

November 18, 2011

Commissioner Christopher F. Koller  
Health Insurance Commissioner  
1511 Pontiac Avenue, Bldg. 69-1  
Cranston, RI 02920

Subject: Filing of Subscription Rates for Class DIR

Dear Commissioner Koller:

This letter, together with the actuarial schedules enclosed, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs. This filing includes proposed rates to become effective April 1, 2012.

The rates proposed in this filing will affect the approximately 15,200 members enrolled in Class DIR as of September 2011.

#### **Definition of Class DIR**

Class DIR is the rating classification for persons not eligible for employer-based (other than as a self-employed individual), nor State or Federal programs. Enrollment is on a non-group basis either through direct application to Blue Cross or through conversion from prior group coverage. Group conversions occur monthly and an annual open enrollment period is conducted for the Basic Pool (Pool I), while enrollment in the Preferred Pool (Pool II) is available continuously throughout the year for applicants passing a health screening. Two rating pools are employed in the Class -- the Basic Pool (Pool I) with rates determined based on the age of the subscriber and the Preferred Pool (Pool II) with rates determined based on the age and gender of the subscriber. It should be noted that we are proposing rate structure changes to the Class DIR Basic Pool (Pool I) effective with this rate filing that would increase the rate differential between young and old subscribers, with the exception of subscribers over the age of 65. These rate structure changes are discussed further below.

#### **Benefit Changes and New Product**

Effective April 1, 2012, Blue Cross is proposing to make changes to its existing products (including renaming several) and to introduce a new product into the individual market. These changes are intended to increase member choice while improving affordability of the products. Another goal of the updates is to standardize the benefit structure both within the individual market and across market segments. This should make it easier for members to understand how their benefits work and allow for an easier transition when members change plans within Direct Pay and convert from group coverage. These

**BLUE CROSS EXHIBIT 1**

updates are further explained in my pre-filed testimony and detailed in the policy forms filed contemporaneously with this rate filing. Contingent upon approval of this rate filing, the following Direct Pay products will be available effective April 1, 2012:

- *VantageBlue Direct 1000/2000 (Formerly HealthMate Coast-to-Coast Direct 500/1000)*: Includes a \$1,000 per individual/\$2,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), \$20 PCP/\$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of \$10/\$35/\$60/\$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of \$3,000 per individual / \$6,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.
- *VantageBlue Direct 1500/3000 (Formerly HealthMate Coast-to-Coast Direct 1000/2000)*: Includes a \$1,500 per individual/\$3,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), \$20 PCP/\$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of \$10/\$35/\$60/\$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of \$4,500 per individual / \$9,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.
- *HealthMate Coast-to-Coast Direct 2500/5000 (Formerly HealthMate Coast-to-Coast Direct 2000/4000)*: Includes a \$2,500 per individual/\$5,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), \$20 PCP/\$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of \$10/\$35/\$60/\$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of \$7,500 per individual / \$15,000 per family. The out of pocket maximum includes the deductible. Members have the option of engaging in the Wellness Reward Program and may receive a reward equal to 10% of their annual paid premiums if they meet certain wellness requirements. In general, member cost share is greater at out-of-network providers.
- *BlueSolutions for HSA Direct 3000/6000 (Formerly HealthMate for HSA 3000/6000)*: The BlueSolutions for HSA Direct 3000/6000 Plan includes deductibles of \$3,000 per

