sufficient to recommend that Blue Cross refrain from making this classification and, until a more equitable rating scheme devised, those who are 65 and older should pay the same rates as those who are 60 to 64. However, because a potential constitutional violation may inhere in this rating structure, I strongly recommend that the Commissioner modify the Filing to eliminate the 65+ rating category until Blue Cross can develop, with the approval of he Commissioner, a rating slope that does not unfairly discriminate against a particular group of subscribers.

## V. FINDINGS OF FACT

After full consideration of the issues raised in the public comment, the exhibits and testimony offered at the public hearing, the documents and papers submitted by Blue Cross and the AG, I make the following findings of fact:

1. The preceding sections I through IV of this Recommendation are incorporated into these Findings of Fact.
2. On November 19, 2010, Blue Cross filed a request with the OHIC for a rate increase for its Direct Pay products. The filing contained new rates to become effective April 1, 2011.
3. Blue Cross provided a copy of the filing of the proposed rates to the Insurance Advocacy Unit of the Attorney General's Office.
4. The filing was advertised in *The Providence Journal* on Friday, January 5, 2011.
5. Members of the public provided comments to OHIC prior to the hearing through correspondence and through emails.
6. Public hearings were held on January 21, 2011 and February 3 and 4, 2011.
7. Public comment was taken at the January 21, 2011 and February 3, 2011 hearing dates.
8. Blue Cross and the AG were given a full opportunity to provide testimony in support of their respective positions.
9. The average increase sought by Blue Cross in the Filing is 7.9%.
10. Current rates have been in place since April 1, 2010 and the new rates are to be in place for all subscribers for the one-year rating period beginning April 1, 2011 and ending March 31, 2012.

11. Blue Cross has projected its rates by analyzing its experience for Direct Pay and projecting it forward using trend factors for four major health care component (inpatient, outpatient, medical/surgical and prescription drug) for each pool, for a total of eight trend categories.
12. The trend factors used by Blue Cross for five of the eight categories (Pool I hospital inpatient, Pool I hospital outpatient, Pool I surgical/medical, Pool II hospital inpatient, and Pool II hospital outpatient) are based largely on unexamined and unsubstantiated commercial group trend factors not in the record.
13. No explanation or description has been provided for the commercial group trend factors used to develop the Direct Pay trends. There is no indication of how those commercial group trends were calculated and there is nothing in the record to support their use. There is no evidence that those trends are reasonable or accurate.
14. Use of the unexamined and unsubstantiated commercial group trends is an insufficient basis upon which to develop the Direct Pay trends and does not satisfy Blue Cross' statutory burden of demonstrating that the non-administrative portion of its proposed rates are consistent with the proper conduct of its business and in the interest of the public.
15. As a result of Blue Cross' use of unexamined and unsubstantiated commercial group trends to develop its trends for Direct Pay, the Hearing Officer cannot recommend that the non-administrative portion of Blue Cross' proposed rates, which rely on those trends, be approved.
16. The Hearing Officer cannot recommend that alternative trends suggested by the Attorney General be substituted for the unsupported Pool I hospital inpatient, Pool I hospital outpatient, Pool I surgical/medical, Pool II hospital inpatient, and Pool II hospital outpatient trends proffered by Blue Cross. The Attorney General did not contest Blue Cross' Pool I

hospital inpatient and Pool II hospital outpatient trends. The Attorney General did propose alternative trends for the Pool I hospital outpatient, Pool I surgical/medical, and Pool II hospital inpatient trends proffered by Blue Cross. Those alternative trends are not sufficiently supported by the evidence in the record.

17. The Budget proposed by Blue Cross is not supported by sufficient evidence. As a result of Blue Cross' use of unsubstantiated budget figures, the Hearing Officer cannot recommend that the administrative portion of Blue Cross' rates, apart from the Blue TransIT and state assessments and premium taxes, which are addressed separately, be approved.
18. As a part of its proposed rate increase, Blue Cross seeks a .34% increase to cover expenditures for its new IT system. Blue Cross has included this component in its Direct Pay rate filings since 2007. Given the fact that there is no evidence of mismanagement and that the .34% increase would have been requested by Blue Cross even if there had not been cost overruns, it is not unreasonable for Blue Cross to request .34% in this Filing. The Hearing Officer recommends that the .34% increase to cover expenditures for its new IT system be approved.
19. In last year's Direct Pay decision, the Commissioner determined that Blue Cross should not pass along certain premium tax costs and state assessments to Direct Pay subscribers because the method used by Blue Cross to allocate those costs risked allocating to Direct Pay subscribers medical costs greater than the costs they actually incurred. The Commissioner ordered Blue Cross to develop a more accurate method of allocating those costs to Direct Pay subscribers. He ordered that Blue Cross not include those costs in its Direct Pay rates until it develops a more accurate method of allocating those costs to Direct Pay subscribers.

