

1 A. I have been employed in that capacity for the last 3 years. I was hired into
2 this position on July 27, 2005.

3 Q. Have you previously qualified and been accepted as an expert on actuarial
4 matters in proceedings before the Office of Health Insurance Commissioner (OHIC)?

5 A. Yes, for the last two years I was accepted as an actuarial witness and
6 testified as such at the rate hearings pertaining to Blue Cross' request to increase rates for class
7 DIR. Additionally, numerous filings have been submitted to the OHIC over my signature during
8 the last 3 years.

9 [Offer as an expert witness on actuarial rate matters.]

1 **II. DESCRIPTIONS AND BACKGROUND INFORMATION.**

2 Q. I am showing you a document marked as Blue Cross Exhibit 1 for
3 identification purposes. Would you please explain what this is?

4 A. Yes. This is a letter, dated November 21, 2008, that I wrote to the Health
5 Insurance Commissioner notifying him of the filing of new subscription rates by Blue Cross for
6 Class DIR and summarizing the content and purpose of the filing, which accompanied that letter.

7 Q. Is Blue Cross Exhibit 1, for identification, an accurate summary of Blue
8 Cross' filing for new Class DIR subscription rates?

9 A. Yes.

10 Q. Would you please generally describe who the subscribers are for Class
11 DIR?

12 A. Yes. Class DIR subscribers are individuals and families who reside in
13 Rhode Island and who are neither eligible for employer based coverage, nor state or federal
14 programs. Self-employed individuals are eligible for coverage as a Class DIR subscriber or as a
15 small employer.

16 Q. What is the rate structure for Direct Pay subscribers?

17 A. For Direct Pay, we have two pricing structures. They are:

- 18 • **Basic Rates (Pool I)** which is the regular Blue Cross DIR program and is
19 community rated.
- 20 • **Preferred Rates (Pool II)** is a Blue Cross DIR program that is rated by age
21 and gender and utilizes a health statement.

22 We believe it is critical to affordability to continue these pricing structures. It is
23 important to have Preferred Rates (Pool II) in order to continue to encourage healthy individuals

1 to purchase Direct Pay. This is crucial to keeping rates more affordable for all Direct Pay
2 subscribers.

3 Q. Please describe the goal behind this rate structure.

4 A. Blue Cross alone insures this segment of Rhode Islanders. Blue Cross has
5 set two goals for itself in Direct Pay: (1) to make coverage available to all Rhode Islanders; and
6 (2) to make the coverage as affordable as possible—while recognizing that in the long run this is
7 not an issue which Blue Cross alone can resolve. The use of the different pools with a health
8 screening and application process for Pool II assists in attracting younger and healthier
9 subscribers, thereby benefiting all in Direct Pay, including Pool I subscribers. Pool II became a
10 vehicle which helped slow down the cost spiral that had been experienced by this class. It has
11 helped address problems associated with the health characteristics, age, and relatively high
12 claims expenditures for Class DIR by injecting the potential for better health experience in the
13 future and to rejuvenate that class. By continuing to seek to better align the rates of the pools
14 Blue Cross believes that Direct Pay will continue to attract more healthy subscribers for the
15 benefit of all subscribers.

16 Q. Has Blue Cross been successful with its strategies to control costs in the
17 Direct Pay market?

18 A. The empirical evidence suggests that we have had some success in
19 controlling the escalating cost of health care in the Direct Pay market. In fact, the Market
20 Merger Task Force of the Office of the Health Insurance Commissioner released a report in
21 February 2008 concluding that the Rhode Island individual insurance market is relatively stable.
22 Further, the report also stated that “...the share of young, healthy members has remained
23 relatively stable (and even increased) over the past three years” and that “Rhode Island’s

1 individual market compares favorably with individual markets in other states.” We believe this
2 stability and increase in healthy members is due in large part to the pricing and benefit strategies
3 that Blue Cross has employed over the last several years. These strategies include gradually
4 reducing the cross subsidy that Pool II contributes toward Pool I and extending the AccessBlue
5 program to Pool II subscribers.

6 Q. Would you please describe the recent enrollment changes in Class DIR?

7 A. Yes. Since the AccessBlue program was introduced to Preferred (Pool II)
8 members in April 2007, the number of members enrolled in Preferred (Pool II) has steadily
9 increased. In April 2007, there were approximately 13,900 members enrolled in Class DIR. Of
10 these, approximately 7,400 were enrolled in Basic (Pool I) (53%) with 6,500 in Preferred (Pool
11 II) (47%). In April 2008, the number of Preferred (Pool II) members had increased to
12 approximately 6,900, with approximately 7,100 enrolled in Basic (Pool I). As of September
13 2008, the number of Preferred (Pool II) members has grown to approximately 7,100 members
14 (50%), while the number of Basic (Pool I) members has held fairly steady at 7,000 members
15 (50%). Overall, while the enrollment in Preferred (Pool II) has grown by 600 members since
16 April 2007, the Basic (Pool I) enrollment has declined only modestly, and has remained fairly
17 stable since April 2008.

18 Q. What is the significance of the Preferred (Pool II) percentage?

19 A. Assuring that Preferred (Pool II) is attractive in the market is critical to
20 sustaining the Direct Pay market. The financial stability of the entire Class DIR is dependent to
21 a significant degree on the continuing ability of Blue Cross to attract subscribers into Preferred
22 (Pool II) since they help to subsidize Basic (Pool I). As a consequence, it is important that
23 Preferred (Pool II) rates bear a reasonable relationship to the pool’s own underlying experience

1 level and not be higher than necessary, in order to balance attractiveness in the market with some
2 continuing subsidy of Basic (Pool I). The entire Class DIR pool would be on a financially
3 sounder basis if the Pool I subsidy could be generated from a smaller Pool II surcharge collected
4 from a larger Pool II enrollment. Since the percentage of Pool II members in the Direct Pay
5 population has increased from 45% at December 2006 to 50% at September 2008, it appears that
6 the steps Blue Cross has taken in recent years to encourage Pool II enrollment are having their
7 intended effects.

