

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF THE HEALTH INSURANCE COMMISSIONER  
1511 PONTIAC AVENUE, BLDG. 69-1  
CRANSTON, RHODE ISLAND 02920

IN RE: BLUE CROSS & BLUE SHIELD OF : RH-2013.4  
RHODE ISLAND RATES FILED :  
APRIL 15, 2013 FOR INDIVIDUAL :  
MARKET PLANS :

REPORT AND RECOMMENDATION

I. THE FILING

On April 15, 2013, Blue Cross & Blue Shield of Rhode Island (“Blue Cross”) filed a request for approval of rates for Direct Pay subscribers in the individual market (“Filing”). The rate filing seeks an average increase of 18.1% for current members on an equivalent benefit basis.<sup>1</sup> The rate filing is sought for the period from January 1, 2014 through December 31, 2014. Further, Blue Cross requests that the rates currently in place for Direct Pay products, that were approved by the Commissioner on February 29, 2012, remain in effect until December 31, 2013. With this Filing, Blue Cross also noted that its Access Blue premium assistance program will remain in effect until December 31, 2013, at which time it would be eliminated. Blue Cross proposes the introduction of 11 different plans to the Direct Pay members. Blue Cross Exhibit 1, Appendix G.

This Filing not only must meet the requirements of the applicable state laws discussed below, it must also navigate through the new requirements of the Patient Protection and Affordable Care Act (“ACA”).<sup>2</sup> In order to effectuate the ACA, Governor Lincoln Chafee

<sup>1</sup> Blue Cross submits a proposed average premium to an age 21 Essential Health Benefits (“EHB”) plan at \$330.97. The 18.1% average rate increase is unlikely to be experienced by any member. The range of the increases will be broader, from a possible rate decrease of approximately 4% for current Pool I members to as much as over 50% increase current Pool II members.

<sup>2</sup> Pub. L. 111-148, 124 Stat. 119.

implemented the Rhode Island Health Benefit Exchange.<sup>3</sup> Individuals and small employers who reside in Rhode Island will utilize the Exchange to access insurance information and acquire insurance products commencing on January 1, 2014.

The Filing is intended to comply with the ACA requirements for plans that will be sold both through the Exchange and outside of the Exchange in the individual market. The ACA required Blue Cross to change much of its rating structure. For example, Blue Cross can no longer use two rating pools in Direct Pay. Historically, Blue Cross used a guaranteed issue pool with annual open enrollment with age rating (Pool I) and an age/gender rated pool for those who passed medical underwriting requirements (Pool II). The Pool II subscribers have a lower morbidity rate and traditionally have subsidized the rates for Pool I subscribers. The ACA eliminates such subsidies and prohibits such medical underwriting requirements.

The ACA also prohibits rating based upon age and gender. The new federal law requires that the ratio of the age 64 rate to the age 21 rate not exceed 3 to 1 using a federal age curve. *See*, AGBN-15. This will significantly raise the rates for the youngest members while somewhat reducing the rates for older members. *Id.* With the elimination of gender rating, rates for males will increase while the rates for females will decrease. Likewise, with the elimination of health status as a rating factor, healthier insured members will pay more while the premiums for less healthy members will be reduced than they would otherwise pay under current rating practices. *Id.* Historically, Blue Cross has charged either a single rate or a family rate with the family rate based upon the subscriber's age and gender, independent of the actual age, gender or number of dependents. Under the ACA, the family rate will be the sum of the premium for all of the family members based upon the age of the family members with only the limitation being that a maximum of three family members under the age of 21 will be included. *Id.*

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<sup>3</sup> Executive Order 11-09.

The ACA also increases expenses with the introduction of the Health Insurer Tax, Transitional Reinsurance Fee, the Patient Centered Outcomes Research Trust Fund Fee and the Federal Risk Adjuster Fee.<sup>4</sup>

It is anticipated that rate increases may increase significantly for some current subscribers. For example, those persons who currently qualify for lower premiums under Pool II may see premium increases as high as 55%.

## 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 April 16, 2013, the Health Insurance Commissioner appointed Raymond A. Marcaccio, Esq. as the Hearing Officer for this matter. Hearing Officer Marcaccio was directed to make recommended Findings of Fact and Conclusions of Law to the Commissioner.

### C. Notice of the Hearing

Pursuant to a Scheduling Order entered on May 2, 2013, this matter was scheduled for evidentiary hearings on May 29 and May 30, 2013. Likewise, the public was invited to appear before the Hearing Officer to provide comments concerning the Blue Cross rate proposal on May 29 and May 30, 2013. The Filing was advertised, in accordance with applicable law and with the

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<sup>4</sup> In 2014, the new taxes and fees will be offset by the Temporary Reinsurance payments that Blue Cross projects to receive. During the following two filing periods, the Reinsurance program is phased out and completely eliminated by the 2017 filing. Blue Cross Exhibit 1, McLane letter of April 15, 2013 to Commissioner Koller. *See also*, Exhibit I at Appendix F, ACA Related Taxes and Fees.

aforesaid Order, in a newspaper of general circulation, the *Providence Journal*, on May 17, 2013.

*D. Pre-filed Testimony, Exhibits and Witnesses*

Prior to the commencement of the evidentiary hearing, the Attorney General and OHIC engaged in pre-hearing discovery with Blue Cross to determine the basis for Blue Cross' rate request. The Attorney General issued three sets of data requests to Blue Cross seeking additional information concerning the Filing. Likewise, OHIC issued several data requests to Blue Cross.

Blue Cross submitted Exhibit 1, which was its rate filing, as well as Exhibit 2, which established proof and substance of the public notice. During the hearing, Blue Cross submitted an additional exhibit to correct its rate template 4 of the Filing, Blue Cross Exhibit 3. All of the Blue Cross exhibits were admitted as full exhibits by agreement of the parties.

The Attorney General, as the Insurance Advocate, submitted the report of Barbara Niehus, FSA, MAAA ("Niehus"), who served as the Attorney General's consulting actuary. The Attorney General's report, which consisted of Exhibit A with attachments AGBN – 1 through 16, as well as Exhibits B through AA, were admitted as full exhibits by agreement of the parties.

OHIC submitted a report by its consulting actuary, Charles C. DeWeese, FSA, MAAA ("DeWeese"), which was admitted in full as Exhibit 1, as well as supporting Exhibits 2 through 9. OHIC also submitted Exhibits 2, 3, 4 and 5 at the hearing, each of which were marked as full exhibits with the exception of Exhibit 3.

At the two-day evidentiary hearing, Blue Cross presented testimony from its actuary, Jeffrey McLane, FSA, MAAA ("McLane"); David Fogerty, managing Director of Financial Planning and Strategic Sourcing for Blue Cross; and Augustin Manocchia, M.D., Senior Vice

President and Chief Medical Officer for Blue Cross. The Attorney General presented testimony from Ms. Niehus and OHIC presented testimony from Mr. DeWeese.

