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

***In re:* Blue Cross & Blue Shield of
Rhode Island—Class DIR**

OHIC-2008-01

(Filed November 15, 2007)

RECOMMENDATION OF THE HEARING OFFICERS

In response to the November 15, 2007 request of Blue Cross & Blue Shield of Rhode Island (Blue Cross) for approval of new subscription rates for Direct Pay subscribers¹ in Class DIR Basic (Pool I) and Preferred (Pool II) programs with an average increase of 12.7% (15% for Pool I and 8% for Pool II), and after full consideration of the evidence presented at a hearing and the applicable statutes and regulations, we recommend that the proposed subscription rates be modified to an average increase of approximately 9.5% (11.8% for Pool I and 4.8% for Pool II). The bases for this recommendation, described more fully below, are:

1. an elimination of the contribution to reserves component (1.25% of premium) from the proposed rate (which includes associated taxes on that contribution);
2. an elimination of the wellness health benefit plan component (0.4% of premium) of the rate;
3. a reduction of the Direct Pay budget by approximately \$250,000 (equivalent to 0.4% of premium);
4. a reduction of the “core system” component from 0.5% of premium to 0.35% of premium; and
5. a reduction based on affordability principles (1.0% of premium).

¹ “Subscribers” and “members” are distinct terms. Subscribers are the members who purchase the health insurance contract (i.e., this is the number of Direct Pay contracts) and members are all those covered by the contract (i.e., the subscriber and all dependents).

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Appearances:

Normand G. Benoit for Blue Cross & Blue Shield of Rhode Island.

Genevieve M. Martin and Brenda K. Gaynor for the Department of the Attorney General.

I. INTRODUCTION

On November 15, 2007, Blue Cross filed a request for approval of rate increases for its Direct Pay products to be effective April 1, 2008 (the Filing).² The Blue Cross Direct Pay products provide health insurance coverage for persons and families not eligible for employer-based or state or federal health insurance programs.³ Enrollment is on a non-group basis either through direct application to Blue Cross or through conversion from prior group (i.e., employer-based) coverage. There are about 14,000 members in the Direct Pay class,⁴ a decrease from last year.

Two rating pools are used for Direct Pay.⁵ One rating pool, Pool I, applies community rates, which vary only by family status and by whether or not a member is over age 65. The other pool, Pool II, applies rates based on the age, gender and family status of an applicant. In order to qualify for Pool II, an applicant must pass a medical screen. An annual open enrollment period is conducted for Pool I, while enrollment in Pool II is available continuously throughout the year. Rates for members 65 and older are the same regardless of Pool.

Individuals and families seeking Direct Pay coverage who either (1) do not submit a questionnaire or (2) submit the screening questionnaire but do not meet Blue Cross' medical underwriting guidelines are assigned to Pool I. Pool I members generally are expected to require a higher level of medical services, thus Pool I rates are higher than those for Pool II. In order to

² BC Ex. 1.

³ Id.

⁴ Id. This is approximate membership as of October 2007.

⁵ Forty-seven percent of Direct Pay members are in Pool II and fifty-three percent are in Pool I. BC Ex. 4 at 8.

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maintain lower rates for the Pool I population, Pool I's rates are subsidized in part by Pool II premiums.

The four Direct Pay products offered by Blue Cross are HealthMate Coast-to-Coast Direct 400/800 (HM 400), HealthMate Coast-to-Coast Direct 2000/4000 (HM 2000), HealthMate for HSA Direct Plan 3000/6000 (HM for HSA 3000) and HealthMate for HSA Direct Plan 5000/10000 (HM for HSA 5000). The features of these products have been described in detail in previous Direct Pay decisions and thus will not be described here again.⁶ This year, however, there is a slight variation on the HM2000 product. Health insurers in the individual market are now required to offer a wellness health benefits plan (WHBP).⁷ Blue Cross has proposed to meet this requirement by designating the HM 2000 product as the WHBP and offering a 10% end-of-year premium rebate for compliance with certain wellness requirements.⁸

The Filing proposes premium rates effective April 1, 2008. The overall rate increase is about 12.7%, with an average rate increase of approximately 15% for Pool I subscribers and subscribers 65 and over, and an average rate increase of approximately 8% for Pool I subscribers. The rates currently charged by Blue Cross for these products are as follows:

Basic (Pool I) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 65	Individual	\$595.52	\$447.52	\$383.62	\$303.14
	Family	\$1,126.39	\$847.40	\$727.20	\$575.56
65 and over	Individual	\$934.75	\$702.07	\$601.51	\$474.93
	Family	\$1,768.60	\$1,329.30	\$1,139.67	\$900.76

⁶ See, e.g., *In re Blue Cross & Blue Shield of Rhode Island -- Class DIR*, HIC No. 06-RH-01 (Feb. 21, 2007) [hereinafter 2007 Direct Pay Decision]; *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, HIC No. 05-RH-02 (Feb. 20, 2006) [hereinafter 2006 Direct Pay Decision]. Indeed, many aspects of the Filing and the details of the Direct Pay line of products are similar to or identical to previous filings. Thus, revisiting many of those details is unnecessary.

⁷ R.I. Gen. Laws § 27-18.5-8.

⁸ BC Ex. 1.