8 Q. Has Blue Cross employed any other strategies to help control the
9 escalating cost of healthcare?

10 A. Yes. Effective April 1, 2006, Blue Cross redesigned the portfolio of
11 products available in the individual market. These new products have more modernized benefit
12 structures and cost sharing features designed to encourage more appropriate use of the health
13 care system. The emerging evidence suggests that the new plan designs are having a favorable
14 impact on the utilization of health care services.

15 Q. What are the products currently available to Class DIR subscribers?

16 A. HealthMate Coast-to-Coast Direct Plan 400/800 (“HealthMate Direct
17 400”) offers comprehensive coverage for medical care and prescription drugs. HealthMate Direct
18 400 has a \$20 copay for a visit to a primary care physician and a \$40 copay for a specialist visit.
19 There is a \$75 urgent care copay and a \$200 emergency room copay. These copay levels are
20 designed to incent members to obtain services at the least costly, most appropriate setting. For all
21 other in-network services, a \$400 per member/\$800 per family deductible is applied, with a 10%
22 member paid coinsurance after the deductible. There is an in-network out-of-pocket maximum of
23 \$2500 per member/\$5000 per family. Prescription drug coverage is provided at participating

1 pharmacies with a member paid coinsurance of 20% generic/25% brand/50% non-preferred
2 brand and \$75 specialty prescription drugs. Pharmacy coverage does not go toward meeting the
3 deductible.

4 HealthMate Coast-to-Coast Direct Plan 2000/4000 (“HealthMate Direct 2000”)
5 coverage is similar to HealthMate Direct 400. The differences are in the deductible, coinsurance
6 percentages and out of pocket maximums. The HealthMate Direct 2000 deductible is \$2000 per
7 member/\$4000 per family, and the member paid coinsurance is 20% for in-network benefits up
8 to a maximum of \$3000 per member/\$6000 per family per calendar year. Finally, HealthMate
9 Direct 2000 is designated as a Wellness Health Benefit Plan and includes a Wellness Reward
10 Program.

11 The HealthMate for HSA Direct Plan 3000/6000 (“HealthMate for HSA 3000”)
12 and HealthMate for HSA Direct Plan 5000/10000 (“HealthMate for HSA 5000”) products also
13 provide comprehensive coverage for medical care and prescription drugs. These products have
14 deductibles of \$3000 per member/\$6000 per family and \$5000 per member/\$10000 per family,
15 respectively. The deductibles apply to all covered services except for certain preventive services.
16 The following selected preventive services do not apply to the deductible and are covered at
17 100% in-network: adult and pediatric well visits and immunizations, PAP smears, screening
18 mammography and prostate screening. Prescription drug costs will count toward meeting the
19 deductible. After satisfaction of a member’s deductible, in-network benefits are paid at 100% for
20 all covered services. The HealthMate for HSA 3000 and HealthMate for HSA 5000 products are
21 designed to be health savings account (HSA) qualified high deductible health plans (HDHPs)
22 under federal law. These plans permit subscribers to open health savings accounts and set aside
23 tax deductible dollars to fund eligible health care expenses. While these two plans are designed

1 to be HSA qualified HDHPs, the subscriber need not establish and fund an HSA account in order
2 to purchase HealthMate for HSA 3000 or 5000. In those circumstances, these plans would
3 effectively be higher deductible plan options, without the tax benefits for those subscribers who
4 elect not to fund a health savings account.

5 In general, members have a greater expense (i.e., higher deductibles and
6 coinsurance) for services rendered out-of-network. We have seen little usage of out-of-network
7 providers given the very broad network Blue Cross has in Rhode Island and through the Blue
8 Card[®] PPO national network. The Blue Card[®] network administered under the auspices of the
9 national Blue Cross Blue Shield Association provides a comprehensive network for our Class
10 DIR members available throughout the country.

11 Contemporaneous with this rate filing, Blue Cross has filed with the Office of the
12 Health Insurance Commissioner (OHIC) proposed revisions to the contract forms for each of the
13 four products described above. These proposed forms provide detailed descriptions of the
14 benefits and other terms of the subscriber agreements.

15 Q. Does Blue Cross offer a Wellness Health Benefit plan as required by
16 Rhode Island General Laws § 27-18.5-9?

17 A. Yes. Effective April 1, 2008, the HealthMate Direct 2000 product was
18 designated as a Wellness Health Benefit Plan. Subscribers who elect this plan option have the
19 opportunity to receive a reward equal to 10% of paid premium if they meet the program
20 requirements. As of September 2008, 146 subscribers have successfully engaged in the program
21 by completing all of the initial engagement requirements and an additional 206 subscribers have
22 expressed interest by completing at least one of the initial engagement requirements.

1 Q. Has Blue Cross done anything else to address the affordability of the Class
2 DIR plan premiums?

3 A. Yes. In 2006 Blue Cross launched AccessBlue, previously named the
4 Direct Pay Premium Assistance Program, to help lower income subscribers and absorb some of
5 the escalating costs of health insurance premiums. A separate report discussing our experience to
6 date with AccessBlue has been submitted under separate cover to the OHIC contemporaneous
7 with this filing.

8 Q. Is AccessBlue part of the rates?

9 A. Blue Cross' legal position is that the program is part of its charitable
10 mission and return to the community, described below, and not part of the Direct Pay rates.
11 AccessBlue is not included in the rates charged to Direct Pay subscribers. We believe this
12 question is academic in the context of this filing, and Blue Cross' legal counsel can further
13 explain our position at the hearings if need be.

14 Q. Please describe AccessBlue.

15 A. This program is a direct outreach activity, authorized by the Blue Cross
16 Board of Directors to help improve the affordability of healthcare coverage in Rhode Island for
17 eligible subscribers who have acted responsibly by purchasing their own Direct Pay coverage,
18 but (1) are not eligible for either employer or government sponsored or assisted healthcare
19 coverage plans (i.e., employer group coverage, other than a self-employed individual, and state
20 or federal programs, including Medicare and Medicaid) and (2) have relatively low incomes
21 (their annual gross household income is less than 350% of federal poverty levels (FPL)) with
22 which to purchase coverage.