*E. Public Comment*

The public commented on the proposed rate increases through emails and letters and also through live testimony at the hearing. These comments concerning the rate proposal were quite consistent and echoed the concerns that have been expressed nationally: the current health insurance premiums are unaffordable and many people are struggling to maintain coverage. Any increase, particularly one of this magnitude, raises serious concerns about affordability, particularly for people who are on limited budgets or have been unemployed. While these public comments do not carry the weight of testimonial evidence or the analysis of actuarial science, they are nonetheless significant in their own right and a palpable measure of the difficulty that people currently experience in maintaining health insurance coverage for themselves and their loved ones.

**III. STANDARD OF REVIEW**

This hearing is governed by the administrative proceeding requirements set forth under the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.* (“APA”). Pursuant to the APA, the rules of evidence used in civil court proceedings shall be followed. R.I. Gen. Laws § 42-35-10. As such, the moving party must meet the burden of proving, by a preponderance of the evidence which, “shows that the fact to be proved is more probable than not.” *Miele v. Bd. of Med. Licensure and Discipline*, 1991 WL 789899 (R.I. Super. Ct. 1999). Blue Cross has the burden of proving by a preponderance of the evidence that the Filing is consistent with both its conduct of business and meeting the interests of the public in providing affordable health insurance plans.

Blue Cross must provide “affordable and accessible health insurance to insureds.” R.I. Gen. Laws § 27-19.2-3(1). Such insurance must be accessible to a “comprehensive range of consumers, including business owners, employees and unemployed individuals.” R.I. Gen. Laws § 27-19.2-3(5). To achieve this important goal, Blue Cross must “employ pricing strategies that enhance the affordability of healthcare coverage...” R.I. Gen. Laws § 27-19.2-10(3). In 2004, the General Assembly established the Office of the Health Insurance Commissioner for the purpose of reviewing Blue Cross’ conduct and to ensure that its administrative costs are reasonable. R.I. Gen. Laws § 42-14.5-3(b). It is the role of the Commissioner to approve rates proposed by Blue Cross that achieve the legislative purpose of providing quality health insurance products at a reasonable cost. By doing so, the Commissioner has the duty to both guard the solvency of health insurers, including Blue Cross, and provide affordable and accessible health insurance to Rhode Islanders.

#### **IV. DISCUSSION**

OHIC and the Attorney General acknowledge that the actuarial methodology applied by Blue Cross in this Filing was appropriate. Instead, several challenges are launched to specific assumptions and trends that were utilized by Blue Cross. They include challenges to the morbidity rate, utilization trend factors, administrative expenses, state assessment charges, and proposed contributions to corporate reserves.

##### *A. Morbidity Rate*

The Filing includes certain assumptions regarding the health, or morbidity, of people enrolled in the Direct Pay plans. The morbidity rate factor has a significant impact on the calculation of the EHB Base Rate.

1. *Assumed Attrition Rate for Pool II Members*

This Direct Pay rate filing assumes that 15% of the current Pool II members will decide to drop insurance coverage in 2014. Hearing Transcript (“Tr.”) I at 74 (Testimony of McLane). Pool II consists of those people who have successfully passed medical underwriting criteria. *Id.* They have demonstrated themselves to be relatively healthy when they applied for insurance coverage. *Id.* Their rates are affected by gender, which will no longer be a permitted criterion under the ACA. *Id.* Pool II members will be merged with Pool I members, who did not undergo medical underwriting. Mr. McLane opined that when the Pool II members see a significant increase in their insurance rates, a portion of them will decide to drop coverage. Tr. at 77. Mr. McLane admitted that his selection of 15% is an assumption without underlying data to support it: “There is not a calculation that backs that up.” *Id.* at 75.

The attrition rate of Pool II members is significant since these certified healthy members help presently support the rate level of the direct market and would also benefit the rate levels for Direct Pay members in 2014. Tr. II, at 64-65 (Testimony of DeWeese). Their departure would adversely affect the morbidity of the Direct Pay population. Thus, by reducing 15% of the Pool II population from the 2014 calculations, “the morbidity [goes] up for the remaining Direct Pay group.” Tr. II at 66. Mr. DeWeese found Mr. McLane’s assumption of a 15% attrition rate to be too conservative and “speculative.” Tr. II at 65. However, Mr. DeWeese likewise opined that the appropriate or reasonable range for an assumed attrition rate would be anywhere between 0 and 15%. *Id.* at 65.

Ultimately, neither Mr. McLane nor Mr. DeWeese provided any data to support their assumed attrition rates. In my opinion, the proposed attrition rates fail to give reasonable weight to the following considerations: (1) current Pool II members have established that they value

health insurance coverage, having voluntarily acquired insurance coverage in the face of significant health insurance premiums in the past, (2) the ACA imposes financial penalties or taxes on those people who fail to procure coverage, and (3) some members will be eligible for federal subsidies designed to make the premiums more affordable. While the ACA penalties are very limited initially,<sup>5</sup> one must also consider the social pressure to conform to the law, rather than to stand in violation of it. Moreover, no evidence has been introduced that assesses and weighs the purchasing history of this population. For example, Pool II members have already experienced significant increases in premiums in past years. No analysis has been introduced that analyzes the historic attrition rate of these members when confronted with rate increases in the past. For example, when the Direct Pay rates increased, what percentage of the Pool II members dropped coverage? Fifteen percent? Zero percent? From a review of the historical attrition rate, projections could be made about the anticipated attrition rate for 2014. Additionally, how will the existence of a legal mandate to have insurance coverage affect Pool II members' decision to drop enrollment? Also, will the introduction of federal subsidies influence and persuade members to remain? There simply is no record to suggest that these considerations have been weighed before calculating the attrition rate.

Blue Cross makes passing reference to an "internal forecast model" when projecting how people might buy insurance. Tr. I at 80-81 (Testimony of McLane). The model was apparently prepared by the Blue Cross Strategic Marketing and Forecasting departments. *Id.* at 81. Mr. McLane offered no specifics concerning this model nor did Blue Cross introduce it as an exhibit with this rate filing. I conclude that if this model materially supported the Filing, it would have been introduced.

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<sup>5</sup> The initial penalty for opting out of coverage in 2014 is limited, resulting in either a \$90 penalty per year or a certain percentage of their income. Tr. I at 116-117.

In the absence of any evidence on the record, I do not find that it is appropriate to assume any attrition rate for the current Pool II population. Consequently, I find that it is more appropriate to utilize a 0% attrition rate for the Pool II population.<sup>6</sup>

2. *Assumed Migration Rate of Sole Proprietors from Small Group to Direct Pay*

Sole proprietors currently choose between individual and small group plans. Blue Cross believes that the ACA – with its removal of underwriting, reinsurance credits and premium subsidies – will cause many sole proprietors to migrate to Direct Pay plans in 2014. The question is what percentage will migrate? Blue Cross makes two assumptions in this regard. First, that 60% of the Small Group Market is comprised of sole proprietors with one member. Blue Cross Ex. 1, Pre-Hearing Actuarial Report at 4. Blue Cross further assumes that 60% of this subset will migrate to Direct Pay at the beginning of 2014. Tr. I at 46 and Pre-Hearing Actuarial Report at 4.