individual / \$6,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is also applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 80% for all covered services except prescription drugs (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). For prescription drugs, members will pay co-payments of \$10 for tier 1 drugs, \$35 for tier 2 drugs, \$60 for tier 3 drugs, and \$100 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of \$6,000 per individual and \$12,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *BlueSolutions for HSA Direct 5000/10000 (Formerly HealthMate for HSA 5000/10000)*: The BlueSolutions for HSA Direct 5000/10000 Plan includes deductibles of \$5,000 per individual / \$10,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is also applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). For prescription drugs, members will pay co-payments of \$10 for tier 1 drugs, \$35 for tier 2 drugs, \$60 for tier 3 drugs, and \$100 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of \$6,050 per individual and \$12,100 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.
- *BlueValue Direct 2500*: The BlueValue Direct 2500 plan will be available on an individual basis only (no family coverage) and includes a deductible of \$2,500. Most services are covered at 50% after satisfaction of the deductible up to an out of pocket maximum of \$7,500 (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). The out of pocket maximum includes the deductible. Certain physician visits and emergency room visits, however, are covered pre-deductible. The first two visits to a primary care physician or specialist are covered with a \$30 co-payment pre-deductible. Subsequent visits are covered at 50% after satisfaction of the deductible. Likewise, the first visit to an emergency room is covered with a \$200 co-payment pre-deductible, with subsequent visits subject to the deductible and 50% coinsurance. A separate \$500 deductible is applicable to tier 2, tier 3, and specialty drugs. Tier 1 drugs are covered pre-deductible with a \$4 co-payment. Tier 2 and tier 3 drugs are covered at 50% after satisfaction of the deductible. Specialty drugs are also subject to the deductible with a \$200 co-payment. BlueValue Direct 2500 also covers 1 annual dental cleaning and 1 set of bitewing X-rays per year with no member cost sharing. Finally, an annual fitness reimbursement of \$100 toward a gym membership is available with this plan.

Effective April 1, 2012, we are also introducing an innovative new program that reduces the deductible over time. This program will be available with all of our Direct Pay plans and helps to address affordability by reducing the deductible amount in the following calendar year for those subscribers who do not meet their deductible. The deductible continues to be reduced so long as the subscriber does not meet the deductible in any given calendar year until the fourth year, or until the deductible is 50% of the original amount. After the fourth year, the reduced deductible is maintained as long as the deductible is not met. If the deductible is met in any year, the deductible resets to the original amount the following year. After reset, the subscriber can begin to earn the reduced deductible again as long as insurance coverage is maintained. Subscribers must have had coverage for six consecutive months within the calendar year to be eligible for a credit the following year. The table below illustrates the program.

<b>Year</b>	<b>Percent Reduction</b>	<b>Example</b>
Calendar Year 1	Original Deductible	\$5,000
Calendar Year 2	20% Reduction	\$4,000
Calendar Year 3	40% Reduction	\$3,000
Calendar Year 4	50% Reduction	\$2,500

**Communicating Benefit Changes**

We will include information about the benefit changes as part of the notification existing subscribers receive about this filing. Subscribers will have an opportunity to select any plan by completing an election form. If no election is made, subscribers will be transitioned to the updated plan that is most closely aligned with their current benefits according to the following chart. Additional details regarding the transition process and Blue Cross' communication plans are detailed in the pre-filed testimony of Kimberly Cormier.

<b>Current Plan</b>	<b>Plan Effective April 1, 2012</b>
HealthMate Direct 500	VantageBlue Direct 1000
HealthMate Direct 1000	VantageBlue Direct 1000
HealthMate Direct 2000	HealthMate Direct 2500
HealthMate for HSA 3000	BlueSolutions for HSA Direct 3000
HealthMate for HSA 5000	BlueSolutions for HSA Direct 5000

### **Rating Structure Changes Effective With This Filing**

With this rate filing, Blue Cross is proposing to introduce rate structure changes for the Basic Pool (Pool I). Effective April 1, 2012, the maximum rate differential by age for subscribers under age 65 will be increased to 1.5 to 1 for Basic (Pool I) subscribers. The current rate differential is 1.25 to 1. This change will improve the financial equity between young and old Pool I subscribers and will lessen the rate shock to Direct Pay subscribers in 2014 when the Patient Protection and Affordable Care Act (PPACA) requires the removal of rating by health status.

Also, rate structure changes for subscribers aged 65 and over are being proposed for both Basic (Pool I) and Preferred (Pool II). In last year's Order and Decision, the Commissioner raised concerns regarding the rate structure for Direct Pay subscribers aged 65 and over for both Basic (Pool I) and Preferred (Pool II). This rate filing addresses those concerns. The rate differential between subscribers aged 65 and over and aged 60-64 is being reduced to 24% from the current 49%. This is equivalent to these subscribers receiving no rate change from last year assuming no change in benefits. In addition, a new rate band is being introduced for subscribers aged 65 and over in Preferred (Pool II) to limit the rate shock for those subscribers turning age 65. The rate differential within Pool II between subscribers aged 65 and over and aged 60-64 will be the same as that within Pool I.