23 Q. Why is Blue Cross offering the program?

1 A. This program is a central part of Blue Cross’ overall corporate
2 commitment to performing as a successful business enterprise, and then making a return from
3 that success to the community. It is one of the ways in which we intend to fulfill our corporate
4 mission to “provide our members with peace of mind and improved health by representing them
5 in their pursuit of affordable high quality healthcare” (from our corporate mission statement).
6 AccessBlue focuses directly on the issue of the affordability of the company’s healthcare
7 coverage for a segment of Rhode Islanders who are taking responsibility for covering their
8 healthcare needs—but who have lower incomes and do not have the benefit of employer or
9 government sponsored or supported plans available to them.

10 Q. How much assistance will be made available to each subscriber?

11 A. There are two levels of assistance provided through Access Blue.
12 Subscribers with an annual household income less than or equal to 200% of the FPL qualify for
13 Level 1 subsidy status. Over the course of the 12-month rating period beginning April 1, 2009,
14 Level 1 will provide \$984 for each eligible Direct Pay individual subscriber and \$1,848 for each
15 eligible family subscriber. This equates to assistance ranging from 7% to 87% of the total
16 proposed premium depending on the pool and the selected product.

17 Additionally, Direct Pay subscribers who have incomes between 201% and 350%
18 FPL are eligible for Level 2. Over the course of the 12-month rating period, Level 2 will provide
19 \$648 for each eligible individual subscriber and \$1,224 for each eligible family, on a monthly
20 basis. This equates to assistance ranging from 5% to 57% of the total proposed premium
21 depending on the pool and the selected product.

22 Q. What are the federal annual income poverty levels and how does that
23 relate to Direct Pay demographics?

1 A. The 2009 federal poverty levels are expected to be released in February of
2 2009. Once released, Blue Cross intends to implement the new levels on the income guidelines
3 for April 1, 2009. The 2008 federal poverty levels are as follows:

Family Size	100%	200%	350%
1	\$10,400	\$20,800	\$36,400
2	\$14,000	\$28,000	\$49,000
3	\$17,600	\$35,200	\$61,600
4	\$21,200	\$42,400	\$74,200

4
5 Approximately 7,500 or 79% of Direct Pay contracts are for individual coverage.

6 With respect to family coverage, the average size family in Direct Pay is three persons.

7 Q. How much has Blue Cross set aside for AccessBlue?

8 A. In 2006, Blue Cross set aside \$9 million to provide assistance through this
9 program and in 2008 Blue Cross has set aside an additional \$2 million. Blue Cross' goal is to
10 generate sufficiently favorable ongoing financial results so that a portion of the favorable results
11 can continue to be available to fund worthy programs such as AccessBlue. This money was set
12 aside solely to provide assistance to qualified Rhode Islanders and to ensure that assistance could
13 continue to be provided through this program during periods when Blue Cross' financial results
14 may not enable a dividend, or return, in the form of additional funding.

15 Q. How long will Blue Cross continue AccessBlue?

16 A. AccessBlue is entering its fourth year and Blue Cross continues to study it,
17 and adapt the program as its effectiveness and Blue Cross' means of support warrant.
18 Underpinning the program's ongoing viability is the need for Blue Cross to be able to implement
19 actuarially justified, adequate premium rates – for Direct Pay, as well as all other segments of
20 business. The program is monitored closely by Blue Cross, and future funding, payment levels,

1 and eligibility will be modified or terminated as appropriate. Based on the current expenditure
2 level, funding for the program is expected to run out in 2012.

3 Q. What is the availability of Class DIR to the public?

4 A. Blue Cross and its Board of Directors have taken pride in the fact the
5 Direct Pay program has been offered to anyone who wants it (who is not eligible for other
6 employer or government provided coverage) and that, because of Blue Cross, there is no one
7 who is uninsurable in the state of Rhode Island from an availability perspective. There are
8 several ways to qualify for coverage. The most common way is through Rhode Island Gen. Laws
9 § 27-18.5-3, which provides that coverage is guaranteed for our Pool I Basic rate for eligible
10 individuals and families who have had creditable coverage that ended less than 63 days prior and
11 was in force for 12 continuous months or was in force for 18 months with no breaks of more than
12 63 days. The Pool II plans are available to any eligible individual or family who can meet our
13 medical underwriting guidelines throughout the year. Finally, Blue Cross also offers guaranteed
14 coverage during open enrollment.

15 Q. Has Blue Cross recently conducted an open enrollment?

16 A. Yes. The last open enrollment was held between May 15, 2008 and June
17 15, 2008 for a July 1, 2008 effective date. Open enrollment was advertised on BCBSRI.com as
18 well as in the Providence Journal on May 14, 2008 and during the weeks of May 12th and 19th
19 2008 in the Rhode Island Newspaper Group (RING) newspapers. In addition, individuals who
20 applied and were not eligible to join throughout the year were sent a postcard reminding them
21 about open enrollment.

22 As a result of this most recently completed open enrollment approximately 540
23 new applications were received with 206 for Basic rates (Pool I) and 334 for Preferred rates

1 (Pool II). Subscribers who pass the health screen can enroll at any time during the year into
2 Preferred rates (Pool II).

3 Q. When was the last rate increase implemented for the Direct Pay Class?

4 A. The last rate increase was effective April 1, 2008. This was the result of a
5 filing for Class DIR that was submitted to the OHIC on November 15, 2007. On February 15,
6 2008 the rate filing was approved with some modifications.

7 Q. As a result of the February 15, 2008 decision by the OHIC, can you
8 quantify what the modifications were that were made?

9 A. Yes. As a result of the decision by the OHIC, the required rate increase
10 was reduced by 4.0%. This reduction was comprised of the following six items; an elimination
11 of the contribution to reserve component, an elimination of the wellness health benefit plan
12 component, a reduction to the Direct Pay budget, a reduction to the core system component, a
13 reduction due to affordability principles, and a reduction related to inpatient utilization rates.