The Blue Cross small group data does not distinguish between sole proprietor and a group that has only one member. Blue Cross Ex. 1, Pre-Hearing Actuarial Report at 4. It derives the 60% assumption from Mr. McLane's discussion with members of the Sales and Marketing Department. Mr. McLane testified that the 60% assumption was not based upon data, but rather was an "assessment" of the market by Sales and Marketing. Tr. I at 115. No evidence was submitted on this issue. If the Sales and Marketing assessment was probative, I believe that Blue Cross would have introduced it into the record through a witness from either Sales and Marketing or through Mr. McLane. I find that Blue Cross did not satisfy its burden in proving the actuarial reasonableness of 60% of small proprietors dropping coverage in the small market group. Evidence is necessary to support such assumptions and to counter the competing interest

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<sup>6</sup> Blue Cross also assumed that all members of the PCIP Plan will transition to the Direct Pay. Neither OHIC nor the Attorney General dispute that assumption. See, e.g., Tr. II at 75 (Testimony of DeWeese).

in providing affordable health insurance. The Commissioner cannot simply accept assumptions – without supporting evidence – that will increase Direct Pay insurance premiums.

There is another issue with respect to the small group projected population. In order to reach its rate calculations, different populations can be expected to have different claim costs. Blue Cross uses a population adjustment factor to project claims costs for the population that is expected to be covered under Direct Pay in 2014. The Attorney General's actuary discovered an error in Blue Cross' small group projected population in Appendix B of its Filing. Blue Cross calculated that cost as \$453.29, by weighting the projected claims for Pool I, Pool II and sole proprietors. In response to a data request from OHIC (DBR 2-1), Blue Cross indicated that its \$453.29 cost for this group is based upon a projected population of 55,593 for Pool I, 48,205 for Pool II, and 35,613 for sole proprietors. Tr. II at 8-10 (Testimony of Niehus). The first two classes accurately reflect the projected populations for 2014. However, the sole proprietor figure does not. It should reflect Blue Cross' projected population for sole proprietors in 2014, which is 21,368. Thus, Appendix B has reduced numbers – reflecting 2014 populations – for Direct Pay Pool I and II, but unreduced numbers for the sole proprietor population. When the reduced figure of 21,368 is applied, the average small group claim costs drops from \$453.29 to \$449.30. Tr. II at 10 (Testimony of Niehus). Since I do not find that Blue Cross correctly assumed a 60% migration to the Direct Pay market, I do not believe that this issue is relevant.

Testimony was also developed concerning a challenge to the higher average claim utilization rate of sole proprietors. OHIC challenged those assumptions noting that there was no adjustment to address what sole proprietors would utilize if they were to purchase less generous individual market plans when migrating to Direct Pay. Tr. II at 67 (Testimony of DeWeese). However, after reviewing the testimony from Blue Cross' actuary, OHIC now agrees with the

Blue Cross adjustment that was used for richer benefits purchased by sole proprietors in the small group market. OHIC Post-Hearing Memorandum at 7.

Blue Cross makes certain assumptions regarding employers who decide to drop employee insurance. Some of these employees would then purchase coverage in the individual market. Tr. II at 71 (Testimony of DeWeese). Blue Cross did not make a separate determination of what the morbidity would be for this population. *Id.* Instead, Blue Cross assumed that the morbidity rate would equal the average morbidity of the current Direct Pay members (adjusted for the 15% attrition rate discussed above) and all of the sole proprietors. *Id.* at 71-72. No evidence was developed to establish why the Direct Pay population and sole proprietor population would be the most appropriate average for the group of small market employees migrating to the individual market. *Id.* at 72. Instead, the Blue Cross assumption is based upon an “internal collaborative judgment.” *See*, Attorney General Exhibit J (Direct Pay Request AG1-21). Again, based upon the lack of evidence developed on the record, this assumption is not adopted.

*B. Utilization Trend Factors*

The Blue Cross utilization trend factors are set forth in Appendix C of the Blue Cross Rate Filing. Blue Cross developed utilization trend factors for inpatient, outpatient, professional (or medical/surgical) and pharmacy (or prescription drug services). Blue Cross used the linear least squares methodology, which is similar to what it has used in previous filings for projecting utilization/mixed trend factors. Tr. II at 80-82 (Testimony of DeWeese). This method takes data points over three years and fits them to a line in order to project future trends.

The Attorney General’s Pre-Hearing Memorandum challenged the accuracy of the utilization trend selections, claiming that the rate increase was overstated by 3.9% as it relates

to the utilization trend factors. During the hearing, the Attorney General withdrew the challenge to these Blue Cross calculations. Tr. II at 6-7.

OHIC's actuarial expert, Mr. DeWeese, challenged the Blue Cross utilization/mixed trend factors specifically as they relate to hospital inpatient and outpatient categories. With respect to the outpatient claims, Mr. DeWeese opined that the projected 4% increase for 2014 was inappropriate, recommending instead a 0% trend. Tr. II at 81 (Testimony of DeWeese). Mr. DeWeese explained that Blue Cross reviewed three years of hospital inpatient data on a month-by-month basis. *Id.* at 80. Mr. DeWeese explained Blue Cross methodology in detail in his testimony. *See generally*, Tr. II at 80-84; *see also*, OHIC Pre-Hearing Actuarial Report at 8. Blue Cross obtained an annual 3.1% utilization by relying upon data beginning in November, 2011 and continuing through November, 2012. It used 13 data points for experience data from Direct Pay, small group and large group insured market segments. It used 12-month moving values, beginning with the period ending November, 2012. Blue Cross Pre-Hearing Actuarial Report at 6-7.

Mr. DeWeese testified that, based upon his review of the inpatient data, the long-term trend on hospitalizations is either flat or trending in a downward direction. Tr. II at 83. The data demonstrates that "the absolute level of this information [on inpatient] from two years ago is the same as it is today." *Id.* at 84. By Blue Cross focusing on 13 particular data points, with the last data point moving upward, it reached its recommended increase of 3%. The data "showed a pattern of claims going down or admissions going down each month for 12 data points, and then going up for 13 data points, and they fitted it only to the part where it was going up." *Id.* at 83. An analysis of the data points over a two-year period shows a definite flat or downward trend for inpatient utilization. Mr. DeWeese concluded that a more statistically appropriate assumption

would be 0% for the inpatient trend. I am persuaded by OHIC's explanation and analysis on this issue.

The same reasoning applies to the outpatient utilization trend. Blue Cross derived a 4% trend on the basis of 13 data points. Had Blue Cross conducted the same analysis over a longer period of time, it would have arrived at a 3.2% trend for outpatient utilization. Tr. II at 84-85. When Mr. DeWeese's trend figures are applied, the EHB rate is reduced by 2.4%, from \$330.97 to \$324.31. Tr. II at 86. Again, I am persuaded by the actuarial analysis advanced by OHIC with respect to the outpatient utilization trend.

