

AG EXHIBIT A

**STATE OF RHODE ISLAND AND PROVIDENCE
PLANTATIONS**

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

In Re: Blue Cross and Blue Shield of Rhode Island

Rates Filed April 15, 2013 for Individual Market Plans OHIC-2013-4

**REPORT OF BARBARA P. NIEHUS, FSA, MAAA
SUBMITTED ON BEHALF OF THE ATTORNEY GENERAL**

May 21, 2013

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I. NATURE AND PURPOSE OF REPORT

Rhode Island law requires a public hearing with respect to premium rates charged by Blue Cross and Blue Shield of Rhode Island (“Blue Cross”) for health insurance coverage sold to individuals. Pursuant to §27-36-1 R.I. Gen. Laws, the Attorney General is charged with representing the citizens of Rhode Island in that hearing. Blue Cross filed rates on April 15, 2013 to become effective on January 1, 2014 for plans to be offered in the individual market (the “Filing”). The purpose of this Report is to provide the results of my review and analysis of Blue Cross’s Filing and provide the Attorney General’s alternative recommendations and calculations to Blue Cross’s requested rates.

II. PERSONAL QUALIFICATIONS

I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I am also president of Niehus Actuarial Services, Inc., which I founded in 2001.

I have over forty years of experience in the insurance industry dealing with life and health insurance products. I have been active in the Society of Actuaries (“SOA”) for much of my career and completed my second term on the SOA’s Health Section Council in 2010. During my career as an actuary, I have assisted in the syllabus design and have authored SOA materials that were used by actuarial students in preparing for actuarial exams required to attain professional credentials.

My curriculum vitae is provided as Attachment AGBN-1.

I have prepared this report on the basis of my review, analysis, research work to date, and over forty years of experience working as an actuary. Revisions and supplementation may occur as further information becomes available or is otherwise discovered or developed, or as any additional matters or issues may be raised.

III. BACKGROUND¹

Pursuant to §27-19.2-10(2) R.I. Gen. Laws, Blue Cross is required to offer coverage to citizens of Rhode Island in the individual market. Blue Cross is currently the only carrier offering products in the Rhode Island individual market and, for many years, has offered individual coverage on both a medically underwritten and (for those unable to pass medical underwriting) a guarantee-issue basis. Individuals and families that were healthy enough to pass medical underwriting (“Pool 2”) were charged lower rates. Those who were not healthy enough to pass medical underwriting (“Pool 1”) were able to enroll (under stated conditions, including an annual open enrollment period) but paid a higher rate. In addition, Blue Cross provided certain premium subsidies to low-income members under the AccessBlue program. The underwriting and premium structure of Blue Cross’s individual product offerings appears to have encouraged both healthy and unhealthy lives to purchase insurance and premium rate increases have been fairly moderate since 2006.

Blue Cross’s last rate filing in the individual market was submitted in late 2011, with rates becoming effective April 1, 2012.

In March 2010, the 111th Congress passed health reform legislation, the Patient Protection and Affordable Care Act (“ACA”; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111- 152) and other laws. The ACA expands federal private health insurance market requirements, and requires the creation of health insurance exchanges effective January 1, 2014 to provide individuals and small employers with access to insurance. The Filing is intended to comply with all of the ACA requirements for plans that will be sold both through the Exchange and outside the Exchange. Complying with the ACA requires Blue Cross to redesign its product offerings and also requires, with certain qualifications, that premium rates be the same for both Exchange and non-Exchange products. Moreover, the ACA’s restrictions on rating (which do not allow rates to vary by gender or by health status and substantially modify variation by age and family status) require Blue Cross to fundamentally change

¹ As additional background information, I have included Attachments AGBN-15 (Affordable Care Act (ACA) Impact on the Filing) and AGBN-16 (Glossary).

its rating structure in the Filing and eliminate the previous Pool 1 / Pool 2 distinction. Because the only other health insurer planning to offer products in the Rhode Island individual market in 2014 is Neighborhood Health Plan of Rhode Island, it is expected that Blue Cross will have the bulk of that market in 2014.

IV. FINDINGS

Blue Cross made errors and inappropriate assumptions in calculating its requested rates that, in total, overstate these requested rates by 12.2%. The issues resulting in the overstatement by Blue Cross of its requested rates are described in detail in Sections A, B, C, and D below. Attachment AGBN-2 provides a listing of these issues, as well as their impact on the rates requested by Blue Cross.