14 Q. Was there disagreement with the actuarial development or assumptions
15 identified in the decision?

16 A. There were no disagreements with any underlying assumptions or the
17 actuarial methodology. However, during the hearing, updated information became available and
18 resulted in a reduction to both the Direct Pay administrative budget and the Direct Pay portion of
19 the new system charge.

20 Q. I am showing you a document marked as Blue Cross Exhibit 2 for
21 identification. Would you please identify it?

22 A. These are actuarial schedules that were enclosed with exhibit 1 and
23 submitted as support of the calculation of the required rates for both Basic (Pool I) and Preferred

1 (Pool II). They apply to Class DIR for the rate year commencing April 1, 2009. Blue Cross
2 exhibit 2 consists of schedules 1 through 46.

3 Q. I am showing you a document marked as Blue Cross exhibit 3 for
4 identification. Please describe what is contained in this document.

5 A. Blue Cross exhibit 3 is entitled “Trend and Comparison Supplement
6 Submitted in Conjunction with the Direct Pay Rate Filing Effective April 1, 2009.” This exhibit
7 compares trends used in the current and previous Direct Pay filings with actual historical claims
8 trends and industry average rating trends. Also included in this exhibit is a comparison of Blue
9 Cross’ medical loss ratios, administrative expenses, and premium rates and benefits to other
10 regional plans offering coverage to the individual market.

11 Q. Are the required rates the same for comparable products between Basic
12 (Pool I) and Preferred (Pool II)?

13 A. No. As I indicated previously, Basic (Pool I) utilizes community rates,
14 while Preferred (Pool II) rates vary by the underwritten subscriber’s age and gender.
15 Furthermore, the development of their respective required rates in this filing reflects some of the
16 difference in claims expense levels experienced between Basic (Pool I) and Preferred (Pool II).

17 Q. How does this difference in claims expense levels experienced by Blue
18 Cross between Basic (Pool I) vs. Preferred (Pool II) affect the respective required rates?

19 A. It causes the underlying level of the Preferred (Pool II) rates to be
20 relatively lower, and correspondingly the level of the Basic (Pool I) rates to be relatively higher.

21 Q. Does this reflection of a portion of the difference in experience between
22 pools affect the overall aggregate amount of premium revenue required by Blue Cross for Class
23 DIR in total?

1 A. No. The aggregate premium revenue required is unchanged.

2 Q. Does the fact that only a portion of the experience difference is utilized to
3 separate the rates for the two pools imply that one pool has some subsidization effect on the
4 other pool?

5 A. That is correct. The Basic rates (Pool I) are subsidized to some degree by
6 the Preferred (Pool II) rates.

7 Q. How did Blue Cross determine the amount of subsidy that the Preferred
8 rates (Pool II) should provide to the Basic rates (Pool I)?

9 A. In setting the relationships for this rating period we reviewed the
10 experience of the pools separately. The Basic pool (Pool I) experience on its own indicated that
11 a 19.5% increase was necessary. The Preferred pool (Pool II) experience indicated that a 20.7%
12 decrease was possible. Although we would like to continue to reduce the subsidizing that Pool II
13 does for Pool I, we feel that some cross subsidization is appropriate, and completely eliminating
14 the cross subsidy between the pools would be too large a rate increase to ask of Pool I
15 subscribers. Instead we decided we would limit the average Pool 1 increase to 6.8%. In order to
16 meet the overall premium requirements of the Direct Pay pool, this decision meant that an
17 average Pool II rate increase of 4.3% would be required.

18 Q. You mention that the proposed average increases are 6.8% and 4.3% for
19 Pool 1 and Pool 2, respectively. Does this imply that the proposed rate increases vary within
20 each pool?

21 A. Yes. In addition to reducing the cross subsidy across rating pools, we are
22 also changing the rate relationships between the products. The current rate relationships have
23 been in effect since the Direct Pay product portfolio was redesigned effective April 1, 2006.

1 Since then, the emerging claims experience indicates that a different allocation of premium
2 amongst the products is appropriate.

3 Q. How did you determine the appropriate rate relationship between the
4 products for use in this filing?

5 A. We looked at the claims experience for each product and determined that
6 it was appropriate to increase the rate differential between the HealthMate Direct products and
7 the HealthMate for HSA products. However, we did not feel that it was appropriate to give any
8 particular rate class a decrease in rates at the expense of other subscribers. Therefore, we set the
9 rate relationships so that the healthiest class of subscribers, those in Pool 2 enrolled in
10 HealthMate for HSA 5000, would receive a zero percent rate increase. The rate relativity factors
11 for the HealthMate Direct products were then rebalanced to achieve the required revenue overall
12 for Class DIR. However, the rate relationships between the two HealthMate Direct products and
13 the two HealthMate for HSA products were maintained.

14 Q. Did you prepare or cause to be prepared Blue Cross Exhibit 1 for
15 identification and the actuarial schedules attached thereto, marked as Blue Cross Exhibit 2?

16 A. Yes. These rate calculations and the actuarial assumptions and
17 methodology underlying the required rates were developed under my direction by the actuarial
18 staff at Blue Cross.

19 Q. Are you of the opinion that these rate calculations and the actuarial
20 assumptions and methodology underlying these required rates are actuarially sound?

21 A. Yes.

22 Q. Would you please describe in general terms the purpose of this filing?

1 A. The purpose of the filing is to seek approval of new subscription rates to
2 be effective for the April 1, 2009 billing cycle. The filing schedules are intended to provide
3 actuarial justification for the required rates needed by Blue Cross in order for the products to be
4 financially self-supporting, both in the interest of its subscribers and its mission to provide
5 quality health insurance programs.

6 The required subscription rates must provide for the expected costs of the
7 products and contribute to the financial needs of Blue Cross. Such required rates are intended to
8 provide sufficient income during the new rate period to cover the costs of subscribers' incurred
9 claims for this period and to administer the programs. In addition, the required rate levels must
10 include a contribution to reserve component that will contribute Class DIR's fair share toward
11 maintaining corporate reserves at an adequate level. The required rates also provide subscribers
12 an investment income credit.