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Preferred (Pool II) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Male	\$179.30	\$135.18	\$116.26	\$92.32
	Female	\$249.48	\$187.85	\$161.34	\$127.86
	Family	\$600.59	\$452.79	\$389.37	\$309.14
25-29	Male	\$197.98	\$149.21	\$128.26	\$101.78
	Female	\$282.28	\$212.46	\$182.41	\$144.47
	Family	\$671.53	\$506.04	\$434.94	\$345.07
30-34	Male	\$225.07	\$169.53	\$145.66	\$115.50
	Female	\$334.91	\$251.96	\$216.21	\$171.12
	Family	\$711.58	\$536.08	\$460.66	\$365.35
35-39	Male	\$257.10	\$193.57	\$166.24	\$131.73
	Female	\$332.26	\$249.96	\$214.49	\$169.77
	Family	\$750.48	\$565.28	\$485.65	\$385.06
40-44	Male	\$274.65	\$206.74	\$177.51	\$140.60
	Female	\$363.15	\$273.14	\$234.34	\$185.42
	Family	\$766.88	\$577.58	\$496.18	\$393.35
45-49	Male	\$331.48	\$249.39	\$214.01	\$169.39
	Female	\$402.05	\$302.34	\$259.34	\$205.12
	Family	\$807.69	\$608.20	\$522.40	\$414.03
50-54	Male	\$419.21	\$315.22	\$270.36	\$213.82
	Female	\$469.17	\$352.72	\$302.44	\$239.11
	Family	\$898.47	\$676.32	\$580.70	\$460.01
55-59	Male	\$536.31	\$403.08	\$345.55	\$273.11
	Female	\$535.16	\$402.22	\$344.82	\$272.52
	Family	\$1,004.50	\$755.89	648.81	\$513.69
60-64	Male	\$573.30	\$430.83	\$369.32	\$291.85
	Female	\$573.30	\$403.83	\$369.32	\$291.85
	Family	\$1,090.71	\$820.58	\$704.17	\$557.34
65 and over	Male	\$934.75	\$702.07	\$601.51	\$474.93
	Female	\$934.75	\$702.07	\$601.51	\$474.93
	Family	\$1,768.60	\$1,329.30	\$1,139.67	\$900.76

The rates proposed by Blue Cross in the Filing are as follows:

Basic (Pool I) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 65	Individual	\$684.67	\$514.55	\$440.97	\$348.41
	Family	\$1,294.77	\$974.29	\$835.67	\$661.28
65 and over	Individual	\$1,074.81	\$807.27	\$691.55	\$545.97
	Family	\$2,033.34	\$1,528.43	\$1,310.04	\$1,035.29

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Preferred (Pool II) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Male	\$193.57	\$146.09	\$125.56	\$99.72
	Female	\$269.29	\$202.91	\$174.20	\$138.07
	Family	\$648.45	\$489.37	\$420.57	\$333.99
25-29	Male	\$213.74	\$161.22	\$138.51	\$109.93
	Female	\$304.69	\$229.46	\$196.93	\$155.99
	Family	\$725.00	\$546.80	\$469.74	\$372.76
30-34	Male	\$242.96	\$183.14	\$157.28	\$124.73
	Female	\$361.48	\$272.07	\$233.41	\$184.75
	Family	\$768.21	\$579.22	\$797.49	\$394.64
35-39	Male	\$277.53	\$209.08	\$179.48	\$142.23
	Female	\$358.60	\$269.91	\$231.56	\$183.29
	Family	\$810.19	\$610.71	\$524.45	\$415.89
40-44	Male	\$296.46	\$223.28	\$191.64	\$151.82
	Female	\$391.93	\$294.92	\$252.97	\$200.17
	Family	\$827.89	\$623.99	\$535.82	\$424.86
45-49	Male	\$357.78	\$269.29	\$231.03	\$182.87
	Female	\$433.91	\$326.41	\$279.93	\$221.43
	Family	\$871.92	\$657.03	\$564.10	\$447.15
50-54	Male	\$452.43	\$340.31	\$291.82	\$230.80
	Female	\$506.34	\$380.76	\$326.45	\$258.10
	Family	\$969.87	\$730.52	\$627.01	\$496.75
55-59	Male	\$578.77	\$435.10	\$372.97	\$294.78
	Female	\$577.54	\$434.17	\$372.18	\$294.16
	Family	\$1,084.27	\$816.35	\$700.50	\$554.69
60-64	Male	\$618.69	\$465.05	\$398.61	\$315.00
	Female	\$618.69	\$465.05	\$398.61	\$315.00
	Family	\$1,177.28	\$886.14	\$760.24	\$601.79
65 and over	Male	\$1,074.81	\$807.27	\$691.55	\$545.97
	Female	\$1,074.81	\$807.27	\$691.55	\$545.97
	Family	\$2,033.34	\$1,528.43	\$1,310.04	\$1,035.29

The rates proposed by Blue Cross in the Filing result in the following rate increases:

Basic (Pool I) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 65	Individual	14.97%	14.98%	14.95%	14.93%
	Family	14.95%	14.97%	14.92%	14.89%
65 and over	Individual	14.98%	14.98%	14.97%	14.96%
	Family	14.97%	14.98%	14.95%	14.94%

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Preferred (Pool II) Monthly Rates

Age	Category	HM 400	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Male	7.96%	8.07%	8.00%	8.02%
	Female	7.94%	8.02%	7.97%	7.99%
	Family	7.97%	8.08%	8.01%	8.04%
25-29	Male	7.96%	8.05%	7.99%	8.01%
	Female	7.94%	8.00%	7.96%	7.97%
	Family	7.96%	8.05%	8.00%	8.02%
30-34	Male	7.95%	8.03%	7.98%	7.99%
	Female	7.93%	7.98%	7.96%	7.97%
	Family	7.96%	8.05%	73.12%	8.02%
35-39	Male	7.95%	8.01%	7.96%	7.97%
	Female	7.93%	7.98%	7.96%	7.96%
	Family	7.96%	8.04%	7.99%	8.01%
40-44	Male	7.94%	8.00%	7.96%	7.98%
	Female	7.93%	7.97%	7.95%	7.95%
	Family	7.96%	8.04%	7.99%	8.01%
45-49	Male	7.93%	7.98%	7.95%	7.96%
	Female	7.92%	7.96%	7.94%	7.95%
	Family	7.95%	8.03%	7.98%	8.00%
50-54	Male	7.92%	7.96%	7.94%	7.94%
	Female	7.92%	7.95%	7.94%	7.94%
	Family	7.95%	8.01%	7.97%	7.99%
55-59	Male	7.92%	7.94%	7.94%	7.93%
	Female	7.92%	7.94%	7.93%	7.94%
	Family	7.94%	8.00%	7.97%	7.98%
60-64	Male	7.92%	7.94%	7.93%	7.93%
	Female	7.92%	15.16%	7.93%	7.93%
	Family	7.94%	7.99%	7.96%	7.98%
65 and over	Male	14.98%	14.98%	14.97%	14.96%
	Female	14.98%	14.98%	14.97%	14.96%
	Family	14.97%	14.98%	14.95%	14.94%