20. Blue Cross has not developed a more accurate method of allocating the assessments to Direct Pay subscribers. As a result, I cannot recommend that these costs be passed along to Direct Pay subscribers as a part of Blue Cross' proposed rate increase.
21. In last year's Direct Pay decision, the Commissioner determined that certain state premium taxes should not be passed along to Direct Pay subscribers based on affordability concerns. As was noted in the 2007 Direct pay Decision, the Direct Pay class is particularly vulnerable to the high costs of health care, and as a matter of principle and policy, Direct Pay members should be afforded reasonable aid in their efforts to purchase affordable health insurance, including elimination of unnecessary administrative expenses in relation to its products. For this reason, the state premium taxes should again not be passed along to Direct Pay subscribers as a part of Blue Cross' proposed rate increase.
22. The proposed rate increase also includes a 1% contribution to surplus component. Federal income tax on this amount adds another .25%. This component of Blue Cross' proposed rate increase is not appropriate this year based on affordability grounds.
23. Blue Cross' present rate structure contains a hidden, excessive rate increase for Direct Pay subscribers who turn 65. The rate jump caused by this increase constitutes rate shock, is not supported by the record, and is not in the public interest. Furthermore, there is a substantial risk that this rating structure may violate the equal protection clause of the US and Rhode Island constitutions. For these reasons, the Commissioner should eliminate the 65+ age bracket for Direct Pay.
24. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a Finding of Fact.

## VI. CONCLUSIONS OF LAW

1. The preceding sections I through V of this Recommendation are incorporated into these Conclusions of Law.
2. The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.5-1 *et seq.*, 27-19-6 and 27-20-6.
3. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*
4. All of the procedural prerequisites for the conduct of the hearing have been followed.
5. The OHIC has jurisdiction in this proceeding to conduct a hearing for purposes of considering whether or not Blue Cross' proposed rates for its Direct Pay products are consistent with the proper conduct of its business and in the interest of the public.
6. The "proper conduct" of Blue Cross' business requires Blue Cross to take steps to enhance to affordability of its products.
7. Blue Cross bears the burden of proving that the proposed rates are consistent with the proper conduct of its business and in the interest of the public.
8. In addition, the OHIC must comply with the requirements of the OHIC Statute when rendering a decision in this matter. The OHIC Statute requires the Commissioner to render a decision so as to, among other things, protect consumer interests, encourage policies that improve the quality and efficiency of health care delivery, and encourage and direct Blue Cross toward policies that advance the welfare of the public.
9. The OHIC is authorized to accept, reject, or modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6. Modification of rates includes any of the components or structures that go into those proposed rates.

10. For all the reasons set out above, the proposed rate increase of 7.9% is not supported by the record, is not within the proper conduct of Blue Cross' business, and is not in the public interest.
11. A rate increase of 0.34% is supported by the record, is within the proper conduct of Blue Cross' business, and is in the public interest. Such a rate also protects consumer interests and advances the welfare of the public.
12. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.



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John Aloysius Cogan Jr.  
Hearing Officer

February 25, 2011

## **ORDER AND DECISION OF THE COMMISSIONER**

Christopher F. Koller, Health Insurance Commissioner of the State of Rhode Island hereby issues his Order and Decision with respect to the Rate Filing made by Blue Cross & Blue Shield of Rhode Island for its Direct Pay health insurance line of business on November 19, 2010, after having first carefully reviewed the Recommendation of the Hearing Officer dated February 25, 2010, the testimony and exhibits entered into the record, the arguments of the parties, and the public testimony.

Except as set forth below, the Commissioner adopts and accepts the Findings of Fact, Conclusions of Law, and Recommendation of the Hearing Officer.