*C. Administrative Expenses.*

Blue Cross projects administrative expenses for Direct Pay of \$52.05 per member per month ("PMPM") which would equal 3.2% of the total 18.1% average increase. This amounts to a 26.8% increase in the PMPM charge, when compared to the current approved rate. See, AG-D, AG-1-10, and Tr. I at 175. This is significant since OHIC approved an expense charge of \$41.04 for Direct Pay in its last filing. Mr. Fogerty testified that the approved administrative expense did not have any bearing on what was actually spent. Mr. Fogerty explained that:

there is very little that we decide to spend directly upon Class DIR, but rather Class DIR is part of a much larger operation of which we make business decisions on what we need to spend and then from that amount we allocate the costs equitably amongst the various product lines.

Tr. I at 176. Based upon Rate Table IV, Blue Cross actually allocated expenses of \$63.44 PMPM to the 2012 individual market, which is 18% more than its current proposed rate for 2014 of \$52.04. Nonetheless, my starting point must be what was approved for 2012, rather than what was actually spent by Blue Cross. Otherwise, the OHIC approved rates for 2012 will have little, if any, relevance to the rate filing process. These rates were fixed by the Commissioner on the

basis of his assessment as to what would be most appropriate for costs attributable to the Direct Pay class. Thus, I view the request for \$52.05 against the base point of \$41.04.<sup>7</sup>

The Blue Cross allocation methodology appears reasonable and OHIC's actuary acknowledged as much. Tr. II at 90. However, Blue Cross has not quantified what portion of the requested increase is for: (1) the loss of membership, (2) the changes in allocation methodology and (3) the additional expenses attributable to the ACA. Tr. II at 91-92 (Testimony of DeWeese). OHIC points out that Blue Cross estimates that the Direct Pay population could quadruple in size. OHIC reasons that with a larger class of Direct Pay enrollees, there will be more people amongst whom to distribute the administrative costs. I do not believe that there is any way of knowing how significant an increase there will be in Direct Pay enrollment at the beginning of 2014. Will most or all of the uninsured population immediately enroll? Will it be a gradual process over the course of months or years? This rate filing has many unknown elements that cannot be predicted with any level of certainty. Nonetheless, it is reasonable to conclude, based upon all of the testimony, that Blue Cross' administrative expenses should be adjusted upward.

Both OHIC and the Attorney General offer alternative (and similar) methods for calculating the administrative expense charge. I adopt the methodology set forth by the Attorney General's actuary. Ms. Niehus' calculation results in a 1% reduction in the requested EHB rate. Tr. II at 11-12. The calculations are set forth in AGBN-9 and explained in the Attorney General's Pre-Hearing Memorandum at 8-9. In summary, both OHIC and the Attorney General propose the use of a medical CPI to reasonably limit the increase in the administrative cost component. While the medical CPI does not necessarily measure costs incurred, it is a "fairly

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<sup>7</sup> The \$41.05 vs. \$63.44 is an approximation of relevant figures. The \$41.05 was for the rate year beginning on April 1, 2012 through September, 2013 and the \$63.44 figure was the actual administrative expenses for calendar year 2012. Tr. II at 89 (Testimony of DeWeese).

common approach to measuring reasonable increases and various numbers.” Tr. II at 34 (Testimony of Niehus). Moreover, such a measure was adopted by the Hearing Officer in the last rate filing for Direct Pay. *See*, February 16, 2012 Decision of Hearing Officer at 19, AGBN-7. There was no legal challenge to that finding. The Attorney General utilized a CPI of 2.65%, derived from the Bureau of Labor Statistics. *See*, Attorney General Report at 9 and AGBN-9. This rate was applied to the rate requested by Blue Cross in the previous filing, which was 7% higher than what was approved (*i.e.* approximately \$44.27). The result is a base administrative cost of \$46.70 PMPM. To this figure is added the increase in taxes, licenses and fees associated with the ACA, amounting to \$1.61 PMPM, concluding with a final expense rate of \$48.31 PMPM, or a reduction of 7.2% from the proposed \$52.05 PMPM requested by Blue Cross in this Filing.

Finally, with respect to the administrative expenses, OHIC has requested that any approval of the administrative expenses be accompanied by a financial accounting of its administrative expenses incurred in addition to the 2012 approved amount, together with a justification for those additional expenses. Specifically, Blue Cross seeks that the following condition be imposed:

On or before November 1, 2013, Blue Cross shall file with the Office an audited report of its administrative expenses, net of state and federal taxes, fees and other assessments. The report shall be filed in a form and with expense categories approved by the Office, and shall: (i) identify by category and amount the administrative expenses allocated to the individual market during the 2012-2013 rate period; (ii) identify and the administrative expenses Blue Cross intends to allocate to the individual market during the 2014 rate year; (iii) with respect to 2014 rate year expenses, justify the necessity of each expense, and the reasonableness of each expense amount; and (iv) identify and compare by administrative expense amounts which Blue Cross believes should be allocated to the individual, small group and large group markets in different proportions, together with an explanation of the different allocations.

In light of Blue Cross' statutory mission to provide affordable insurance, and in accordance with the regulatory oversight by OHIC over Blue Cross, I find the request to be reasonable and adopt it as a condition to this Filing.

Before departing the discussion on administrative expenses, I wish to briefly address the Attorney General's observations concerning potential reductions in the rates it charges to subscribers by incorporating better management practices.

Blue Cross proposes the introduction of 11 different plans to the Direct Pay members. Blue Cross Exhibit 1, Appendix G. No testimony was developed on the record concerning what plans or intentions Blue Cross has to assist its members in understanding these myriad plan options and how they differ from current coverage available to Direct Pay members. The Attorney General recommends that Blue Cross work with OHIC to review Blue Cross' communication plan, including training that is to be provided to its customer service employees in order to guarantee that Direct Pay members have sufficient information concerning the changes to these plans. The Attorney General also recommends that OHIC require Blue Cross to develop materials that are informative and clearly written for both current and prospective Direct Pay members. Post-Hearing Memorandum of Attorney General at 19.

The Attorney General also questions the level of employee benefit plans provided to its own employees which require only an average 12.5% level of contributions for the employees' health insurance plans. Tr. I at 142-143; Attorney General Exhibit K. Blue Cross also provides generous benefits to its employees without requiring any contribution from its employees. Tr. I at 157-60, AG Exhibit M. Blue Cross continues to fund the pension plan for its employees. AG Exhibit M. Also, Blue Cross funds substantial employee incentive plans

for its executives with, for example, over \$1 million in bonuses being paid to the two individuals who served as Chief Executive Officer during 2012. Tr. I at 160-61, 191, 197-98; AG Exhibit R. During that same year, Blue Cross paid out in excess of \$1.8 million to its top 10 executives. AG Exhibit R. This is significant especially in light of the fact that Blue Cross has the second lowest level of reserves of any Blue Cross entity in the nation. Blue Cross counters that these benefits and salaries are connected to the median level of compensation packages. Tr. I at 143 and 193. In summary, the Attorney General argues that Blue Cross' spending must be restrained before such generous entitlements and benefits are provided to its executives and employees, particularly when these expenses are passed through to its members, including Direct Pay subscribers.