II. THE HEARING

A. Jurisdiction

The Office of the Health Insurance Commissioner (OHIC) 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.*

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B. Hearing Officers

On January 11, 2008 the Health Insurance Commissioner entered an Order appointing the undersigned Hearing Officers. In light of the fact that this proceeding was initiated prior to the Rhode Island Supreme Court's December 24, 2007 decision in *Arnold v. Lebel*, -- A.2d --, 2007 WL 4481524 (R.I. 2007) (No. 2006-254-appeal), the Commissioner and the parties agreed to the appointment of the Hearing Officers and agreed to conduct the hearing in the same manner as previous Direct Pay rate hearings before the OHIC and Department of Business Regulation (DBR).

In addition, in light of the *Arnold* decision, the Commissioner agreed that:

(1) in the event that any Hearing Officer had communications of any type (including written or oral) regarding this matter, other than for procedural or scheduling purposes, with any person(s) (including OHIC or DBR staff) other than with other Hearing Officers, the OHIC would notify the parties and afford them an opportunity to cross-examine such person(s) at the hearing; and

(2) any and all information consulted or relied upon by the Hearing Officers, individually or collectively, in arriving at the Recommendation that was not already in the record would be provided to the parties and would be made a part of the formal record of this proceeding, with the exception of independent analysis by any of the Hearing Officers based on information or documentation in the record.

C. Notice of the Hearing

The parties agreed to a hearing date and notice of the filing and the hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, on Friday, January 4, 2008.⁹

⁹ BC Ex. 10.

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D. Prefiled Testimony and Exhibits

The Following Exhibits were entered into the record:

Blue Cross Exhibits

- BC Ex. 1 Letter dated November 15, 2007 to Commissioner Koller from John Lynch requesting approval of rates by Blue Cross for its Direct Pay products
- BC Ex. 2 Actuarial schedules and supporting calculations submitted in support of Blue Cross' request for approval of rates by for its Direct Pay products
- BC Ex. 3 Trend and Comparison Supplement
- BC Ex. 4 Prefiled direct testimony of John Lynch
- BC Ex. 5 Prefiled direct testimony of Thomas A. Boyd
- BC Ex. 6 Comparison of calendar year 2008 Direct Pay budget to calendar year 2007 estimated actual Direct Pay budget by natural account
- BC Ex. 7 Comparison of calendar year 2009 Direct Pay budget to calendar year 2008 Direct Pay budget by natural account
- BC Ex. 8 Narrative of calendar year 2007 Direct Pay budget
- BC Ex. 9 Prefiled direct testimony of Augustine Manocchia, MD
- BC Ex. 10 Affidavit of Notice
- BC Ex. 11 Premium Assistance Report

AG Exhibits

- AG Ex. A Prefiled direct testimony of Barbara Niehus
- AG Ex. B Curriculum Vitae of Barbara Niehus
- AG Ex. C 2006 Annual Employment Wages
- AG Ex. D Response to Data Request
- AG Ex. E Blue Cross Affordability Report dated October 2007
- AG Ex. F Responses to Data Request
- AG Ex. G Responses to Data Request
- AG Ex. H Responses to Data Request
- AG Ex. I Responses to Data Request
- AG Ex. J Actuarial Schedules
- AG Ex. K Responses to Data Request
- AG Ex. L Responses to Data Request

OHIC Exhibits

- OHIC Ex. 1 Responses to Data Request

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E. Witnesses at the Hearing

The following witnesses provided live testimony at the hearing:

Blue Cross

<i>Name</i>	<i>Subject of Testimony</i>
John Lynch	(actuarial support for the rates requested)
Thomas Boyd	(Direct Pay program issues, management of the Direct Pay program and affordability issues)
Kimberly Holway	(Direct Pay customer service)
David Fogerty	(administrative costs)
Augustine Manocchia	(affordability issues)

The AG

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

F. Public Comment

Public comment was received in the form of emails, letters and testimony at the hearing. Approximately 50 emails and letters were received by the OHIC and nine persons provided comment during the hearing.

G. Positions of the AG and the Public

The AG

The AG disputed some aspects of Blue Cross' filing and did not dispute others. In general, the AG suggested that four adjustments be made to Blue Cross' filing:

1. The proposed rates should not include a contribution to reserves of 1.25% (including expected federal tax liability);
2. The proposed rates should not include a contribution to reserves of 0.5% to recoup expected expenditures for a new claims processing system;
3. The proposed rates should not include a 0.4% component to recoup expected costs of the WHBP; and

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4. The inpatient hospitalization component of the proposed rates should be reduced to reflect a similar reduction imposed by the OHIC on Blue Cross' most recent large employer trend filing.

Public Comment

The public comment was overwhelmingly opposed to the proposed rate increases. In general, the public comment touched on one or more of the following:

1. Blue Cross' rates should not be raised to recover a \$20 million penalty paid by Blue Cross to resolve potential federal corruption charges;
2. Blue Cross received a rate increase last year and should not get one this year; and
3. Blue Cross' rates are already too high.
4. Blue Cross's products require too high a level of cost sharing.