### **Change in Rate Renewal Date**

The rates proposed in this rate filing will be in effect for the period April 1, 2012 through September 30, 2013 (18 months). Under proposed Exchange regulations, beginning in 2014, individual market rates need to be in effect for the entire calendar year. This necessitates an eventual change in the renewal date for Direct Pay. Our proposed solution is to extend the rating period for this filing through September 30, 2013. This would allow our members more time to become familiar with the updated plan designs and provide peace of mind that their rate will not increase for 18 months, unless the subscriber moves into a new age band. The subsequent rate filing will be effective with the beginning of the Exchange related open enrollment on October 1, 2013 and extend through the end of calendar year 2014. Thereafter, rate changes will be effective on a calendar year basis.

### **Reserve Contribution**

Blue Cross is not requesting a reserve contribution component from Class DIR subscribers in this rate filing. Historically, Blue Cross and its Directors have taken the position that Direct Pay should not only recover its claims and administrative expenses, but should contribute its fair share towards corporate reserves. Although Blue Cross has not changed its philosophy in this regard, given the current economic conditions in Rhode Island, we are not asking Class DIR subscribers to contribute to corporate reserves at this time. It should be noted that as of September 30, 2011, Blue Cross corporate reserves

were at 19.0% of annual premium, which is below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium.

### **State Premium Tax and Assessments**

In the previous rate decision for Class DIR for rates effective April 1, 2011, the Office of the Health Insurance Commissioner ("OHIC") disallowed charges for the state premium tax and state assessments. The required rates in this filing include the state premium tax and a documented allocable portion of the state assessments.

The basis for the Commissioner's denial of state assessments in rates charged to Class DIR subscribers was that Blue Cross had not developed a more accurate method of allocating the assessments to Direct Pay. In this rate filing, Blue Cross is including only those expenses that can be explicitly shown to have accrued as a result of a Direct Pay member receiving an immunization during the experience period analyzed. This new methodology is detailed on schedules 25 and 26 of Blue Cross Exhibit 2.

The required rates in this filing include 2% for the state premium tax. In last year's rate filing, the Commissioner's denied inclusion of the state premium tax in Direct Pay rates on the basis of affordability concerns. For the reasons outlined in pre-filed testimony, we believe this rate filing addresses these affordability concerns, and thus the rating component for premium taxes should be allowed in Class DIR rates. Moreover, for the reasons our attorneys will articulate in connection with the hearings, we believe the law requires inclusion of the premium taxes in the Class DIR rates.

The state premium tax is assessed on a premium base that includes Class DIR and the determination of the assessments to Blue Cross is based on premium reported on annual financial statements, including premium for the Class DIR line of business. If Blue Cross is continued to be denied a mechanism to collect these taxes and assessments from Class DIR subscribers, Blue Cross subscribers in other market segments would be assessed a disproportionate share of these fees.

The inclusion of these taxes and assessments in Class DIR premiums is fair and makes practical business sense. State premium tax and assessments are borne by all fully insured subscribers in Rhode Island, in accordance with State law. The state premium tax and assessment requirements combined add approximately 3.8% to the cost of insurance coverage in all markets, including Class DIR.

### **Affordability as Addressed in the Rate Filing**

In consideration of previous rate decisions issued by the OHIC, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Among these are the value based benefits inherent in the updated plan designs and the introduction of a new product targeted at the uninsured population. Specifics of these programs will be detailed in the pre-filed testimonies of Dr. Manocchia, Kimberly Cormier, and me. In addition,

along with this rate filing, we are submitting as Exhibit 3 the “Resources for Health System Improvements - Survey”. Exhibit 3 outlines Blue Cross’ strategies regarding improving the overall affordability of health care in Rhode Island.

**Required Rates**

Blue Cross last filed rate changes for its Class DIR subscribers on November 19, 2010 for an effective date of April 1, 2011. In its decision rendered on March 7, 2011, The OHIC approved an aggregate increase of 1.9%.

The overall average required rate increase projected in this filing, exclusive of any AccessBlue (premium assistance) amounts, is 4.4%. This projected average increase is based on the same subscriber migration pattern inherent in the premium rate calculations. Actual rate changes will vary based on the actual benefit plan selected. All rates included in this filing will remain in effect for the eighteen-month period commencing April 1, 2012. The Class DIR Basic (Pool I) required monthly rates and the Preferred (Pool II) required monthly rates for the six Direct Pay products are included in the following tables.