I have prepared a number of attachments to this Report that analyze the impact on Blue Cross's requested rates by changes that are recommended by the Attorney General, including Attachments AGBN-4, 5, 6, 9, 11, 13, and 14. For each of those, I have relied upon the formats and formulas that Blue Cross used in its Filing. However, in each of these Attachments, I have highlighted certain items that I have corrected/changed as are explained in the applicable sections of my Report. I have measured the value of each of the corrections/changes by looking at the impact on the "Base EHB Rate" that Blue Cross calculates in Appendix I to the Filing. Attachments AGBN-4, 5, 6, 9 and 11 each focus on one issue (described in this Report) in isolation, while Attachments AGBN-13 and 14 include the impact of all issues combined.

A. Blue Cross made errors in its rate calculations, overstating its requested rates by 4.5%.

Blue Cross made errors with respect to selection of its utilization trend factors and the calculation of the Class DIR population adjustment factor. When these errors are corrected, the resulting rates are 4.5% lower than those requested by Blue Cross.

1) Blue Cross's selection of its Utilization Trend Factors was in error, causing its requested rates to be overstated by 3.9%.

In developing its requested rates, Blue Cross begins with historical claim costs and then makes a number of adjustments. Two of those adjustments are related to claim cost trends; one component is price or unit cost trend and the other component is utilization trend. In Appendix C of the Filing, Blue Cross provided historical trend data. Data was provided for both total trend (looking at allowed costs per member per month – “PMPM”) and utilization trend (looking at utilization and mix of services, but excluding price).

Utilization trend selections for projection purposes are discussed on page 5 through 7 of the Actuarial Memorandum in the Filing. For hospital inpatient and hospital outpatient utilization trends, Blue Cross argues that Class DIR business alone is not credible enough and that it is more appropriate to rely on the utilization trends observed when Blue Cross's Class DIR, Small Group and Large Group business are all combined. For the remaining categories (Professional Services and Pharmacy), Blue Cross believes that Class DIR business data is credible and can be relied upon for projection purposes.

On page 7 of the Actuarial Memorandum in the Filing, Blue Cross states that it selected a utilization trend rate of 4.3% for medical/surgical (also referred to as professional services), based on an analysis of its historical data. This determination by Blue Cross was in error, since its source is the data analyzing total trend (the first page of tables as included in Appendix C²), rather than just the utilization component of trend (the second page of tables in Appendix C). The correct number, as shown in the second page of tables in Appendix C of the Filing, should be 3.3%, not the 4.3% used by Blue Cross in its calculations. The same kind of error was made by Blue Cross in determining its pharmacy costs; however, the magnitude of this error is much more significant. In this instance, Blue Cross selected a utilization trend factor of 8.7% (which actually is the total price and utilization trend), when its own data indicates a utilization trend factor of 2.2% should have been used by Blue Cross in calculating its requested rates.

² The Appendix C tables have been provided as Attachment AGBN-3 to my report, for ease of reference.

Blue Cross's selection of a 3% utilization trend factor for hospital inpatient is supported by the combined data for Class DIR, Small Group and Large Group. However, in selecting the factor for hospital outpatient, Blue Cross incorrectly again looked at total trend, rather than utilization trend. The correct selection should have been 1.3%, rather than the 4.0% used by Blue Cross in its calculations.

The correction of these errors results in a reduction to Blue Cross's requested rates of approximately 3.9%, as shown in Attachment AGBN-4.

2) Blue Cross made an error in its calculation of the Population Adjustment Factor shown in Appendix B of the Filing, causing its requested rates to be overstated by 0.6%.

Because of the changes required by the ACA effective January 1, 2014, the characteristics of the population insured under Blue Cross's Class DIR products are expected to change. The change in the population covered in the individual market is one of the major impacts of the ACA. It is anticipated by Blue Cross that the ACA provisions will cause some individuals to drop coverage due to rate increases, others to purchase coverage due to the elimination of medical underwriting and availability of premium subsidies, and still others to change coverage and purchase the new options that will be available.

For its rate calculations, Blue Cross recognizes that different populations can have different expected claim costs. In Appendix B of the Filing, Blue Cross recognizes and quantifies these differences by identifying the source of new enrollment and magnitude of drops in enrollment in its current population. The resulting population adjustment factor is used by Blue Cross to project claim costs for the population that is expected to be covered in 2014. It does this by estimating the claim cost of each segment of its projected population and calculating a weighted average based on the size of each segment, but made an error in this calculation. Specifically, Blue Cross's calculation of the Small Group member claim cost PMPM was incorrect, for the reasons explained below.