III. STANDARD OF REVIEW

The rates requested by Blue Cross must be “consistent with the proper conduct of the applicant’s business and with the interest of the public”¹⁰ In 2004 the Rhode Island General Assembly established the meaning of “proper conduct of the applicant’s business” with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*¹¹ They decreed that Blue Cross’ mission includes providing “affordable and accessible health insurance to insureds”¹² and “affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals.”¹³ The Board of Directors was specifically charged with “ensuring that the corporation effectively carries out the charitable mission for which it was incorporated” Under the new law, Blue Cross must also “employ pricing strategies that enhance the affordability of

¹⁰ R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

¹¹ See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff’d*, *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

¹² R.I. Gen. Laws § 27-19.2-3(1).

¹³ R.I. Gen. Laws § 27-19.2-3(5).

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health care coverage”¹⁴ These newly enacted legislative directives make clear that the “proper conduct of the applicant’s business” is no longer left solely to the management’s discretion unless that discretion is exercised to provide “affordable” and “accessible” health insurance.¹⁵

In addition, the 2004 legislation empowered the OHIC to review Blue Cross’ administrative costs and determine the reasonableness of such costs.¹⁶ Blue Cross, therefore, has the burden of providing detailed information and justification for all administrative expenses in its rate filings if it is to satisfy the requirements of R.I. Gen. Laws § 42-14.5-3.

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

- (a) Guard the solvency of health insurers;
- (b) Protect the interests of consumers;
- (c) Encourage fair treatment of health care providers;
- (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.¹⁷

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

The Commissioner may approve, disapprove, or modify the rates proposed by Blue Cross.¹⁸

IV. FINDINGS OF FACT

After full consideration of the issues raised in the public comment, the exhibits and testimony offered at the public hearing, the documents and papers submitted by Blue Cross and the

¹⁴ R.I. Gen. Laws § 27-19.2-10(3).

¹⁵ Id.

¹⁶ R.I. Gen. Laws § 42-14.5-3(b) (“[T]he commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs.”).

¹⁷ R.I. Gen. Laws § 42-14.5-2 (the OHIC Statute). See also OHIC Regulation 2.

¹⁸ R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

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AG, the analysis provided by the OHIC's consulting actuary, and a review of other relevant administrative materials in the OHIC's files, we make the following findings of fact:

1. The preceding sections I through III of this Recommendation are incorporated into these Findings of Fact.
2. On November 15, 2007, Blue Cross filed a request with the OHIC for a rate increase for its Direct Pay products. The filing contained new rates to become effective April 1, 2008.¹⁹
3. Blue Cross provided a copy of the filing of the proposed rates to the Insurance Advocacy Unit of the Attorney General's Office.
4. The filing was advertised in *The Providence Journal* on Friday, January 4, 2008.²⁰
5. Members of the public provided comments to OHIC prior to the hearing through correspondence and through emails.
6. Public hearings were held on January 14, January 17, January 28 and January 29, 2008.
7. Public comment was taken at the January 14, January 17, 2008 hearing dates.
8. Blue Cross and the AG were given a full opportunity to provide testimony in support of their respective positions.
9. The average increase sought by Blue Cross in the Filing is 12.7% (15% for Pool I and 8% for Pool II).²¹
10. Current rates have been in place since April 1, 2007 and the new rates are to be in place for all subscribers for the one-year rating period beginning April 1, 2008 and ending March 31, 2009.²²
11. No significant product changes have been proposed. Other changes to the Direct Pay program include the designation of the HealthMate 2000 as a WHBP,²³ the introduction of a specialty

¹⁹ BC Ex. 1.

²⁰ BC Ex. 10.

²¹ BC Ex. 1.

²² Id.

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pharmacy network and a \$75 copayment for specialty drugs in the HM400 and HM2000 plans,²⁴ and a change in the open enrollment period from August 15 through September 15 to May 15 to June 15 (July 1 effective date).²⁵

12. Direct Pay covers approximately 14,000 members (with 53% in Pool I and 47% in Pool II).

Membership has been on the decline for the last two years (2006 and 2007), with an overall decrease of 6% in membership between 2006 and 2007, the bulk of which was in Pool I membership (a 10% decrease between 2006 and 2007).²⁶ The following chart shows member months of coverage. A member enrolled for the entire year would count as twelve in this chart, while a member enrolled for three months would count as three, for example.

	Pool I only	Change from previous year (number)	Change from previous year (percentage)	Pool II only	Change from previous year (number)	Change from previous year (percentage)	Pool I and Pool II	Change from previous year (number)	Change from previous year (percentage)
CY 2000	57,036	--	--	47,558	--	--	104,594	--	--
CY 2001	65,531	8,495	0.15	49,890	2,332	0.05	115,421	10,827	0.10
CY 2002	73,063	7,532	0.11	54,170	4,280	0.09	127,233	11,812	0.10
CY 2003	77,671	4,608	0.06	60,346	6,176	0.11	138,017	10,784	0.08
CY 2004	93,414	15,743	0.20	68,453	8,107	0.13	161,867	23,850	0.17
CY 2005	102,416	9,002	0.10	76,421	7,968	0.12	178,837	16,970	0.10
CY 2006	98,179	(4,237)	(0.04)	79,254	2,833	0.04	177,433	(1,404)	(0.01)
CY 2007	88,601	(9,578)	(0.10)	78,816	(438)	(0.01)	167,417	(10,016)	(0.06)

13. Blue Cross has projected its rate need by analyzing its experience for the Direct Pay plan year April 1, 2006-March 31, 2007 and projecting it forward for two years using price and utilization

²³ BC. Ex. 2. As noted above, Blue Cross is required to implement a WHBP pursuant to R.I. Gen. Laws §§ 27-18.5-9.