**Class DIR Basic (Pool I)**  
**Required Rates Effective April 1, 2012**

		<b>VantageBlue/HealthMate</b>			<b>Blue Solutions for HSA</b>		<b>BlueValue</b>
		1000	1500	2500	3000	5000	2500
Under 25	Individual	\$542.94	\$492.06	\$428.36	\$376.62	\$302.23	\$267.89
	Family	\$1,022.18	\$926.39	\$806.47	\$709.05	\$569.00	N/A
25-29	Individual	\$554.70	\$502.72	\$437.64	\$384.78	\$308.78	\$273.69
	Family	\$1,043.74	\$945.93	\$823.48	\$724.01	\$581.00	N/A
30-34	Individual	\$575.28	\$521.37	\$453.88	\$399.05	\$320.23	\$283.84
	Family	\$1,082.94	\$981.46	\$854.41	\$751.20	\$602.82	N/A
35-39	Individual	\$596.84	\$540.91	\$470.89	\$414.01	\$332.23	\$294.48
	Family	\$1,124.11	\$1,018.77	\$886.88	\$779.75	\$625.73	N/A
40-44	Individual	\$609.58	\$552.46	\$480.94	\$422.85	\$339.33	\$300.77
	Family	\$1,147.63	\$1,040.08	\$905.44	\$796.07	\$638.83	N/A
45-49	Individual	\$647.81	\$587.10	\$511.10	\$449.36	\$360.60	\$319.63
	Family	\$1,220.15	\$1,105.81	\$962.66	\$846.38	\$679.20	N/A
50-54	Individual	\$707.59	\$641.28	\$558.26	\$490.83	\$393.88	\$349.12
	Family	\$1,331.87	\$1,207.06	\$1,050.81	\$923.88	\$741.39	N/A
55-59	Individual	\$787.95	\$714.11	\$621.67	\$546.58	\$438.61	\$388.77
	Family	\$1,483.78	\$1,344.73	\$1,170.66	\$1,029.25	\$825.95	N/A
60-64	Individual	\$814.41	\$738.09	\$642.55	\$564.93	\$453.34	\$401.83
	Family	\$1,532.78	\$1,389.14	\$1,209.32	\$1,063.24	\$853.22	N/A
65+	Individual	\$1,012.38	\$917.51	\$798.74	\$702.25	\$563.54	\$499.51
	Family	\$1,910.10	\$1,731.10	\$1,507.01	\$1,324.97	\$1,063.26	N/A

**Class DIR Preferred (Pool II)**  
**Required Rates Effective April 1, 2012**

		VantageBlue/HealthMate			Blue Solutions for HSA		BlueValue
		1000	1500	2500	3000	5000	2500
Under 25	Male	\$206.73	\$187.36	\$163.10	\$143.40	\$115.07	\$102.00
	Female	\$289.06	\$261.98	\$228.06	\$200.51	\$160.90	\$142.62
	Family	\$692.67	\$627.78	\$546.49	\$480.48	\$385.56	N/A
25-29	Male	\$228.65	\$207.23	\$180.40	\$158.61	\$127.27	\$112.82
	Female	\$327.54	\$296.86	\$258.42	\$227.21	\$182.32	\$161.61
	Family	\$775.90	\$703.21	\$612.15	\$538.22	\$431.89	N/A
30-34	Male	\$260.42	\$236.02	\$205.46	\$180.65	\$144.96	\$128.49
	Female	\$389.29	\$352.82	\$307.14	\$270.04	\$216.69	\$192.08
	Family	\$822.88	\$745.79	\$649.22	\$570.81	\$458.04	N/A
35-39	Male	\$298.01	\$270.09	\$235.12	\$206.72	\$165.88	\$147.04
	Female	\$386.16	\$349.98	\$304.66	\$267.87	\$214.95	\$190.53
	Family	\$868.52	\$787.15	\$685.23	\$602.47	\$483.44	N/A
40-44	Male	\$318.59	\$288.74	\$251.36	\$221.00	\$177.34	\$157.20
	Female	\$422.40	\$382.83	\$333.26	\$293.01	\$235.12	\$208.42
	Family	\$887.76	\$804.59	\$700.41	\$615.81	\$494.15	N/A
45-49	Male	\$385.26	\$349.17	\$303.96	\$267.25	\$214.45	\$190.09
	Female	\$468.04	\$424.19	\$369.27	\$324.67	\$260.53	\$230.94
	Family	\$935.64	\$847.98	\$738.19	\$649.03	\$520.81	N/A
50-54	Male	\$488.18	\$442.44	\$385.16	\$338.64	\$271.74	\$240.87
	Female	\$546.80	\$495.57	\$431.40	\$379.30	\$304.36	\$269.79
	Family	\$1,042.13	\$944.50	\$822.21	\$722.90	\$580.08	N/A
55-59	Male	\$625.55	\$566.94	\$493.54	\$433.93	\$348.20	\$308.65
	Female	\$624.21	\$565.73	\$492.48	\$432.99	\$347.45	\$307.99
	Family	\$1,166.53	\$1,057.24	\$920.35	\$809.19	\$649.33	N/A
60-64	Male	\$668.95	\$606.28	\$527.78	\$464.03	\$372.36	\$330.07
	Female	\$668.95	\$606.28	\$527.78	\$464.03	\$372.36	\$330.07
	Family	\$1,267.65	\$1,148.89	\$1,000.13	\$879.33	\$705.62	N/A
65+	Male	\$831.38	\$753.49	\$655.93	\$576.70	\$462.77	\$410.21
	Female	\$831.38	\$753.49	\$655.93	\$576.70	\$462.77	\$410.21
	Family	\$1,579.53	\$1,431.56	\$1,246.20	\$1,095.68	\$879.22	N/A