13 Q. Did the Blue Cross Board of Directors authorize this filing?

14 A. Yes. The Blue Cross Board of Directors met on November 6, 2008, at
15 which time this filing was considered, discussed, and approved for submission. The Directors'
16 Finance Committee, which has primary oversight of all rate matters, also reviewed and
17 authorized this filing at its meeting, held on September 25, 2008.

18 Q. Based upon your job responsibilities and based upon your discussions with
19 the officers and Directors of Blue Cross, as well as all information to which you have been privy
20 as a result of your duties at Blue Cross, are you familiar with the issues considered by Blue Cross
21 and its Directors with respect to the interest of Blue Cross and with respect to the public interest
22 in requesting the rates which are the subject of this rate proceeding?

23 A. Yes, I am.

1 Q. Would you please describe what Blue Cross and its Directors considered
2 regarding the interest of the public with respect to the proposed rates?

3 A. Yes. Blue Cross and its Directors have historically taken the position that
4 Direct Pay should recover not only its claims and administrative expenses, but it should
5 contribute its fair share towards corporate reserves. This over-arching long-term policy remains
6 unchanged.

7 Q. Would you please describe, in general terms, any product changes being
8 proposed in connection with the subscription rates developed in this filing?

9 A. Yes. There are no major product or benefit changes being proposed at this
10 time. There are, however, a couple of minor benefit changes related to recently enacted
11 mandated benefits and our transition to our new core system.

12 Effective January 1, 2009, HealthMate Direct 400 and HealthMate Direct 2000
13 will apply a \$50 copayment per ambulance service in accordance with 2008 R.I. Pub. Laws Ch.
14 68 and 70. Also effective January 1, 2009, in accordance with R.I. Pub. Laws Ch. 253, all of our
15 Class DIR products will cover medically necessary enteral nutrition products for patients with
16 certain specified illnesses, when determined to be medically necessary and ordered by a
17 physician under the medical equipment and medical supplies benefit up to a limit \$2,500 per
18 member per calendar year.

19 In conjunction with the implementation of our new core system, which has a
20 target implementation date of July 1, 2009 for Direct Pay, Blue Cross is making the following
21 changes to the Class DIR products. Blue Cross is expanding the list of preventive services
22 covered pre-deductible on all of the Class DIR products to include the following colorectal
23 cancer screenings: fecal occult blood testing, flex sigmoidoscopies, colonoscopies and double

1 contrast barium enemas. These tests will be covered in accordance with our medical policy.
2 Blue Cross will also be changing the way the family deductible and out of pocket maximums are
3 calculated on HealthMate Direct 400 and 2000. The family deductible will be met by adding the
4 amount of covered healthcare expenses applied to the deductible for all family members;
5 however no one family member will contribute more than the individual deductible amount
6 towards the calendar year family deductible. The family out of pocket maximum will be
7 calculated in the same fashion. Lastly, on HealthMate Direct 400 and 2000, anti-neoplastic
8 drugs used for cancer treatment will be covered in accordance with the member's injectable
9 drug, infused drug and pharmacy benefits and no longer covered at 100%. The injectable and
10 infused drug benefits apply the deductible and coinsurance up to the calendar year out of pocket
11 maximum. Once the out of pocket maximum is met the member's coverage will increase to
12 100%. The pharmacy benefit will apply to these drugs when purchased at a retail or mail order
13 pharmacy. The specialty drug benefit will continue to apply to these drugs when they are
14 purchased at a specialty pharmacy. This change is being implemented to be consistent with the
15 coverage of anti-neoplastic drugs used for the treatment of members with other diseases or
16 conditions.

17 Q. Are there any other changes being proposed in this rate filing?

18 A. Yes. Effective January 1, 2009, Blue Cross has decided not to renew its
19 organ transplant reinsurance contract with BCS Insurance Company. As of that date, Blue Cross
20 will be liable for 100% of the organ transplant claims incurred by Direct Pay members.

21 Q. Why is the decision now being made to eliminate organ transplant
22 reinsurance for Class DIR?

1 A. Blue Cross has purchased organ transplant reinsurance for Class DIR since
2 1998. At that time, Blue Cross was experiencing its third consecutive year of significant losses
3 and, as a result, corporate reserves were severely eroded. At the end of 1998, Blue Cross
4 corporate reserves were at approximately \$76.6M, or only 11.4% of annual premium. Given our
5 financial position, we felt that we needed to insulate ourselves from the potentially significant
6 shock of claims that could arise from organ transplants. Since that time, however, we have built
7 our reserves to a much healthier position. As of September 30, 2008, our reserves stand at
8 \$443.8M, or 25.0% of annual premiums. We feel our current reserve position gives us the ability
9 to absorb potentially high organ transplant claims without adversely affecting our financial
10 strength and eliminates our need for outside reinsurance. Additionally our claim experience has
11 convinced us that organ transplantation is a much less likely source of large catastrophic claims
12 than we had initially feared it would be.

13 Q. Will the elimination of organ transplant reinsurance result in more rate
14 fluctuation for Class DIR?

15 A. No. In the last five years, there have been 43 claims incurred by Direct
16 Pay members that cost over \$100,000. Only one of these claims was due to an organ transplant
17 case. Accordingly we do not feel there is any need to focus special attention on these types of
18 claims. We also point out that by chiefly focusing on the aggregate required rate increase our
19 DIR rating methodology automatically dampens the impact of random statistical fluctuations due
20 to “shock” claims in the rate increases applied to any particular product and pool cohort.

21 Q. Will the elimination of the organ transplant reinsurance impact subscriber benefits?

22 A. No. The organ transplant benefit will remain the same and the elimination
23 of the reinsurance will be seamless to the subscribers.

1 Q. How will the elimination of organ transplant reinsurance impact the rates
2 proposed in this filing?

3 A. With the elimination of the organ transplant reinsurance, Blue Cross will
4 be able to pass along approximately 1% in premium savings. This premium savings is reflected
5 in the rates proposed in this filing.