²⁴ BC. Ex. 2.

²⁵ BC Ex. 5 at 12.

²⁶ OHIC Ex. 1. These numbers seem to be at odds with Blue Cross' assertion that "Over the last several years the Direct Pay market in Rhode Island has been stable with enrollment being fairly steady." BC Ex. 1.

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trend factors for four major health care components (Inpatient, Outpatient, Medical/Surgical and Prescription Drug).²⁷

14. The trend factors Blue Cross has used are generally reasonable. They are relatively consistent with factors approved for use in connection with Blue Cross's large group business, and result in a similar aggregate trend factor (approximately 8.3%). Blue Cross generally uses the same factors for large group and small group. In aggregate, the factors filed are lower than those contained in last year's filing.²⁸
15. The factors incorporate fee increases that are planned or already in place and utilization increases based on analysis of experience. After a long period in which Blue Cross had reported flat utilization trend for inpatient care, they are now reporting an increase in inpatient days of approximately 2.8% annually. Blue Cross was required to eliminate this element of their trend projection in connection with their large group rate filing last fall, primarily because it was based on relatively few months of data. They have now shown a continuing pattern of experience to support the increased trend in the experience. Based on the experience alone, it is apparent that this is a trend that has continued for all months reported after October 2006.²⁹ There are, however, remaining questions of whether increased utilization of inpatient services is medically necessary, and of whether Blue Cross is taking adequate steps to control the increased utilization.
16. When calculating its proposed rates, Blue Cross added the cost of various benefit mandates, new technologies and state assessments that are not included in the Direct Pay experience base.

²⁷ See generally BC Ex. 2 and BC Ex. 4.

²⁸ BC Ex. 3; 2007 Direct Pay Decision.

²⁹ BC Ex. 2, schedules 54 (and supplement), 58: Tr. II at 32-35.

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These add approximately 1% to the cost of care.³⁰ The demonstration of these additions is reasonable.

17. Blue Cross followed methods for determining and projecting price, utilization and mix that are generally consistent with those of its prior rate filings, and consistent with standard actuarial methods.

18. No portion of the Filing or the calculations contained therein were designed or intended to recoup the recent \$20 million settlement reached by Blue Cross with the US Attorney's Office.

Wellness Health Benefit Plan

19. Blue Cross is required to offer a wellness health benefit plan (WHBP) pursuant to R.I.G.L. § 27-18.5-8. This statute requires that Blue Cross offer a "wellness health direct benefit plan" to "eligible individuals." The statute also requires that the direct wellness health benefit plan create appropriate incentives to, among other things

1. Focus on primary care, prevention and wellness;
2. Actively manage the chronically ill population;
3. Use the least cost, most appropriate setting; and
4. Use evidence based, quality care.

20. Blue Cross has proposed a single product, the HM2000, as the WHBP. The WHBP will be available April 1, 2008. Subscribers will have the opportunity to receive a reward of 10% of their annual premiums if they comply with certain wellness requirements. This program adopts some aspects of the *HEALTHpact* plans currently available in the small employer group market.

To be eligible for the program, participants must:

- Designate a primary care physician;
- Complete a personal health assessment (18 and over);

³⁰ BC Ex. 2, schedules 24-28.

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- Pledge to either remain at a healthy weight or participate in weight management programs if morbidly obese;
- Pledge to either remain smoke free or participate in a smoking cessation program; and pledge to participate in disease and case management programs if applicable.

Within 8 months, participation must be demonstrated by:

- Submitting an annual PCP checklist (age 12 and over);
- Submitting the annual self-reporting form (age 18 and over); and
- Participating in disease and case management programs if identified as a candidate.

If the requirements are met, the subscriber will receive at the end of the year a 10% rebate on the annual premium paid.³¹

21. Blue Cross has estimated that about 20% of HM2000 members would qualify and receive the reduction. However, no explanation has been provided for this number. Take-up in the small group market appears to be much lower, but the WHBP is not a stand-alone product in this market and there is no downside to a subscriber already using this product to sign up for the WHBP discount. Therefore the take-up in Direct Pay could be higher than twenty percent.
22. Blue Cross proposes to spread the cost of the WHBP discount across all subscribers. Based on the 20% take-up rate, the cost of the WHBP discount is estimated to be about .4% across all Direct Pay subscribers.
23. Blue Cross does not expect to reap any cost savings this year from the WHBP.
24. A similar issue was faced in the OHIC's 2007 Medigap decision.³² In that case, this Office did not allow Blue Cross spread the cost of enrollment incentives, referred to as the "Age-In Discount," across the whole book of business:

While this program may be worthwhile, neither I nor the AG are convinced that existing Plan 65 members should fully bear the costs associated with this

³¹ BC Ex. 5 at 6-7.

³² *In re Blue Cross & Blue Shield of Rhode Island Filing for New Non-Group Subscription Rates for Plan 65 Medigap Plans A, B and C, New Non-Group Subscription Rates for Plan 65 Select Plans B and C, and New Non-Group Subscription Rates for Plan 65 Select Plan L*, OHIC-2006-4 (Dec. 14, 2006) [hereinafter 2006 Medigap Decision].

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program, especially since no benefits are immediately expected. Therefore, the costs associated with the Age-In program may not be passed on to existing Plan 65 members.³³

25. If, in the future, Blue Cross is able to demonstrate some benefit to the entire Direct Pay population because of enhanced health status or lower healthcare costs resulting from the WHBP, Blue Cross ought then to be allowed to pass the costs of the incentives along to all Direct Pay subscribers. Until then, however, we should not ask all Direct Pay subscribers to bear the cost of a statutorily mandated product that does not yet produce returns. Based on the reasoning in the 2006 Medigap decision with respect to the Age-In program, Blue Cross' recent success in the market (i.e., its record profits), Blue Cross' more than adequate reserves, and the 10% drop in Pool I membership, we recommend that the .4% cost of this program not be charged to the subscribers but instead should be recovered from reserves.³⁴

Budget

26. The Filing uses a budgetary approach on operating expenses consistent with past directives of the OHIC, and its predecessor, DBR.