For Small Group members, Blue Cross provided its calculation of claim costs PMPM (\$453.29) in response to data request DBR 2-01, AG Exhibit V. Blue Cross's calculation and a corrected calculation are shown in my Attachment AGBN-5.

Blue Cross's objective was to weight Pool 1, Pool 2, and Sole Proprietor costs to calculate an average applicable to Small Group members. For weighting the claim costs, in Blue Cross's response to data request DBR 2-01, AG Exhibit V it indicates that it intends to use projected population counts³ (which can be found in Appendix B of the Filing). In fact, for Pool 1 and Pool 2 Blue Cross used projected populations, but used a different number for Sole Proprietors. For the Sole Proprietors, Blue Cross used a count of 35,613 rather than 21,368 found in Appendix B to the Filing. After correcting for this error by using the projected population for Sole Proprietors, the average Small Group claims PMPM becomes \$449.30, rather than \$453.29 as shown in Attachment AGBN-5. As further illustrated in Attachment AGBN-5, the effect of this change is to reduce Blue Cross's requested rates by 0.6%.

B. Blue Cross failed to substantiate its Price / Unit Cost trend factors. An analysis of Blue Cross's prior experience supports lower trends, which would reduce Blue Cross's requested rates by 4%.

After devoting more than two full pages to explaining how it determined utilization trends, Blue Cross then provides a one paragraph explanation of its choice of price / unit costs trends at the top of page 8 of the Actuarial Memorandum in the Filing. The justification that Blue Cross provides states:

“The price projection factors are based on actual unit cost increases, estimates of price increases based on negotiations, and any planned or estimated increases and adjustments to provider contracts. This information was provided by BCBSRI's provider contracting area. I have reviewed the information for reasonableness, but have not independently audited or otherwise verified the information provided.”

³ On page 4 of the Actuarial Memorandum in the Filing, Blue Cross states: “Their claims, therefore, are based on the combination of the current Direct Pay population (with the selection adjustment discussed above) and the Sole Proprietors currently in the Small Group market.” This would indicate that the weighting should be based on current enrollments. However, Blue Cross also stated that they cannot determine the number of enrolled Sole Proprietors (also page 4 of the Actuarial Memorandum in the Filing). It appears that Blue Cross's intent (as indicated in its response to data request DBR 2-01) is to use projected populations.

Data request AG 1-06, AG Exhibit B, requested all analyses supporting the price / unit cost trends. In its response, Blue Cross stated:

“Price factors are provided by the contracting department. They reflect all existing contracts. For contracts that are in negotiation or will be renewed within the projection period, the contracting department determines their best estimate of the result. The impacts of each contract are weighted together based on claim volume.”

No further information regarding the contracts or the analysis of the contracts was provided. Blue Cross has failed to substantiate its selection of cost / unit price trends both in its Filing and in its response to the Attorney General’s data request seeking such substantiation.

As an appropriate alternative to using the unsubstantiated trend values put forward by Blue Cross, I am able to review Blue Cross’s own data; namely, its historical price / unit cost trends from the data that Blue Cross provided in Appendix C to the Filing. In its analysis, Blue Cross looked at both total trend (the combination of utilization and price / unit cost trends) and stand-alone utilization trend. The difference between these two trend rates will reflect stand-alone price / unit cost trends, based on Blue Cross’s own historical data.

After reviewing the Filing including the information in Appendix C (see Attachment AGBN-3), my findings are as follows:

- Hospital Inpatient – When looking at hospital inpatient utilization trend, Blue Cross relied upon combined data for large group, small group, and Class DIR because Class DIR data lacked credibility (see pages 6-7 of the Actuarial Memorandum in the Filing). Using the combined data consistent with Blue Cross’s choice of utilization trend factors demonstrates that the utilization trend is 3.1% and the total trend is 2%. This would indicate a negative price trend of 1.1%, as compared to Blue Cross’s unsubstantiated selection of a positive trend of 3.7%. Accordingly, I have selected the indicated price trend resulting from Blue Cross’s own data.