The Hearing Officer is quite clear in his Recommendation that he was troubled by the state of the actuarial evidence in the record, and what from his perspective are defects in the reasoning and logic used by both Blue Cross and the AG's Office to support their opposing positions on medical inflation trends. The Hearing Officer also felt strongly that certain elements of administrative costs offered by Blue Cross, specifically costs relating to facility construction, were inadequately supported by the evidence. The Commissioner shares many of the concerns expressed by the Hearing Officer, but the Commissioner has made different decisions as to certain Findings of Fact and Conclusions of Law recommended by the Hearing Officer.

The Commissioner also remains troubled by the vulnerability of the Direct Pay class of subscribers. As has been noted in many past Orders and Decisions of the Commissioner, Direct Pay subscribers bear the full brunt of unsustainable medical inflation and its impact on health insurance premiums, not only because they must pay the full cost of the premium without any contribution from an employer, but also because

they must pay the full premium without the tax benefits that exist in group markets.<sup>1</sup> Consequently, when Blue Cross prepares its Direct Pay rate filings and when the Commissioner reviews those filings, particular attention must be given to balancing the financial needs of the insurance company with the affordability needs of subscribers. The Commissioner is hopeful that when the key affordability provisions of the Patient Protection and Affordable Care Act are implemented in January 2014, Direct Pay subscribers in Rhode Island will finally see some relief from the steady and unrelenting increases in their health insurance premiums. It remains the statutory obligation of the Commissioner and OHIC, however, to insist that all health insurance rate filings continue to be carefully scrutinized, and that all reasonable efforts are made to address the affordability needs of subscribers.

In consideration of the entire record (with the exceptions noted in the next succeeding paragraph, below) and the evidence introduced in this matter, the Commissioner hereby amends the Findings of Fact and Conclusions of Law recommended by the Hearing Officer as set forth below. In making such amendments, the Commissioner is relying on the same evidence and record before the Hearing Officer. The Commissioner is simply fulfilling his statutory responsibility and exercising his discretion as the final, regulatory decision-maker under the law, by reaching independent judgments to ensure that the rates filed by Blue Cross are “consistent with the proper conduct of its business and in the interests of the public.” R.I.G.L. §§ 27-19-6, 27-20-6, 27-19.2 *et seq.*, and 42-14.5 *et seq.* The Commissioner notes that the Hearing Officer’s Findings and Conclusions do not appear to be based in any manner upon the credibility of the witnesses as observed by the

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<sup>1</sup> See *In re Blue Cross Class DIR, HIC No. 05-RH-02*, at 62-67; *In re Blue Cross Class DIR, HIC No. 06-RH-01* at 36-38; *In re Blue Cross Class DIR, OHIC-2008-01* at 22-23; and *In re Blue Cross Class DIR, OHIC RH-2010-01* at 7-10.

Hearing Officer; therefore the Commissioner may adopt amended Findings of Fact based upon his independent review of the evidence and the record, without remand or supplementary hearing.

Two additional observations must be made. First, the Commissioner notes the AG's Office has objected to the introduction into the record of certain PowerPoint charts prepared by the Hearing Officer. The Commissioner finds that it would be improper to exclude these documents from the record after they have been entered into the record by the Hearing Officer; however, the Commissioner has neither read nor reviewed the PowerPoint charts, and the Commissioner hereby expressly excludes the PowerPoint charts from any consideration of this Order and Decision. Second, after the Hearing Officer submitted his Recommendation to the Commissioner, the Commissioner requested assistance from the Hearing Officer and the parties in identifying historical loss ratios for the Direct Pay line of business. Counsel for Blue Cross identified a document titled "Total Direct Pay Contribution to Reserve", attached to Blue Cross' Post-Hearing Memorandum at the request of the Hearing Officer. This document was relied on by the AG's Office in its own Post-Hearing Memorandum; however, because it does not appear that the attachment was ever formally admitted into evidence by the Hearing Officer or by agreement of the parties, the Commissioner will not consider this document to be part of the evidentiary record, and the Commissioner has not relied upon this document in any manner in issuing this Order and Decision.