27. The administrative budget in the Filing projected an increase in administrative costs of approximately 2% (an increase of about \$157,885) from CY2007 to CY2008.³⁵

28. However, according to a data request answer submitted by Blue Cross, the Direct Pay budget was overstated by \$128,414 or \$1.11 per contract month.³⁶ This overstatement resulted from layoffs that were made after budget was created, but before the filing was submitted.³⁷ Further

³³ Id. at 17.

³⁴ The AG has recommended a new separate plan for a WHBP instead of HM2000. We don't think it is reasonable to further fragment an already small market segment, and we think there is likely to be greater uptake and awareness by using an existing plan.

³⁵ BC Ex. 6.

³⁶ Hearing Transcript, Jan. 29, 2007 at 144 (hereinafter Tr. II).

³⁷ Tr. II at 136.

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testimony provided by Mr. Fogerty at the hearing revealed that further budgetary cuts were made in addition to the layoffs, some of which may have filtered down to the Direct Pay budget:

Mr. Fogerty:

There were other expense reductions that were made at the same time. I'm sure some of them would have some downstream impact to Direct Pay, some would not. I don't have the itemized list in front of me.

Mr. DeWeese:

How might that correspond in total order of magnitude, the effect of the layoffs?

Mr. Fogerty:

The total budget reduction was approximately \$13 million, so roughly it doubles the size in total. If the layoffs were \$6 million, there is another \$7 million in overall reductions.

Mr. Cogan:

That would translate to roughly 200, \$250,000 budget savings to Direct Pay?

Mr. Fogerty:

That's off the top of my head, doing a rough order of magnitude that's likely. Again, as I said, you know, it is possible that some of the items that we eliminated would not allocate to Direct Pay, but rough order of magnitude, you're correct.³⁸

29. Mr. Fogerty's testimony reveals that the number may be somewhere in the \$200,000-\$250,000 range, although we cannot be certain that all the cost savings were passed on to Direct Pay. Indeed, Mr. Fogerty testified that, "it is possible that some of the items that we eliminated would not allocate to Direct Pay."

30. There has to be a temporal cut off point for the preparation of the Direct Pay filing, including budget items. As both a practical and policy matter, we cannot go searching for trend and budget numbers from Blue Cross that are current right up to the point of the hearing. Nevertheless, a major alteration to the overall Blue Cross budget resulting in total savings of approximately \$13 million dollars prior to the filing, some or all of which saving were allocated

³⁸ Tr. II at 137-38.

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to Direct Pay, should have been reflected in the filing. Mr. Fogerty agreed that this is something he should have “flagged” as the person responsible for the Direct Pay budget.³⁹

31. As was noted in the 2007 Direct pay Decision, the Direct Pay class is particularly vulnerable to the high costs of health care, and as a matter of principle and policy, Direct Pay members should be afforded reasonable aid in their efforts to purchase affordable health insurance, including elimination of unnecessary administrative expenses in relation to its products.⁴⁰ Assuming that the budget savings to Direct Pay were approximately \$200,000 to \$250,000, then the rate should be reduced by approximately 0.4% to reflect those savings.

Claims Processing System

32. Blue Cross proposes to upgrade its current claims processing system. Initially, the proposed rate increase includes 0.5% contribution to reserves intended to recapture the anticipated costs of the new claims processing system. The cost of the system is estimated to be about \$140 million. Blue Cross had not intended to recapture the costs of the system from its self-insured business because of competitive pressures on self-insured charges.
33. At the hearing, Blue Cross revised its position and announced that it would attempt to recapture a share of the costs of the system from its self-insured business. Based on this change in policy, the proposed 0.5% contribution to reserves intended to recapture the anticipated costs of the new claims processing system was reduced to from 0.5% to 0.35% because of being spread over a larger total membership.
34. This appears to be a necessary expense for Blue Cross. Since all Blue Cross customers will benefit from the system and all will be charged in a similar manner for the costs of the system, it seems reasonable and equitable to charge Direct Pay members the same as everyone else. Thus,

³⁹ Tr. II at 140.

⁴⁰ 2007 Direct Pay Decision at 22.

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we are inclined to accept Blue Cross' proposal to reduce this component of premium reduction from 0.5% to 0.35%.

D. Contribution to Reserves

35. The proposed rate increase also includes a contribution to reserves component. Federal income tax on any actual contribution to reserves adds another .25%.⁴¹ Thus, the contribution to reserves component accounts for 1.25% of the composite rate increase of 12.7%. While reserves contributions (and the associated taxes) are generally an acceptable component of rate increases, this component is not appropriate for the proposed rate increase this year.

36. In 2007, Blue Cross requested a 2% contribution to reserves, plus a .5% federal tax component.⁴² The request for the reserves contribution was rejected. The rationale for the rejection was discussed extensively in Pages 22-24 of Direct Pay 2007. The reasons included:

- The Direct Pay class was found to be particularly vulnerable to the high costs of health care (e.g., Direct Pay subscribers directly bear all the costs of health insurance and that it also contains a greater component of older, sicker participants (in Pool I) than employer groups, thereby driving up the class' medical claims costs);
- Direct Pay members should be afforded reasonable aid in their efforts to purchase affordable health insurance, including: (1) efforts by Blue Cross to keep health care cost increases low, (2) elimination of unnecessary administrative expenses, (3) investment of plan reserves in income-based subsidy programs and (4) in actuarial estimates that reflect a higher allocation of the risks to Blue Cross of the uncertainties inherent in the rate projection process;
- Blue Cross was expected to realize record-level net income for 2006 (expected \$60 million in net income for 2006); and
- Blue Cross' reserves level was also at an all-time high, with expected earnings bringing it close to its minimum adequate reserves level.