- Hospital Outpatient – For utilization trend, Blue Cross again relied upon combined data for large group, small group, and Class DIR because Class DIR data lacked credibility (see page 7 of the Actuarial Memorandum in the Filing). Using the combined data demonstrates that the utilization trend is 1.3% and the total trend is 4.0%. This would indicate a price trend of 2.7%, as compared to Blue Cross’s unsubstantiated selection of a 4.0% price trend. Accordingly, I have selected the indicated price trend resulting from Blue Cross’s own data.
- Professional Services – For determining utilization trends for professional services, Blue Cross determined that the Class DIR data was credible. The observed utilization trend is 3.3% and the total trend is 4.3%, indicating a price / unit cost trend of 1%. Blue Cross selected separate trends for primary care (9.9%) and other professional services (1.5%), yet Blue Cross’s average projected trend across all professional services approximates 2.9%. Accordingly, I have selected the indicated price trend of 1%, resulting from Blue Cross’s own data for both Primary Care and Other Medical/Surgical.
- Pharmacy – Blue Cross proposes substantial pharmacy plan changes, which makes its historical price trends an unreliable predictor.

When these price / unit cost trends that are based on Blue Cross’s own data are substituted for the values that Blue Cross has failed to substantiate, Blue Cross’s requested rates are further reduced by 4% (see Attachment AGBN-6).

C. Blue Cross has failed to support the large proposed increase in its administrative load. After appropriate adjustments are made, Blue Cross’s requested rates are reduced by 1%.

As compared to the current rates being charged to Class DIR members, Blue Cross’s requested rates include significantly higher administrative expenses. As stated in Blue Cross’s response to data request AG 1-10, AG Exhibit D: “The filed rates include a 26.8% increase in the per member per month charge when compared to the current approved rate.” Blue Cross goes on to indicate that a portion of this change is driven by the fact that, for the current rates, the Commissioner approved a lower expense load

(7.3% lower) than Blue Cross had requested.⁴ Blue Cross also points out that the ACA imposes requirements that will increase its expenses. And finally, Blue Cross claims that it has changed its allocation methodology to more equitably charge expenses, resulting in Class DIR members carrying a larger load of those expenses compared to historical methodologies.

With regard to methodology to more equitably allocate expenses to the Class DIR business, Blue Cross made a similar argument in its filing with regard to the current rates, although the Hearing Officer did not find the arguments to be persuasive (see Attachment AGBN-7, pages 18-19). Even if Blue Cross had been allowed to charge its full expense load at that time, the PMPM charges included in the current rates would have been $\$41.04/(1-.073) = \44.27 . Blue Cross's projected value of \$52.05 in the Filing would still be an increase of 17.6%, when compared to this calculated value of \$44.27, which was not approved in the last filing. In his decision dated February 16, 2012 regarding Class DIR rates to become effective April 1, 2012, the Hearing Officer limited the increase in the administrative cost component of the rates to the medical CPI of 2.65% (see Attachment AGBN-7, page 19).

Data from the Bureau of Labor Statistics as of the end of March 2103 shows that current medical inflation is approximately 3.1% annually (see Attachment AGBN-8). Because the current rates became effective April 1, 2012, the values included in the current rates would be subject to greater than a full year of trend. If the trend projection period is considered to be October 1, 2012 to mid- 2014 (one and three-quarters years), the applicable factor is 1.055. When this factor is applied to the amount of \$44.27 (calculated above), the result is \$46.70.⁵

Blue Cross has indicated (see pages 11-12 of the Actuarial Memorandum in the Filing and the response to data request AG 1-10, AG Exhibit D) that there are new taxes and fees applicable in 2014 due to the ACA. Per the response to data request AG 1-10, AG

⁴ The current rates became effective April 1, 2012. A public hearing was held with respect to Blue Cross's requested rates in January, 2012. The Hearing Officer's decision was dated February 16, 2012. The Commissioner's Order (dated February 21, 2012) with regard to the rate increase adopted the Hearing Officer's Finding of Facts, Conclusions of Law, and Recommended Order. See Attachment AGBN-7.

⁵ $\$44.27 \times (1.031)^{1.75} = \$44.27 \times 1.055 = \$46.70$

Exhibit D, the increase in taxes, licenses and fees amounts to \$1.61 PMPM. When the value calculated above of \$46.70 is increased by adding the additional \$1.61, the calculation produces a more appropriate expense load of \$48.31, which amounts to a decrease of \$3.74, or 7.2% less than the value of \$52.05 requested by Blue Cross. This reduction in the expense load would reduce Blue Cross's requested rates by 1.0% (see Attachment AGBN-9).