The Attorney General also observes that Blue Cross reports the amounts of monies it spends on cost saving initiatives but does not adequately study the benefits derived from implementing such measures. Thus, it is not evident whether or not such expenditures produce the intended results of reducing expenses. The Attorney General proposes that Blue Cross be required to provide more complete reporting to OHIC so that these expenditures can be evaluated and determine whether they produce beneficial results for subscribers.

Finally, the Attorney General requests that Blue Cross be required to continue to offer the Access Blue program for at least the duration of 2014. While it acknowledges that the ACA will provide subsidies for members who enroll on the Exchange and have income less than 400% of the federal poverty level, there will still be subscribers who will incur significant rate increases that are at the poverty margins and who will not qualify for such a federal subsidy. The Access Blue program would provide relief to such subscribers. The Attorney General proposes that Blue Cross and OHIC identify criteria from which subscribers

might qualify for assistance. For example, the Attorney General proposes that families earning less than 500% of the federal poverty level be eligible for some assistance.

Each of the Attorney General's observations bear consideration by the Commissioner. However, at this point, no evidence was introduced that connects the expenses highlighted by the Attorney General to the proposed rate filing. For example, there is nothing on the record that correlates the payment of executive bonuses to the administrative expense rate. Thus, I cannot adopt facts in connection with these recommendations. However, it is factually established that Blue Cross will be introducing 11 plans to Direct Pay subscribers. It is important that Blue Cross employees be adequately trained to assist members in their selection process and that easy-to-read summaries be made available to consumers.

*D. Contribution to Reserves*

Blue Cross requests a 2.34% contribution to its reserves and a .5% contribution for payment of the federal income tax liability. Included in the 2.34% figure is a .34% reserve contribution to amortize costs associated with the development of its claims system known as Blue TransIt. Blue Cross argues that with the implementation of the ACA, the individual market will expand significantly and recent losses will be magnified in 2014 with this anticipated large enrollment. Pre-Filing Report of Blue Cross at 11. Blue Cross points to losses of more than \$10 million in the Direct Pay class between 2010 and 2012 with an additional projected loss of nearly \$8 million for 2013. Blue Cross Exhibit 1, Consumer Narrative Portion at 2; Tr. II at 43-44 (Testimony of Niehus); and Tr. II at 104-105 (Testimony of DeWeese). Based upon the record submitted, there appears to be no debate amongst the parties that corporate reserves are below the recommended minimum range of 23%. Tr. II at 119. The Blue Cross reserve rate is approximately 18%. *Id.* There is also no

challenge to Blue Cross' assertion that it has the second lowest level of reserves of all Blue plans in the nation. Tr. I at 40 (Testimony of McLane).

Corporate reserves protect against adverse events, ensure Blue Cross' ability to pay its obligations, allow Blue Cross to make necessary capital investments and to maintain the appropriate standard of reserves. Tr. II at 120-121. Neither OHIC nor the Attorney General question the importance of maintaining appropriate reserves, and OHIC's actuary opined that "from an actuarial standpoint, Blue Cross' proposed contribution to reserves is reasonable." DeWeese Pre-Hearing Report at 12. Mr. DeWeese concedes that when confronted with significant costs and losses to the Direct Pay class, it can be offset by either relying upon reserves or charging more to small and large group members. Tr. II at 121 (Testimony of DeWeese). Since the small and large group members are competitive already, Blue Cross can only raise premiums in those markets to a limited degree while still remaining competitive in those markets. As the members of small and large group plans diminish, there is even less of an ability to rely upon those premiums to compensate for the losses incurred with the Direct Pay class.

The Attorney General points out that while a number of Direct Pay class members "may qualify for federal subsidies under the ACA...a large proportion of members will not qualify for those subsidies." AG Exhibit A at 14; OHIC Exhibit 1 at 13; Tr. I at 75-78; Tr. II at 45-46. Thus, this population will be particularly vulnerable to the costs of health care and should not be subjected to significant contributions to reserves.

Blue Cross is only one of two carriers that will be offering Direct Pay plans with the implementation of the ACA. Blue Cross is in a very difficult predicament. While other large insurance companies watch from the sidelines, with no participation in the individual market

in 2014, Blue Cross will be assuming a larger portion of the Direct Pay population in 2014. It is impossible to say how many more people will enroll under the Direct Pay plans of Blue Cross. Nonetheless, it is confidently predicted that it will increase. Without adequate contributions to reserves, any losses sustained by Blue Cross will ultimately diminish its competitiveness in small and large group markets in Rhode Island, since some portion of those premiums must sustain Blue Cross losses incurred from the individual markets. Its competitors do not face that challenge in 2014, due to their decision to opt out of providing policies in the individual market.

Mr. DeWeese suggests phasing in reserves over two years in order to balance the competing needs of Blue Cross' financial stability and the affordability of insurance for this vulnerable population. OHIC also observes that if Blue Cross reaches imprudent levels of reserve, it can always file a supplemental rate increase. If the full amount requested by Blue Cross was added to the current premium, it would further burden the members and push members to drop coverage because of "rate shock." OHIC Post-Hearing Memorandum at 12.

The Attorney General proposes that the contribution to reserves be reduced to 1.5%. I am persuaded that the financial stability of Blue Cross should be addressed with this Filing and I adopt the Attorney General's proposal that 1.5% be contributed to Blue Cross' reserves. By allowing some level of contribution to reserves, Blue Cross can begin to address the significant losses it has sustained from this market. It is equally hopeful that this reduced level to reserves will adequately address the important and competing need of maintaining affordability for this particularly vulnerable class of subscribers.

*E. State Assessment Allocations*

Blue Cross is required to pay assessments to the Rhode Island Department of Health to support adults and child immunization programs and to make payments to the Rhode Island Department of Human Services to support children's health account. Tr. I at 70; DeWeese Report at 10. The assessments are based upon premiums. *Id.* The costs are passed along to the Blue Cross membership, based upon premiums generated from all plans. *Id.* However, in recent Direct Pay Filings, the Commissioner has instructed Blue Cross to pass these charges along to Direct Pay members only to the extent that Direct Pay members have utilized the benefits, such as immunizations. DeWeese Report at 10.

The Attorney General recommends that this approach be repeated with the current Filing and that such assessments be directly correlated to the services utilized by the Direct Pay members. Tr. II at 35. Blue Cross asks that the state assessment be passed through to Direct Pay members based upon the premiums generated, consistent with its other plans. In support of this argument, it notes that the Direct Pay class will increase in size. Thus, referring to the historical consumption correlation will not be of assistance with the current rate filing. OHIC's actuary, Mr. DeWeese, agrees, noting that the profile of members in Direct Pay will change and that the number of members will increase. DeWeese Report at 10. Indeed, the insured population that will become enrolled under Direct Pay has directly benefited from the services provided by these state assessments. I am persuaded by the position set forth by Blue Cross. Consequently, I find that Blue Cross should be permitted to calculate the state assessments on the basis of premiums generated through its Direct Pay plans, rather than limiting it to services utilized under these state programs, immunizations.