⁴¹ See generally BC Ex. 2 and BC Ex. 4. Blue Cross will only owe the .25% if it actually realizes the 1% "profit" on Direct Pay business. If Blue Cross does better than the 1%, it will owe more in federal income tax and will make a greater contribution to reserves. Conversely, if Blue Cross loses money in Direct Pay, no federal income tax will be owed for the Direct Pay business and the .25% expected tax component will help buffer Blue Cross' losses.

⁴² 2007 Direct Pay Decision at 15.

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37. Because Blue Cross' reserves level was nearly at the level determined to be adequate, a contribution to reserves by Direct Pay members was found "not in the consumer interest and it is not consistent with Blue Cross' mission as a publicly chartered, nonprofit charitable institution."⁴³
38. Blue Cross' reserves are currently at 24% of SAPOR, or \$425 million (based on 2007 premiums. This is net of the \$20 million paid to the US Attorney.⁴⁴
39. Because Blue Cross' reserves level is above the minimum level determined to be adequate, a contribution to reserves by Direct Pay members at this time is not in the consumer interest and it is not consistent with Blue Cross' mission as a publicly chartered, nonprofit charitable institution. The most vulnerable members of the Blue Cross community of insureds should not be asked to add to Blue Cross' reserves this year.⁴⁵

H. Affordability

40. The affordability guidelines have been discussed extensively and repeatedly in other decisions.⁴⁶ Therefore, while a discussion of those principles is unnecessary here, application of those principles to this rate filing is nevertheless required.
41. Rate reductions have previously been imposed based on affordability principles.⁴⁷ These reductions have been imposed on the ground that Blue Cross has an affirmative statutory obligation to take steps to enhance the affordability of its products and has not adequately done so. This remains the case here. While Blue Cross has taken positive steps, testimony at the hearing revealed continuing inadequacies in Blue Cross' affordability efforts.

⁴³ Consumers and the AG have suggested that no contribution to reserves be made because of the settlement with the US Attorney's Office. This is not a basis for our decision to deny a contribution to reserves in this Filing.

⁴⁴ Tr. II at 72-73.

⁴⁵ Blue Cross again argues that the Direct Pay reserves should be viewed separately. This argument was thoroughly examined and rejected last year. See 2007 Direct Pay Decision at 23-24.

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42. Blue Cross’ management structure and affordability practices appear to suffer from some structural inadequacies and strategic lapses. For example, the recently formed Ad Hoc Affordability Sub-Committee of the Board of Directors is staffed by Mr. Boyd. Yet, while Mr. Boyd has responsibilities for marketing, he has no responsibilities for areas of Blue Cross’ operation that are critical to the ever rising costs of health insurance—medical costs and utilization of medical services. Mr. Boyd has no responsibilities for provider contracting, medical management or utilization review and the medical director does not report to Mr. Boyd.⁴⁸ BASED ON CONFIDENTIAL PORTIONS OF THE HEARING TESTIMONY

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] BASED ON

CONFIDENTIAL PORTIONS OF THE HEARING TESTIMONY

43. The testimony in this case also makes clear that Blue Cross lacks specific goals and/or benchmarks and/or targets for affordability initiatives.⁴⁹ This lack, along with the appearance of inconsistent senior management oversight calls Blue Cross’ affordability efforts into question. Without doubt, Blue Cross has addressed, in part, its affordability obligation. Yet, as was stated in the Commissioner’s Order in the 2006 Direct Pay Decision, “It is neither the obligation of this Office nor the Hearing Panel to elicit testimony from Blue Cross regarding the affordability

⁴⁶ See generally 2007 Direct Pay Decision; 2006 Direct Pay Decision; 2006 Medigap Decision.

⁴⁷ See, e.g., 2007 Direct Pay Decision.

⁴⁸ Hearing Transcript, Jan. 28, 2007 at 78-86 (hereinafter Tr. I).

⁴⁹ Tr. I at 86-92. See also Tr. I at 112-116.; AG Ex. A, p. 19. Blue Cross’ only external benchmarks appear to its own membership association and telephonic information from a firm that provided return on investment estimates. Tr. II at 111-114.

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guidelines. Likewise, the burden is not on this Office to demonstrate that Blue Cross has not taken steps to enhance the affordability of its products. Rather, the burden is on Blue Cross . . .

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44. Without evidence of programmatic goals that might drive affordability initiatives and appropriate corporate structures in support of those and other initiatives, it is not unreasonable to expect that the result will be increased risk of costs to consumers resulting from lost opportunities to enhance product affordability. Thus, the risk of such costs should be borne by Blue Cross. Such a reallocation is consistent with Blue Cross' obligations and mission as a state chartered, nonprofit charitable organization.
45. While the allocation of such a risk of increased costs is difficult to quantify, it is not unreasonable to expect that a reallocation of risk should be effected through a pricing modification. A pricing modification is the most effective method of ensuring that less financial risk is borne by consumers and more financial risk is borne by Blue Cross. A reduction of one percent is appropriate to address the risk associated with these potential costs.
46. The Commissioner must consider the interests of consumers when discharging his duties, including the rendering of a decision on the proposed rates in this case. Given the risks associated with these new products, a one percent rate reduction is in the interests of consumers.
47. Such a reduction will not jeopardize Blue Cross' total reserves, as they now exceed minimum standards established by this Office.
48. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a Finding of Fact.

⁵⁰ 2006 Direct Pay Decision at 59.