6 Q. In last year's rate filing, you mentioned that Blue Cross had purchased a
7 new underwriting manual and was transitioning to the new underwriting procedures in early
8 2008. Could you provide an update of your progress in this area?

9 A. Yes. The Medical Underwriting department completed its testing of the new
10 medical manual, Milliman Individual Medical Underwriting Guidelines (IMUGs) and
11 implemented it effective April 1, 2008. We believe these guidelines strike the correct balance
12 between qualifying as many people as possible for Pool II while at the same time keeping its risk
13 pool relatively clean in order to keep Pool II rates as low as possible. Since the new
14 underwriting guidelines were implemented, as of September 30, 2008, 55% of applications
15 undergoing a medical review were accepted into Pool II.

16 Q. Let us turn now to Blue Cross Exhibit 2, namely the actuarial schedules
17 enclosed with the filing letter marked as Exhibit 1. Please describe for us of what schedules 1
18 through 3 consist.

19 A. Schedules 1 through 3 constitute the table of contents for the actuarial
20 schedules in exhibit 2 that display and support the calculations of the required subscription rates
21 for the April 1, 2009 billing cycle for Class DIR. The actuarial schedules are grouped into
22 sections, labeled as section I through section VII.

23 Q. Please describe briefly what is contained in each of these seven sections.

1 A. Section I consists of schedules 4 through 9, which summarize the
2 calculations of the Basic (Pool I) monthly subscription rates for the April 2009 billing cycle.
3 The monthly subscription rates for each of the Class DIR products for Basic (Pool I) subscribers
4 are displayed separately for those under age 65 vs. ages 65 and over, and by individual vs. family
5 contract type.

6 Section II consists of schedules 10 through 15, which summarize the calculations
7 of the Preferred (Pool II) required monthly subscription rates for the April 2009 billing cycle.
8 These schedules display the monthly subscription rates for each of the Class DIR products for
9 Preferred (Pool II) subscribers by age, gender, and individual vs. family contract type.

10 Section III consists of schedules 16 through 21, which summarize the calculation
11 of the Basic (Pool I) and Preferred (Pool II) monthly base rates for each of the products. This
12 includes the development of the required rates for the two pools within Class DIR overall, so that
13 they can be experience-adjusted.

14 Section IV consists of schedules 22 through 26, which summarize the claims
15 impacts from state assessments. Schedule 23 shows a summary of the overall impacts of each
16 assessment, while the subsequent schedules show the detail behind each one.

17 Section V consists of schedules 27 through 36, which show the projected claims
18 by plan for Direct Pay and calculate the rate period projected incurred claims expense for Basic
19 (Pool I) and Preferred (Pool II) subscribers. Schedule 28 summarizes the projected claims
20 expense by pool and plan for Direct Pay while schedules 29 through 36 calculate the projected
21 claims expense by plan for Basic (Pool I) and Preferred (Pool II).

22 Section VI consists of schedules 37 through 39, providing the administrative
23 expense estimates and calculations.

1 Section VII consists of schedules 40 through 46, and contains trends and
2 projection factors. As part of this, under separate cover, schedule 41 is being submitted on a
3 confidential basis. This schedule displays trend projection factors for incurred allowed claims
4 projections for the various lines of business.

1 **III. RATING METHODOLOGY USED IN FILING**

2

3 Q. Can you please provide an overview of the approach used by Blue Cross
4 to calculate the required rates for Class DIR?

5 A. Yes. The actuarial development of required rates for this filing is similar
6 to the methodology used last year. The basic approach was to begin with base period incurred
7 allowed claims, separately for Basic (Pool I) and Preferred (Pool II) and by benefit plan. To
8 avoid seasonality concerns we chose a twelve month base period which is our usual practice.
9 We chose a base period that consists of allowed claims incurred over the June 1, 2007 to May 31,
10 2008. These allowed claims, expressed on a per contract per month (PCPM) basis, were then
11 projected to the rate period using projection factors which reflect anticipated trends in allowed
12 claims levels and adjusted to reflect anticipated policy, contract, and other changes not reflected
13 in either utilization or pure price trends. Finally, the projected rate period allowed claims were
14 adjusted by a factor that represents the ratio of net claims paid to allowed claims for each benefit
15 plan. These net-to-allowed factors were calculated based on the projected rate period claims so
16 that the effect of trend leveraging would be accounted for. A more thorough description of trend
17 leveraging is included later on in my testimony. This process produced projected paid claims
18 PCPM for each of the products within Basic (Pool I) and Preferred (Pool II). The composite
19 projected paid claims PCPM was then calculated for each pool.

20 The next major stage in the rate development was to determine the required
21 monthly base rates for each of the four products within Basic (Pool I) and Preferred (Pool II).
22 This stage begins with the composite projected incurred claims expense PCPM for each pool,
23 which I have just described. The impact of state assessments was then applied to the projected

1 incurred claims cost. The detail behind the state assessments is in Section IV. To this expense
2 was added retention (administrative expense, investment income credit, contribution to reserve,
3 new system expense, and taxes) to calculate required income PCPM by pool and then overall for
4 Class DIR. Note that in this year's rate filing, the contribution to reserve/tax liability component
5 includes 1.75% to account for the newly revised state premium assessment. This increase in the
6 premium assessment was enacted on June 26, 2008 to be effective January 1, 2009. Also, this
7 year's filing includes a component intended to collect revenue to fund a new core system for
8 claims payment and other business functions. The development of this new system is consistent
9 with Blue Cross' goal to simplify and streamline systems and processes. The new core system
10 was discussed in detail in last year's filing and during the rate hearing. Consistent with the
11 required monthly income PCPM values, required loss ratios for each pool and overall for Class
12 DIR are calculated.

13 The overall required income PCPM for Class DIR is the amount that must be
14 produced by the base rates for Class DIR as a whole. The separate amounts PCPM for Basic
15 (Pool I) and Preferred (Pool II) would be the amounts used in developing the base rates for each
16 of the pools, respectively, if the separate experience of the two pools were to form the sole basis
17 for rates. This experience has not been the basis used in the past, and we chose not to use it as
18 the sole basis in this filing. Instead, we elected to partially reflect the separate experience of the
19 two pools. Thus experience adjusted loss ratios were calculated for Basic (Pool I) and Preferred
20 (Pool II) for use in developing their respective revenue PCPM amounts.