*F. Segregation of Premium for Abortion Services*

OHIC and Blue Cross disagree on the premiums for abortion-related services. Abortion services are covered in the Rhode Island EHB Benchmark Plan and in Blue Cross' individual market benefit plans. OHIC acknowledges that federal funds must not be used to cover abortion services "for which public funds are prohibited." 45 CFR § 156.280(d)(e). When an insurance plan sold on the Exchange covers abortion-related services, the carrier must set up a separate account for the premium which is sufficient to pay for the services so that federal subsidies are not used in connection with the abortion services. 45 CFR § 156.280(e)(2)(3). The carriers must charge at least a \$1 premium per member per month for such services. 45 CFR § 156.280(e)(4). OHIC argues that the EHB base rate for Blue Cross individual market plans must be the same both on and off the Exchange and that the federal law can be satisfied by establishing a separate account for the abortion-related expenses and merely depositing \$1 PMPM from the premium generated by the member. Blue Cross disagrees and argues that a separate \$1 premium must be placed into the segregated account in order to ensure that no federal funds are used to provide abortion related services.

I agree with Blue Cross' interpretation of the federal law as interpreted by the applicable regulations. The ACA clearly manifests an intention to avoid federal monies being used for abortion services. Nothing in the ACA shall in any event have any affect on federal laws concerning conscience protection and a willingness or refusal to provide abortions, and any discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion. 45 CFR § 156.280(h)(2)(i), (ii) and (iii). The ACA clearly prohibits a qualified health plan provider from using any amount

of funding attributable to the premium and cost sharing tax credits paid under § 1412 of the ACA:

The QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

- (i) the credit under § 36B of the Code and the amount (if any) of the advance payment of the credit under § 1412 of the Affordable Care Act;
- (ii) any cost-sharing reduction under § 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under § 1412 of the Affordable Care Act.

45 C.F.R. 156.280(e)(1)(i)(ii). Moreover, a “separate payment” must be collected from each enrollee in the QHP for the actual value of services for which federal funding is prohibited and deposit those payments in a separate account. 45 CFR § 156.280(e) and (f). Blue Cross is required to submit a plan that details its process and methodology for meeting the segregation requirements of the ACA. 45 CFR § 156.280(e)(5). The mere segregation of \$1 for the premium will not achieve the ACA requirements. A separate premium must be generated in order to ensure that no federal monies are used to fund abortion services.

## V. FINDINGS OF FACT

Based upon the evidence submitted, I hereby make the following Findings of Fact with respect to the 2014 Direct Pay Filing:

1. The preceding Sections I through IV of this Report and Recommendation are incorporated into these Findings of Fact.
2. On April 15, 2013, Blue Cross submitted a rate filing for Class DIR with the Health Insurance Commissioner seeking an average increase of 18.1% for current members on an equivalent benefit basis to become effective January 1, 2014. Blue Cross has requested a Base EHB Rate of \$330.97.

3. The Filing also requests that the current Direct Pay rates remain in place for the period October 1, 2013 through December 31, 2013. Neither OHIC nor the Attorney General opposes that request. I find that the current approved Direct Pay rates should remain in effect until December 31, 2013.

4. On April 16, 2013, Commissioner Koller appointed Raymond A. Marcaccio, Esq. as the Hearing Officer in this matter.

5. The Filing was properly advertised in the *Providence Journal* on May 17, 2013.

6. In accordance with R.I. Gen. Laws §§ 29-19-6(a) and 27-20-6(a), Blue Cross mailed written notice of the proposed rate increase for the Direct Pay class to approximately 15,000 members. Said notice was mailed at least 10 days prior to the commencement of the evidentiary hearings.

7. In accordance with an Order entered by Hearing Officer Marcaccio, the matter was scheduled for evidentiary proceedings on May 29 and 30, 2013 which were transcribed and open to the public.

8. In accordance with R.I. Gen. Laws §§ 27-19-6, 27-206, 42-14.5-3(d), and 42-14-5(d), 42-62-13, 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6, the Commissioner, through Hearing Officer Marcaccio, has jurisdiction in this proceeding to conduct the hearings for purposes of considering Blue Cross' Direct Pay Rate Request. The hearing and procedural prerequisites for conducting the hearing have been conducted in accordance with the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

9. Members of the public submitted comments to OHIC and the Hearing Officer prior to the hearing through correspondence and emails. Members of the public likewise provided comments in person at the public hearings conducted on May 29 and 30, 2013. The

public comments indicated that the current premiums are not affordable and any further increase will result in additional financial distress.

10. Both the Attorney General and OHIC issued data requests to Blue Cross, seeking additional information about the Filing.

11. In support of its requested increase, Blue Cross submitted its rate Filing, (BC Exhibit 1) on April 15, 2013. Blue Cross also submitted BC Exhibit 2 providing proof and substance of the public notice. Blue Cross submitted an additional exhibit as a replacement page for Rate Template IV of the Filing, Blue Cross Exhibit 3, at the public hearing. All of Blue Cross' exhibits were admitted as full exhibits.

12. In support of its opposition to Blue Cross' requested increase, the Attorney General submitted the report of Barbara Niehus, FSA, MAAA, the Attorney General's consulting actuary, along with schedules supporting her conclusions (AG Exhibit A with Attachments AGBN-1 through 16), which were admitted in full at the public hearing. The Attorney General also submitted Exhibits B through AA, all of which were admitted as full exhibits at the public hearing.

13. The Office of Health Insurance Commissioner submitted the report of Charles W. DeWeese, FSA, MAAA, and Exhibits 2 through 9, which were admitted in full as OHIC Exhibit 1 at the public hearing.

14. OHIC also submitted Exhibits 2, 3, 4 and 5. OHIC Exhibit 3 was marked for identification and Exhibits 2, 4 and 5 were admitted in full.

15. At the commencement of the evidentiary hearing on May 29, 2013, the following stipulations were entered by agreement:

Notice of the public hearing was published and mailed to all Class DIR subscribers in accordance with applicable law;

The Hearing Officer and the Health Insurance Commissioner have jurisdiction to hear the Class DIR matter;

Each of the actuarial witnesses who were presented by the parties to testify were qualified as experts in the field of actuarial science.

16. The Filing is intended to comply with all of the Patient Protection and Affordable Care Act (ACA) requirements for plans that will be sold by Blue Cross both through the Exchange and outside the Exchange in the individual market.

17. Complying with the ACA required Blue Cross to redesign its product offerings and also required, with certain qualifications, that premium rates be the same for both Exchange and non-Exchange products.

18. Even after low-income subsidies provided by the ACA, many Direct Pay subscribers are particularly vulnerable to the high costs of health care, because many have neither an employer contribution, nor tax subsidy of premium.