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V. CONCLUSIONS OF LAW

1. The preceding sections I through IV of this Recommendation are incorporated into these Conclusions of Law.
2. The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.5-1 *et seq.*, 27-19-6 and 27-20-6.
3. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*
4. All of the procedural prerequisites for the conduct of the hearing have been followed.
5. The OHIC has jurisdiction in this proceeding to conduct a hearing for purposes of considering whether or not Blue Cross' proposed rates for its Direct Pay products are consistent with the proper conduct of its business and in the interest of the public.
6. The "proper conduct" of Blue Cross' business requires Blue Cross to take steps to enhance to affordability of its products.
7. Blue Cross bears the burden of proving that the proposed rates are consistent with the proper conduct of its business and in the interest of the public.
8. In addition, the OHIC must comply with the requirements of the OHIC Statute when rendering a decision in this matter. The OHIC Statute requires the Commissioner to render a decision so as to, among other things, protect consumer interests, encourage policies that improve the quality and efficiency of health care delivery, and encourage and direct Blue Cross toward policies that advance the welfare of the public.
9. The OHIC is authorized to modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6.
10. For all the reasons set out above, a rate increase of 11.8% for Pool I members (as opposed to the rate increase of 15% for this pool sought by Blue Cross) is within the proper conduct of Blue

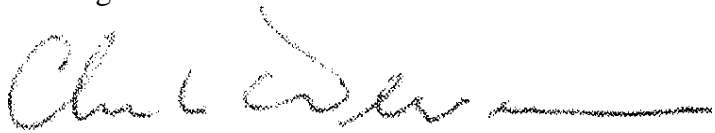
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Cross's business and in the public interest. Such a rate also protects consumer interests and advances the welfare of the public.


11. A rate increase of 4.8% for Pool II members (as opposed to the rate increase of 8% for this pool sought by Blue Cross) is within the proper conduct of Blue Cross's business and in the public interest. Such a rate also protects consumer interests and advances the welfare of the public.
12. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.



John Aloysius Cogan Jr.
Hearing Officer



Charles C. DeWeese
Hearing Officer



Christopher F. Koller
Hearing Officer

February 15, 2008

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ORDER AND DECISION

I, Christopher F. Koller, Health Insurance Commissioner of the State of Rhode Island, accept the consensus recommendations of the Hearing Officers. However, as part of my final Order and Decision, an additional modification will be made to Blue Cross' Filing.

The rates requested by Blue Cross should be further reduced by an additional .8 percent to reflect the estimated value of the recent increase Blue Cross has reported in its inpatient utilization rates.

While the projected increase due to increased inpatient utilization is actuarially defensible, merely detecting, valuing and passing on these increases to customers is not consistent with Blue Cross's affordability obligations. Blue Cross in testimony attributed the increased utilization to increased behavioral health and out of state utilization but could not say why this increase had occurred and admitted that its internal analysis was "not wholly satisfactory." (Transcript, January 29, 2007, p. 37.)

In the absence of explanations, Blue Cross cannot follow the course of least resistance and pass the cost of each detected utilization increase onto its customers, especially those who have no other choice of carrier and are bearing the full costs of insurance themselves. This is particularly the case when the increase is a departure from a previously steady state – such as the rate of use of inpatient services. Based on its affordability obligations, BCBSRI must bear the risk of such increases and the responsibility for taking reasonable and affirmative actions to address such changes.

No evidence was presented of such actions in this hearing, although they would be consistent with Affordability Principles promulgated by this office and presumably of much greater value than many of the reported affordability initiatives. In fact in testimony Blue Cross acknowledged it has incentive to err on the side of caution in its utilization and expense projections

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– an incentive tempered only by competitive market pricing pressures which do not exist in the Direct Pay market. (Transcript, January 29, 2007, p. 41).

It is conceivable that even the best-executed efforts to reduce this increase in inpatient utilization would not immediately be completely successful and thus some increase in expenses would still occur. It is not this Office’s responsibility to make these estimates – in the absence of any such evidence by Blue Cross, the Office must give credit and protection to the consumer.

BASED ON CONFIDENTIAL ACTUARIAL SCHEDULES

[REDACTED]

[REDACTED]

[REDACTED]

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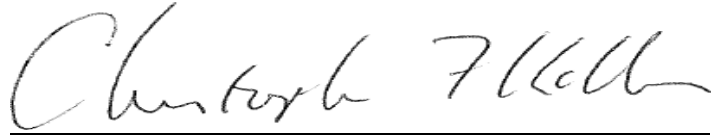
BASED ON CONFIDENTIAL ACTUARIAL SCHEDULES

In closing, Blue Cross is again to be commended for their efforts on behalf of this population. This Office believes a fair and just ruling has been reached on the issue at hand. There is a continued expectation, however, that Blue Cross, by virtue of its non profit mission, its size in the market and its affordability obligations will exercise assertive leadership through its internal management practices consistent with this Office’s affordability principles to change the health care system in Rhode Island and the behavior of insurers, providers and consumers. Although Blue Cross can be justly proud of certain leadership efforts in the health care community as presented in this hearing, particularly on behalf of primary care and health information technology, and its AccessBlue Program, the findings of this hearing demonstrate that more work must be done to translate these general intentions into effective management practices that deliver more affordable

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health care for Blue Cross Direct Pay subscribers, all Blue Cross consumers and the State of Rhode Island.

ENTERED AS AN ADMINISTRATIVE ORDER OF OFFICE OF THE HEALTH INSURANCE COMMISSIONER THIS 15th DAY OF FEBRUARY, 2008.

A handwritten signature in cursive script, reading "Christopher F. Koller", is written above a solid horizontal line.

Christopher F. Koller
Commissioner
Office of the Health Insurance Commissioner

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