21 The experience-adjusted projected loss ratio for Basic (Pool I) was set by deciding
22 to increase Basic (Pool I) rates by an overall 6.8%. As discussed earlier in my testimony, the
23 6.8% rate increase was chosen as a reasonable compromise between our desire to keep Pool I

1 rates affordable and our desire to reduce the Pool II subsidy of Pool I rates. Finally, since the
2 overall projected loss ratio for Class DIR should not change as a result of this alignment of rates
3 between pools, the corresponding experience-adjusted projected loss ratio and experience-
4 adjusted required income PCPM for Preferred (Pool II) were then calculated directly.

5 The last step in calculating base rates was to apply rate relativity factors, by
6 product, to the pool experience-adjusted composite required base rate amounts PCPM. These
7 calculations and results are presented in the schedules contained in Section III. As mentioned
8 previously, the rate relativity factors are being revised with this year's rate filing to more
9 properly align the rate relationships amongst the products to the emerging experience.

10 The final stage in the rate development was to apply age/gender, individual and
11 family rate, and rate-tier normalization factors to the base rates, by product and pool in order to
12 produce the monthly subscription rates. The age/gender and individual/family rate factors are
13 the same as those used in last year's rate filing. It should be noted that there is no explicit rate
14 component being added to the rates for organ transplant benefits as in previous filings. For the
15 reasons previously discussed, Blue Cross has decided to discontinue its reinsurance arrangement
16 with BCS Insurance Group. The costs for organ transplant benefits will be included explicitly in
17 the claims base used for the rate filing insofar as there were organ transplant claims incurred
18 during that period. These calculations and results are presented in the schedules contained in
19 sections I and II for Basic (Pool I) and Preferred (Pool II) respectively.

20 Q. In your description of the basic approach taken to develop the required
21 rates, you state that the starting point was base period incurred allowed claims, as opposed to
22 base period incurred claims expense amounts. Please describe the difference and why allowed
23 claims were used instead of claims expense.

1 A. The difference between allowed claims and claims expense is attributable
2 to deductibles, coinsurance, and co-payments amounts, which are the responsibility of the
3 subscriber. Claims expense reflects the benefit payment amounts under the terms of the
4 particular product. Allowed claims include both claims expense amounts and subscriber cost-
5 sharing amounts. It is the total cost of covered services under the provider contracts maintained
6 by Blue Cross prior to the determination of subscriber cost-sharing, versus Blue Cross benefit
7 payments.

8 Claims expense varies widely from one product to another if the benefit
9 provisions differ significantly, and products with relatively large deductibles have claims
10 expense levels which are skewed during the course of a year, due to deductible accumulations.
11 In addition, the year-to-year increase in claims expense is leveraged by fixed dollar cost-sharing
12 – such as deductibles and per service copayments. The impact of these characteristics is
13 exacerbated when the mix of subscribers by product is changing. Allowed claims, by contrast,
14 do not vary in these ways. In the rate development, base period allowed claims were used as the
15 starting point in order to deal most effectively with these issues.

16 Q. Later in your description of the basic approach taken to developing the
17 required rates, you indicate that the projected allowed claims were adjusted to reflect policy,
18 contract, and other changes and then adjusted to the net benefit level using net-to-allowed
19 factors. Please explain how the factors to accomplish this were developed.

20 A. A claims adjustment factor was applied to the projected allowed claims to
21 adjust for anticipated changes not related to utilization/mix of services or price increases. These
22 include a change in the way Blue Cross reimburses pathologists, the impact of the Radiology
23 Management program, the impact of a contract extension negotiated with Wellpoint effective

1 January 1, 2009, the impact of anticipated new brand name drugs being introduced to the market,
2 and the anticipated availability of new generic drugs.

3 Blue Cross is changing the way it reimburses pathologists at certain hospitals.
4 Previously, the pathologist payment was included in the reimbursement to the hospital. Blue
5 Cross anticipates that, going forward, reimbursements will be sent directly to the pathologist, in
6 accordance with our negotiated fee schedule. This change in payment policy is expected to
7 occur in April 2009 and October 2009 and will impact inpatient and outpatient payments.

8 A claims adjustment factor is also included for the prescription drug line of
9 business to adjust for terms of a new contract with Wellpoint, our pharmacy benefit manager,
10 effective January 1, 2009. Also included in the drug claims adjustment factor are the impacts of
11 anticipated new brand name drugs becoming available in the market and the anticipated
12 availability of new generic equivalents.

13 The Radiology Management program, which has been discussed in previous rate
14 filings, was effective January 1, 2008. The adjustment factor is calculated separately for
15 outpatient and surgical/medical services as the expected savings divided by the base period
16 allowed claims.

17 We also used net-to-allowed factors to adjust the projected allowed dollars to the
18 claims level anticipated to be paid by Blue Cross under each benefit plan. Blue Cross used a re-
19 adjudication process to develop net to allowed factors, which reflect the ratio of claims expense
20 to allowed claims for the benefits under a given product. This methodology is consistent with
21 last year's filing and similar to that employed by Blue Cross in the past to estimate the impact of
22 changes in benefit costs. The first step in the calculation of non-drug net-to-allowed factors for
23 the HealthMate Direct 400 and HealthMate Direct 2000 plans and in the calculation of total net-

1 to-allowed factors for HealthMate for HSA 3000 and HealthMate for HSA 5000 plans was to
2 project incurred allowed claims for Class DIR from the twelve month period ending March 31,
3 2008 to the twelve month rate projection period ending March 31, 2010. The projected rate year
4 allowed claims were then re-adjudicated to the payment level anticipated under each of the
5 respective benefit plans. The ratio of the projected rate period claims at the level paid under the
6 benefit provisions to the total allowed claims level is what we refer to as a net-to-allowed factor.
7 For the calculation of the drug net-to-allowed factors, the projected allowed claims were re-
8 adjudicated to the level of benefits anticipated in the rating period, including the change in
9 benefits and pricing due to the new Specialty Pharmacy program.