Amended Finding No. 12. There is evidence in the record sufficient to demonstrate specific medical trends in five of the eight trend categories: Pool I hospital inpatient, Pool I Pharmacy, Pool II hospital outpatient, Pool II surgical medical, and Pool II

Pharmacy. Both parties, Blue Cross and the AG's Office, agree on the appropriate trend factor in these five categories. The Commissioner observes that this filing demonstrates amply that "actuarial science" relies on expert judgment as well as statistical analysis. A party's burden of proof can be met without absolute certainty as to the factual basis for setting rates; certainty in predicting the future is undoubtedly impossible to achieve. In this matter the actuarial experts of the opposing parties have agreed on the appropriate trend factors that should be applied in five of the eight relevant categories. Such expert opinion, in the absence of contrary evidence, in itself constitutes sufficient evidence to support the following agreed-upon trend factors in these five categories:

|                              |       |
|------------------------------|-------|
| Pool I hospital inpatient:   | 0.0%. |
| Pool I pharmacy:             | 13.4% |
| Pool II hospital outpatient: | 8.0%  |
| Pool II surgical/medical:    | 3.1%  |
| Pool II pharmacy:            | 5.4%  |

Amended Finding No. 13. There are three trend factors concerning which the parties and their expert actuaries do not agree. For the Pool I hospital outpatient trend, Blue Cross entered into evidence its expert testimony in support of a 0.0% increase, whereas the AG's Office entered into evidence expert testimony in support of a -5.0% decrease. For the Pool I surgical/medical trend Blue Cross entered into evidence its expert testimony in support of a 2.0% increase, whereas the AG's Office entered into evidence expert testimony in support of a 0.7% increase. For the Pool II hospital inpatient trend Blue Cross entered into evidence its expert testimony in support of a 0.0% increase,

whereas the AG's Office entered into evidence expert testimony in support of a -3.0% increase.

Amended Finding No. 14. The actuarial experts for both parties testified to the manner in which they each calculated trend factors for these three categories, and the opposing actuarial experts came to different conclusions about the proper trend calculation. That expert witnesses for two opposing parties in administrative litigation disagree as to their opinions is not in itself surprising, nor in itself is it a basis for finding both opinions to be incorrect. Nevertheless, the Hearing Officer concluded that Blue Cross' use of trend data in the commercial group markets to support the establishment of trend factors in the Direct Pay market was improper, and that the AG's Office reasoning for the trend factors it supports was rationally inconsistent and therefore could not be used to support the establishment of trend factors in the Direct Pay market. The Commissioner, after careful review of the evidence and the record finds that the evidence is sufficient to support the establishment of trend factors in these three categories. The Commissioner further finds that to refuse to establish trend factors in these three categories would be inconsistent with his statutory duty. On the basis of the testimony of the opposing actuaries, the Commissioner finds and establishes the following trend factors in connection with the three categories in dispute.

|                             |        |
|-----------------------------|--------|
| Pool I hospital outpatient: | - 2.5% |
| Pool I surgical/medical:    | 1.35%  |
| Pool II hospital inpatient: | -1.5%  |

Amended Finding Nos. 15 and 16. The trend factors set forth in Amended Finding No. 14, above, are consistent with the proper conduct of the business of Blue Cross, and

in the interest of the public. The Commissioner is mindful that the failure to approve trend factors despite sufficient evidence to support some level of trend is not in the interests of Direct Pay subscribers in particular. While no increase in premium may appear to be an unadulterated good, Direct Pay subscribers will not benefit from being subject to sharp, unexpected increases in rates to address previous inadequacies.

Amended Finding No. 17. Blue Cross entered into evidence financial information demonstrating that its building costs will increase by \$306,680 in 2011, and supported its financial information with the testimony of officers of the company. Those officers did not testify in great detail about each specific line item in the company's administrative report, but the Commissioner finds that the administrative budgetary approach on operating expenses used by Blue Cross is "consistent with past directives of OHIC, and its predecessor, DBR." *In re Blue Cross Blue Shield of Rhode Island*, Docket No. OHIC-2008-01 at 17. Moreover, Blue Cross amended its filing prior to the administrative hearing, lowering its projected Direct Pay budget and thereby reducing its rate request by 0.2%. While OHIC has the authority to requested greater detail to support the company's building expenses, the Commissioner finds that there is insufficient reason to disallow the expense in the manner in which it was admitted into evidence, without notice and an opportunity to supplement the evidence, and without notice of what type and quantum of evidence is needed to support allowance of this particular cost element. The AG's Office proposed a lower figure of \$100,000, but as the Hearing Officer found there is no evidence to support allowance of the lower figure.