As mentioned above, Blue Cross has pointed to the additional requirements imposed by the ACA as a factor contributing to its increasing costs, but did not attempt to quantify the impact. I have given little weight to this claim. In light of Blue Cross's significant investment over the last few years in its new administrative system, I would expect operating efficiencies to be gained that can offset the cost of meeting these additional requirements. Moreover, the conversion to the new system should have given Blue Cross new capabilities that should simplify compliance with the new requirements, thereby reducing the cost of compliance.

D. Other adjustments should be made to Blue Cross's requested rates in order to be consistent with Commissioner Koller's prior Orders. The adjustments in total reduce Blue Cross's requested rates by 3%.

- 1) **Commissioner Koller's Class DIR Order in 2010 required that state assessments be allocated to Class DIR based on the benefit to members. The recommended adjustment would reduce Blue Cross's requested rates by 1.6%.**

In his Order dated February 8, 2010 (regarding Class DIR rates to become effective April 1, 2010 AG Exhibit Y, page 9, paragraph #11), Commissioner Koller disallowed state assessments and stated:

“The cost allocations to Direct Pay of state assessments for medical services are not based on the historical consumption of these services by Direct Pay enrollees. Direct Pay enrollees should not be subject to the risk that estimated medical costs allocated to them are greater than the costs they actually incurred....”

Last year, Blue Cross presented an analysis of the assessment-related expenses that was acceptable to the Commissioner. Using the allocation method approved by Commissioner Koller last year, the projected assessments would have reduced Blue Cross's requested base EHB rate from \$330.97 to \$325.69 (per Blue Cross's response to data request AG 2-12, AG Exhibit O), which results in a reduction to Blue Cross's requested rates of 1.6%.

2) Consistent with Commissioner Koller's previous Orders, the provision for contribution to surplus should be reduced, resulting in a premium reduction of Blue Cross's requested rates of 1.4%.

Premium rates for insurance policies typically include a profit margin. In the case of Blue Cross, because it is a not-for-profit organization, this type of provision is referred to as a "contribution to reserves," rather than profit.

Class DIR members purchase their own insurance without the benefit of an employer contribution, and, in many cases, without the benefit of being able to take a tax deduction for the cost of insurance premium. As a result, this class of members is particularly vulnerable and heavily impacted by increasing health insurance costs.

The current Class DIR rates were approved without any component for contribution to reserves (see Attachment AGBN-7, page 16). Historically, the Commissioner has limited the premium component included for contribution to reserves. For example, when rates that became effective April 1, 2011 were approved by Commissioner Koller, the contribution to reserves originally requested by Blue Cross was entirely disallowed. (See Attachment AGBN-10, page 42 paragraph #22, and page 52.)

In the current Filing, Blue Cross has included a total of 2.84% of premium for contribution to surplus (see Filing Rate Template II). In response to question #4 from Charles DeWeese (received by Blue Cross on 4/18/2013) AG Exhibit T, Blue Cross stated: "The 2.84% contribution to reserves includes the target reserve contribution

(2.00%), the amortization of the new claims processing system⁶ (0.34%) and the Federal income tax liability (0.50% assuming 2.00% reserve and 20% tax rate).”

In the interest of affordability, the Commissioner has the authority to limit this component of premium, as has been done in the past. Given the large increases that many Class DIR members will face, it would be appropriate to limit this component to 1.5% of premium, reducing Blue Cross’s requested rates by 1.4% (see Attachment AGBN-11).

E. Blue Cross should take every opportunity available to it in order to manage its business effectively to provide maximum value, and possibly lower rates, to its members.

By running its business as effectively and efficiently as possible, Blue Cross will help assure its viability and also more appropriately serve its members. One area of particular importance is Blue Cross’s efforts to manage claim costs and improve affordability. Blue Cross needs to assure that time and money spent on efforts to improve affordability are spent wisely, using a disciplined approach. Blue Cross provided information in response to data requests from the Attorney General in which it illustrated its management processes for these efforts and provided examples and updates.

I note that the Medical Expense Trend Team (“MET” formed in November 2009) oversees and authorizes a variety of cost-saving initiatives. The MET seems to have improved Blue Cross’s processes for prioritizing initiatives, approving new initiatives, and for ending unsuccessful initiatives. Nonetheless, it appears that Blue Cross can still strengthen efforts even further by more rigorously monitoring and comparing actual to expected implementation costs and actual to expected savings.