19. With respect to the morbidity rate for this Filing, the assumed attrition rate for Pool II members shall be 0%, due to a lack of evidence to establish Blue Cross' proposed attrition rate of 15%.

20. With respect to the morbidity rate, the assumption that 60% sole proprietors will migrate from the small group market to Direct Pay is rejected due to a lack of evidence submitted to substantiate said rate.

21. With respect to the Blue Cross Exhibit B of its Filing, it contains an incorrect projected population figure for sole proprietors. Exhibit B refers to the figure of 35,613 when the correct figure should be 21,368 sole proprietors. When the reduced figure of 21,368 is applied to the Blue Cross methodology, the average small group claim costs drops from \$453.29 to \$449.30. This leads to a reduction in the base EHB rate from \$330.97 to \$329.03 or 0.6%.

22. No evidence was developed to establish why the Direct Pay population and sole proprietor population would be the most appropriate average for the morbidity rate for the small market employees migrating to the individual market and therefore that assumption is rejected.

23. Blue Cross has not demonstrated by a preponderance of the evidence that its proposed administrative costs for the individual market of \$52.05 are necessary and reasonable. With respect to projected administrative expenses for Direct Pay, I find that it is appropriate to apply the medical CPI index in order to address the anticipated increase of administrative expenses, as well as considering the competing need to ensure affordability, particularly amongst this vulnerable class of subscribers. I adopt the medical CPI of 2.65%, derived from the Bureau of Labor Statistics as proposed by the Attorney General. The result is a base administrative cost of \$46.70 PMPM. To this figure is added the increase in taxes, licenses and fees associated with the ACA, amounting to an additional \$1.61 PMPM, resulting in a final expense rate of \$48.31 PMPM, or a reduction of 7.2% from the proposed \$52.05 PMPM requested by Blue Cross.

24. In the last Direct Pay Filing, OHIC approved an expense charge of \$41.04 PMPM. However, Blue Cross spent significantly more than that amount for the Direct Pay class, allocating \$63.44 PMPM to the 2012 individual market. In order to ensure that the additional expenses are demonstrably necessary to Blue Cross operations and are reasonable, I further recommend the adoption of the condition proposed by OHIC in these proceedings as a financial accounting of its administrative expenses in addition to the 2012 approved amount, as follows:

On or before November 1, 2013, Blue Cross shall file with the Office an audited report of its administrative expenses, net of state and federal taxes, fees and other assessments. The report shall be filed in a form and with expense categories approved by the Office, and shall: (i) identify by category and amount the administrative expenses allocated to the individual market during the 2012-2013 rate period; (ii) identify and the administrative expenses Blue Cross intends to allocate to the individual market during the 2014 rate year; (iii) with respect to 2014 rate year expenses, justify the necessity of each

expense, and the reasonableness of each expense amount; and (iv) identify and compare by administrative expense amounts which Blue Cross believes should be allocated to the individual, small group and large group markets in different proportions, together with an explanation of the different allocations.

25. With respect to the hospitalization utilization trends, the evidence supports a finding that the inpatient hospital utilization trend should be lowered from Blue Cross' recommended rate of 3% to a 0% rate and that the outpatient hospital utilization trend should be reduced from Blue Cross' recommended rate of 4% to a 3.2% rate.

26. The evidence supports a finding that Blue Cross is entitled to a contribution to reserves in the amount of 2.34%, including a .34% component that constitutes a charge in the premium rates for the Blue TransIt computer system and an additional .5% for payment of the associated federal income tax liability. Nonetheless, given the competing interest in maintaining the affordability of premiums for Rhode Island citizens, with particular emphasis on this vulnerable class, I recommend that the contribution to reserves be reduced to 1.5%, consistent with the Attorney General's proposal.

27. The reduction of the requested contribution to reserves from 2.84% to 1.5% reduces the requested base EHB rate by approximately 1.4%.

28. With respect to the state assessments, I find that the evidence is sufficient to support a finding that the Direct Pay class should be subject to a 2% assessment (or gross premium tax) as part of the approved rate for Direct Pay subscribers. I do not find the evidence sufficient to support the position that such state assessment should be reduced to correspond to the projected consumption of the services associated with the state assessment.

29. In order to achieve the federal prohibition from ACA funding of abortion related services, Blue Cross shall add \$1 to the On-Exchange Qualified Health Plans which shall be segregated and shall not be applicable to the Off-Exchange Qualified Health Plans. Pursuant to

the federal mandate, the qualified health plan issuer may not estimate the cost of abortion services for which public funding is prohibited at less than \$1 per enrollee per month. 45 CFR § 156.280(d)(1).

30. Blue Cross must provide OHIC with a proposed communication plan, including training to be provided to its customer service representatives, to assure that Direct Pay subscribers obtain clear summaries of the new plans to be provided, including changes between the current plans and those that will take effect on January 1, 2014.

31. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a finding of fact.

#### CONCLUSIONS OF LAW

1. The preceding Sections 1 through V of this Report and Recommendation are incorporated herein.
2. OHIC has jurisdiction to hear and decide 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. This hearing was conducted in compliance 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. In accordance with applicable statutes, OHIC has the jurisdiction and authority to determine whether or not the proposed rates for the Direct Pay plans satisfy each of the legal mandates, including the requirement that Blue Cross provide rates that are affordable and also provide access to healthcare coverage. R.I. Gen. Laws §§ 27-19.2-3(1) and (5).

6. Blue Cross is statutorily required to “employ pricing strategies that enhance the affordability of healthcare coverage” and is also required to protect its financial condition. R.I. Gen. Laws § 27-19.2-10(3) and (4).

7. In accordance with the applicable statutes, OHIC is authorized to accept, reject, or modify the proposed rates submitted by Blue Cross in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

8. Blue Cross’ Direct Pay Rate Filing for 2004 is also governed by the implementation of the Patient Protection and Affordable Care Act (“ACA”), Pub. L. 111-148, 124 Stat. 119. In accordance with the ACA, Governor Lincoln Chafee has established the Rhode Island Health Benefit Exchange which will provide individuals and small employers with access to insurance plans and related information, in accordance with the ACA. The federal legislation expands eligibility for health insurance coverage and also restricts insurance carriers’ use of rating criteria, such as rates based upon gender and health status. Consequently, the application of the ACA to the current Blue Cross Direct Pay Rate Filing has fundamentally changed the rating criteria previously utilized by the carrier.

9. The Commissioner, through his Hearing Officer, Raymond A. Marcaccio, Esquire, has jurisdiction in this proceeding to conduct the hearings for purpose of considering whether Blue Cross’ proposals contained in its filing of April 15, 2013 are consistent with the proper conduct of Blue Cross’ business and also in the interest of the public. R.I. Gen. Laws §§ 27-19-1 *et seq.*, 27-20-1 *et seq.*, 42-14.5-1 *et seq.*, and 42-14-1 *et seq.*

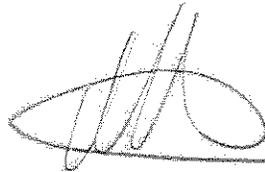
10. Blue Cross has the burden of proof to establish that the proposed rates are consistent with the statutory requirements set forth above. This burden is met by a preponderance of the evidence.