Amended Finding No. 23. The Commissioner is greatly troubled at the effective premium increased faced by Direct Pay subscribers who turn 65 (76% for Pool I

subscribers, and 98% for Pool II subscribers), because of the rating structure developed by Blue Cross over the years. The Commissioner finds that allowing a rate increase for these subscribers is inconsistent with the proper conduct of the business of Blue Cross, not in the interest of the public, and in direct contradiction to these subscribers' affordability needs. The Commissioner also finds, however, that eliminating this premium category as recommended by the Hearing Officer would be inconsistent with OHIC's responsibility to review and act on rate filings in a predictable, rational, and non-arbitrary manner. In making this finding, the Commissioner observes that the rating structure used by Blue Cross that results in these substantial increases for subscribers as they reach the age of 65 has been in effect for many years. The Commissioner finds that Blue Cross should not be ordered to eliminate this rating structure without careful examination and consideration of the alternatives, and notice to the parties. Finally, the Commissioner finds that while the current rate structure should not be eliminated, no portion of the rate increase approved by this Order and Decision should be allocated to the subscribers in the 65 and older rate category, and that the disapproval of any rate increase for this rating category is consistent with the proper conduct of the business of Blue Cross, in the interests of the public, and properly balances the financial needs of the company and the affordability needs of the few subscribers in this category. The Commissioner further finds that the evidence is insufficient to find as fact that the specific rating structure applied by Blue Cross to Direct Pay subscribers age 65 and older is so entwined with governmental policy as to constitute "state action" for purposes of the 14<sup>th</sup> Amendment to the United States Constitution.

The Commissioner adopts and accepts, for the reasons set forth in the Hearing Officer's Recommendation, the Hearing Officer's Findings of Fact Nos. 18, 19, 20, 21, and 22 with respect to: (1) the allowance of Blue Cross' IT capital expenditures; (2) the disallowance of premium tax and state assessment costs; and (3) the disallowance of an expense for contribution to reserves and federal taxes.

Based upon the Findings of Fact of the Hearing Officer, as amended above, the Commissioner hereby adopts and accepts the Conclusions of Law recommended by the Hearing Officer, except as set forth below:

Amended Conclusion of Law No. 10. For the reasons set forth in the Hearing Officer's Findings of Fact which have been adopted and accepted by the Commissioner, the Amended Findings of Fact made by the Commissioner and set forth above, and the Hearing Officer's Conclusions of Law which have been adopted and accepted by the Commissioner, a modified rate increase should be approved, to be calculated in accordance with the trend and expense values set forth in the Commissioner's Amended Findings of Fact Nos. 12 through 17, and No. 23, and in accordance with the expense value set forth in the Hearing Officer's Finding of Fact No. 18 relating to Blue Cross' IT expenses. The modified rate increase hereby approved by the Commissioner is expressly conditional upon the prior approval of the Commissioner of an amended rate filing consistent with this Order and Decision. The conditional, modified rate increase hereby approved is consistent with the proper conduct of the business of Blue Cross, and is in the interests of the public.

Amended Conclusion of Law No. 11. Blue Cross should be directed to propose a modified rate structure for Direct Pay subscribers 65 years of age or older in connection

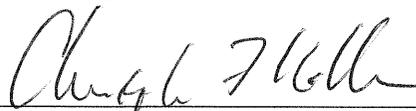
with Direct Pay rates to be effective April 1, 2012. Such directive is consistent with the proper conduct of the business of Blue Cross, and is in the best interests of the public.

The Commissioner further concludes as a matter of law that the evidence in the record of this rate filing is insufficient to demonstrate that Blue Cross' rating structure with respect to Direct Pay subscribers 65 years of age and older constitutes "state action" for purposes of the 14<sup>th</sup> Amendment to the United States Constitution. Jackson v Metropolitan Edison Co., 419 U.S. 345 (1974). Blum v Yaretsky, 457 U.S. 991 (1982).

Wherefore, it is hereby ORDERED:

1. A modified rate increase is approved, to be calculated in accordance with the trend and expense values set forth in the Commissioner's Amended Findings of Fact Nos. 12 through 17, and No. 23, and in accordance with the expense value set forth in the Hearing Officer's Finding of Fact No. 18 relating to Blue Cross' IT expenses, and to be filed as an amended rate filing and approved by the Commissioner before it takes effect.
2. Blue Cross is ordered to propose a modified rate structure for Direct Pay subscribers 65 years of age or older in connection with Direct Pay rates to be effective on and after April 1, 2012.

ENTERED AS AN ADMINISTRATIVE ORDER OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER THIS 7<sup>th</sup> DAY OF March, 2011.



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Christopher F. Koller, Commissioner  
Office of the Health Insurance Commissioner

THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS DECISION MAY BE

APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.