**Filing Schedules**

Schedules displaying the required rates and detailed actuarial schedules documenting the calculation of the required rates are enclosed as Blue Cross Exhibit 2.

The underlying actuarial methodology used in the preparation of the required rates in this filing is similar in nature to the previous Class DIR rate filing submitted to the OHIC. The filing schedules and supporting actuarial pre-filed testimony detail the rating methodology.

**Pre-Filed Testimony**

With this filing, we are submitting the pre-filed testimony of Kimberly Cormier, who will be Blue Cross' witness regarding benefit changes and communication strategies, and myself, who will be Blue Cross' actuarial and policy witness at the upcoming rate hearing on this matter. We will be submitting, no later than November 28, 2011, the pre-filed testimony of Augustine Manocchia, MD, Senior Vice President & Chief Medical Officer, who will be Blue Cross' witness with regards to affordability and medical management issues. We believe submitting the pre-filed testimony contemporaneously with the rate filing will make the discovery process more efficient and decrease the length of time of all aspects of the hearing process.

**Conclusion**

The actuarial assumptions have been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

In accordance with the filing fee requirements contained in section 42-14-18 of the General Laws of Rhode Island, a filing fee of \$150 (\$25 for each policy) has been included with this submission via electronic funds transfer (EFT). This filing pertains to the following direct pay products: *VantageBlue Direct 1000/2000*, *VantageBlue Direct 1500/3000*, *HealthMate Coast-to-Coast Direct 2500/5000*, *BlueSolutions for HSA Direct 3000/6000*, *BlueSolutions for HSA Direct 5000/10000*, and *BlueValue Direct 2500*. The policy form numbers for these products, which (except as noted) have been submitted to the Department under separate cover, are:

- FRONT DIRECT (04-12)
- SUMMARY DIRECT (04-12)
- INTRODUCTION DIRECT (04-12)
- ELIGIBILITY DIRECT (04-12)
- COVERED DIRECT (04-12)
- EXCLUSIONS DIRECT (04-12)
- PAYMENT DIRECT (07-10) (previously approved)
- COB DIRECT (07-10) (previously approved)
- APPEALS DIRECT (04-12)
- GLOSSARY DIRECT (04-12).

When combined, these ten subsections comprise the subscriber agreements for the six Direct Pay policies.

We respectfully ask for your timely approval of this filing as submitted. Blue Cross & Blue Shield of Rhode Island believes that the proposed rates are in the interest of both the public and the Corporation.

Commissioner Christopher F. Koller  
November 18, 2011  
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As always, we shall be pleased to provide any additional information that you may require.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jeffrey McLane', written in a cursive style.

Jeffrey McLane, F.S.A., M.A.A.A.  
Associate Actuary

JGM/swl

Enclosures

cc: Mr. Normand G. Benoit, Esquire  
Ms. Genevieve M. Martin, Esquire