In addition to MET efforts, Blue Cross also pursues a number of initiatives at the direction of OHIC. A periodic status report has been provided to OHIC (see, for

⁶ This provision of 0.34% has been included in approved rates for several years, despite concerns expressed by the Attorney General. The new system implementation was completed in 2012, and the purpose of the charge in 2014 would be to help restore the level of surplus after the impact of the system investments, including significant cost overruns, as compared to Blue Cross’s initial estimates.

example, Attachment AGBN-12). The reporting required by OHIC focuses on expenditures but does not appear to attempt to measure benefits of the initiatives. It is important that valuable resources not be spent on initiatives that provide limited or no return. If Blue Cross has any concerns regarding any of the OHIC initiatives, as a steward of its members, it is important that Blue Cross provide OHIC with information supporting its concerns.

Blue Cross has indicated that it intends to reduce its operating expenses, an effort that should be encouraged. Now that Blue Cross has completed its conversion to its new administrative system, we would expect Blue Cross to exploit fully all possible efficiencies that can be gained, taking a hard look at measuring productivity and monitoring staffing levels. Blue Cross must also assure that compensation levels, including employee benefits, are reasonable. For example, last year we noted that Blue Cross employees on average were contributing only 11% toward the cost of their medical plan, far less than typical private industry practices where the contribution level is frequently 20% or more. Currently that contribution level is still low, at only 12.5% (see response to data request AG 2-04, AG Exhibit K).

Another area of concern as we approach 2014 is with regard to member and public communications. With the substantial benefit and rate changes that will occur effective January 1, 2014, Blue Cross needs to not only provide clear communications, but also assure that its customer service representatives are well trained to field questions. I noted that Blue Cross included in the Filing a document entitled "Consumer Narrative Justification – Individual Market." This document is not user-friendly and uses too much insurance jargon (e.g. "compression of age rating to a 3:1 ratio" and "implementation of single year age bands"). Blue Cross should work together with OHIC to assure that communications are user-friendly and clearer. Moreover, Blue Cross's communications will need to be coordinated with the Rhode Island Health Benefit Exchange.

In previous years, I have noted that the AccessBlue program, which provides premium subsidies to low income members, has been a meaningful and successful effort. AccessBlue offers subsidies to members whose gross annual household income is less

than 350% of the Federal Poverty Level (FPL). Because the ACA will provide subsidies for members who enroll through the Health Benefit Exchange and have income less than 400% of the FPL, Blue Cross plans to discontinue AccessBlue at the end of 2013 (see cover letter to the Filing, page 1, and AG Exhibit C). Blue Cross began this program (formerly called the premium assistance program) in 2006 and through 2013 will have contributed approximately \$15 million toward low income subsidies (see Blue Cross's response to data request AG 1-08, AG Exhibit C). During the transition year of 2014, it would be appropriate for Blue Cross to continue AccessBlue in certain selected situations for members who were enrolled during 2013. For example, there may be current members who face increases in premiums in excess of 50%, but who have income only slightly above the 400% of the FPL cut-off for subsidies through the Exchanges. There also might be current members in the range of, for example, 300-400% of the FPL that face significant rate increases that significantly exceed the subsidy they can receive. Additional subsidies may be necessary for these members to find that insurance continues to be affordable for them.

V. CONCLUSIONS

For all of the foregoing reasons, Blue Cross's requested rates should be reduced by 12.2%. In determining appropriate rates, the Hearing Officer and the Health Insurance Commissioner should give any benefit of the doubt to consumers who, as a whole, are about to experience large rate increases and major changes to the insurance plans they have previously purchased.

In total, the corrections and adjustments to the rates recommended by the Attorney General reduce Blue Cross's requested rates by 12.2% (see Attachment AGBN-13). The alternative calculations recommended by the Attorney General produce the rates shown in Attachment AGBN-14⁷.

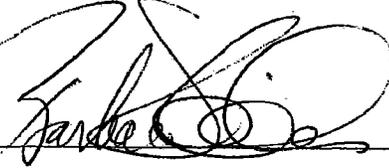
⁷ Rates shown in Attachment AGBN-14 do not include two potential adjustments not yet made by Blue Cross. One is the handling of abortion expenses and the other is the handling of IRS limit changes (see AG Exhibits W and X). These changes are relatively minor and do not affect my findings as presented in this Report.

5/21/2013

(Date)

NIEHUS ACTUARIAL SERVICES, INC.

By:



Barbara P. Niehus, FSA, MAAA