11. Blue Cross has not satisfied its burden of proving that the proposed rate increase of 18.1% is consistent with the proper conduct of its business and also in the interest of providing affordable health insurance coverage to the public.

12. For all the reasons set forth above, the Blue Cross proposal to increase Direct Pay rates by an average of 18.1% is not supported by the evidence, is not within the proper conduct of Blue Cross' business, and is does not provide the public with affordable healthcare plans.

13. A modified rate increase shall be calculated in accordance with the modifications to the morbidity rate, utilization trend factors, administrative expenses, contribution to reserves and segregation of premiums for abortion related services in Findings of Fact Numbers 19 through 29.

14. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.



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Raymond A. Marcaccio, Esq.  
Hearing Officer

Dated: June 21, 2013.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF THE HEALTH INSURANCE COMMISSIONER  
1511 PONTIC AVENUE, BUILDING 69-1  
CRANSTON, RHODE ISLAND 02920

*In re:*      **Blue Cross & Blue Shield of R.I.  
Individual Market Plans  
(Filed April 15, 2013)**

**RH-2013-04**

**ORDER AND DECISION OF THE COMMISSIONER**

Christopher F. Koller, Health Insurance of the State of Rhode Island, hereby issues his Order and Decision with respect to the Rate Filing made by Blue Cross and Blue Shield of Rhode Island for the Direct Pay health insurance line of business on April 15, 2015, after having carefully reviewed the Recommendations of the Hearing Officer dated June 21, 2013, 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, the Conclusions of Law and Recommendations of the Hearing Officer.

The Commissioner notes that it is important to consider this matter in the context of the Affordable Care Act, which provides the back drop for this hearing and order in two important ways.

First, it is estimated that the individual market in Rhode Island will quadruple in size in the coming year. The demographic nature of this new market – and thus its expected costs – is the subject of much speculation and conjecture, and little certainty, both in Rhode Island and nationally. This “morbidity” estimate and its components were the subject of much of this

hearing. As is noted in the record, by their very nature these are based on assumptions and models, rather than actual experience.

In 2014, the morbidity of the individual market will begin to emerge and insurers and regulators will have clearer bases for estimations. In the interim, insurer reserves, federal risk adjustment and reinsurance programs, and subscriber premiums all play roles in mitigating this morbidity risk. Any assumptions used in calculating an estimate of morbidity, to meet the burden of proof of acceptance, should be based on clear evidence, clearly presented. In the face of uncertainty, the Office continues to maintain – as it has in the past - a disproportionate share of that uncertainty must be borne by the insurer, by virtue of its reserves and its multiple lines of business.

Secondly, Blue Cross historically has not been allowed contribution to reserves for the Direct Pay product. The reasons for this are at least two fold. Individual customers purchase health insurance without the benefit of employer – or publicly - financed subsidies; and in a voluntary market, the risk pool will like be composed of people who are more likely to need health insurance, making premium costs higher. The passage of the Affordable Care Act changes this dynamic – it makes public income-based subsidies available, introduces a mandate to require healthier less frequent health care users into the pool, and, more generally, represents a public commitment to having as many citizens as practicable be covered by public and private health insurance. This changes the nature of the individual health insurance market in Rhode Island to one with many customers and potentially many insurance companies. By virtue of its charter, Blue Cross should be a locally based, trusted partner in improving accessibility, quality and affordability of health care in Rhode Island in all insurance markets. It should not, with the

passage of the Affordable Care Act, be expected to be the only carrier in a given market and to subsidize that market while competing in all others.

*When the ACA is successfully implemented and a robust individual market emerges with it – perhaps also merged with the small group market for underwriting purposes – the focus on the affordability of individual insurance will rightly turn to containing the underlying cost drivers in our medical care delivery system. With everyone in the underwriting boat, we can focus on its destination – which must include integrated delivery systems able to give high quality coordinated care to populations, reformed payment methodologies, and engaged and activated patients. Private and public leadership will be required for this effort.*

With these observations as context, in consideration of the entire record 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 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.

**Amended finding 20.** With respect to the morbidity rate, the assumption that 60% sole proprietors will migrate from the small group market to Direct Pay is rejected due to a lack of evidence submitted to substantiate said rate, and for the purposes of calculating the morbidity rate, the assumed sole proprietor migration rate will be zero.

**Amended finding 21.** This fact is not accepted for the purposes of this order.

**Amended finding 22.** No evidence was developed to establish why the Direct Pay population and the sole proprietor population would be the most appropriate average for the small group employees migrating to the individual market and therefore that assumption is rejected and is to be replaced with an assumption that the morbidity of these employees will be identical to the current Direct Pay population. The effect of findings 19,20,21 and 22 is to produce a revised morbidity calculation as follows:

Revised DeWeese Exhibit two - Calculation of Morbidity Factor				
DP 1	55,593.00	\$598.42		
DP2	56,712.00	\$260.03	no pool 2 migration	
Sole	-	\$487.39		
PCIP	1,128.00	\$2,015.36		
Small Gp	12,267.00	\$427.54	weighted p1 and p2	
Uninsured	266,827.00	\$440.37	weighted pool 1 and 2 plus 3% for pent-up demand	
Total	392,527.00	\$440.82		

**Amended finding 26.** The evidence supports a finding that BlueCross is entitled to a contribution to reserves in the amount of 2.34%, including a .34% component that constitutes a charge in the premium rates for the BlueTransIT computer system and an additional .5% for payment of associated federal income tax liability.

**Amended finding 27.** This fact is not accepted for the purposes of this order.

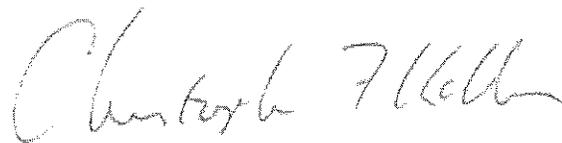
**Amended finding 28.** With respect to the state health assessments and premium tax (collectively "state assessments"), I find the evidence is sufficient to support a finding that the Direct Pay class should be subject to these state assessments as part of the approved rate for DirectPay subscribers. I do not find the evidence sufficient to support the position that such state assessments should be reduced to correspond to the projected consumption of the services associated with the state assessment.

**New Finding 32.** Blue Cross's Access Blue Program has now been, for all purposes, supplanted by the public subsidies available through the Affordable Care Act and their request to discontinue the program light of this is appropriate.

Wherefore it is hereby ORDERED:

1. A modified rate increase is approved, consistent with the Hearing Officer's Findings of Fact 19-23 and 25-29, and Conclusions of Law 12, 13, as amended by the Commissioner.
2. Blue Cross shall also comply with the Hearing Officer's Findings of Fact 24 and 30.

ENTERED AS AN ADMINISTRATIVE ORDER OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER THIS 27 DAY OF JUNE 2013.



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Christopher F. Koller, Commissioner

Office of the Health Insurance Commissioner