10 Q. You mentioned previously that the method of projecting allowed dollars
11 and re-adjudicating to the net benefit level was used to deal with the issue of trend leveraging.
12 Could you explain what is meant by trend leveraging?

13 A. Yes. Briefly, trend leveraging describes the phenomenon that for benefit
14 plans with fixed-dollar cost sharing, claims on a net paid dollar basis increase at a faster rate than
15 claims on an allowed dollar basis if the fixed-dollar cost sharing (i.e. deductibles and co-
16 payments) does not change from year to year. For example, let's say that the underlying increase
17 in medical costs (i.e. the trend in allowed claims) is ten percent annually. Let's further assume
18 that in a given year, one hundred dollars of allowed claims is incurred. As mentioned earlier, the
19 trend in allowed dollars is ten percent and one hundred ten allowed dollars are incurred in the
20 following year. However, if we impose a fifty dollar deductible on the benefit plan, the net
21 claims expense becomes fifty dollars (\$100-\$50) in the first year and sixty dollars in the
22 following year (\$110-\$50). The annual trend in claims expense in this case has been leveraged
23 to 20% (\$60 divided by \$50). The same phenomenon occurs in the Direct Pay products due to

1 the upfront deductibles and other fixed-dollar co-payments in the benefit provisions. Since
2 members do not utilize benefits consistently, the effect of trend leveraging is best handled by
3 projecting and re-adjudicating claims at the member level. This is the process involved in the
4 calculation of the net-to-allowed factors.

5 Q. Toward the latter part of your description of the basic approach taken to
6 develop the required rates, you describe the determination of experience-adjusted composite
7 required base rate amounts PCPM by pool. Is the composite of these Basic (Pool I) and
8 Preferred (Pool II) amounts simply the required average rate PCPM for the entire Class DIR?

9 A. Yes, that is correct.

10 Q. You indicate that Blue Cross elected to target a 6.8% rate increase for
11 Basic (Pool I) in adjusting rate relations between pools. Is that correct?

12 A. Yes.

13 Q. If Blue Cross had elected to use 100% of the experience difference in
14 developing the rates, how would the required rates have differed from those filed?

15 A. If the full experience difference had been reflected, Preferred (Pool II)
16 rates would have been about 24% lower, and Basic (Pool I) rates would have been about 12%
17 higher.

18 Q. If, alternatively, Blue Cross had elected to use the current rate alignment
19 with no adjustment for experience differences in developing the rates, how would the required
20 rates have differed from those filed?

21 A. If no adjustment were made for experience differences, Preferred (Pool II)
22 rates would have been about two percentage points higher, and Basic (Pool I) rates would have
23 been about one percentage point lower.

1 Q. From an actuarial perspective, do you believe it is appropriate to reflect
2 some or all of the experience difference between pools in developing the required rates?

3 A. From an actuarial perspective, I believe that doing so is warranted and
4 appropriate. Although the two pools are part of the same Class DIR, they have separate
5 eligibility requirements; and as a result the two pools have different risk characteristics and
6 different experience levels.

7 Q. Near the end of your description of the basic approach taken to developing
8 the required rates, you indicate that the final step in calculating base rates was to apply product
9 rate relativity factors to the pool experience-adjusted composite required base rate amounts
10 PCPM. Please explain how this was done.

11 A. The product rate relativity factors were applied in the same manner as
12 previous filings to develop required monthly base rates for each product. As mentioned
13 previously, the rate relativity factors have been revised with this year's rate filing to more closely
14 align the rates to the emerging experience. The rate relativity factors were revised so as to target
15 a 0% increase for Preferred (Pool II) members enrolled in the HealthMate for HSA 5000 product.

1 Q. On a column-by-column basis, would you explain what is contained in
2 schedules 29 through 32? Please note any relevant differences among them.

3 A. The first and second columns of each of these schedules show base period
4 incurred allowed claims for each of the respective products. As indicated in the applicable
5 footnotes, and as I indicated earlier in my testimony, allowed claims were tabulated prior to the
6 application of deductibles, coinsurance, or copayments. We used a base period for tabulating
7 these allowed claims, and for the contract months underlying column (2), of June 2007 through
8 May 2008. Incurred allowed claims amounts for this base period reflect actual claim
9 submissions through July 2008, adjusted to a fully complete basis.

10 Column (3) shows the projection factors used to incorporate trends into the
11 projection of allowed claims PCPM for the rate period. The projection factors are developed in
12 schedule 41, as indicated in the footnotes. Consistent projection factors are used in all four
13 schedules.

14 Column (4) shows a claims adjustment factor used to account for anticipated
15 policy changes, contract changes, and one time claims impacts that are not reflected in utilization
16 or pure price trends. These adjustments include the Radiology Management program, direct
17 payments to pathologists, Wellpoint contract savings, and anticipated increases in the generic
18 dispensing rate.

19 Column (5) displays the projected allowed claims PCPM. This column is the
20 product of columns (2) through (4).

21 Column (6) displays the Net-to-Allowed factors by benefit. These factors convert
22 the projected allowed claims to paid claims for the rate year. The factors are unique to each
23 combination of pool and plan since these factors are calculated using the actual claims

1 experience for each pool and plan combination. Since the HealthMate Direct 400 and
2 HealthMate Direct 2000 products have first dollar coverage for drug benefits (i.e. drug benefits
3 are covered without members first having to meet a deductible), separate net-to-allowed factors
4 are calculated for these products. The HealthMate for HSA 3000 and HealthMate for HSA 5000
5 products cover drug benefits only after the deductible has been met. Therefore, net-to-allowed
6 factors for these products are calculated in aggregate for drug and non-drug benefits.

7 Column (7) is the product of columns (5) and (6). Column (7) represents the
8 projected paid claims PCPM by benefit for the rate year.

9 Q. You state that schedules 29 through 32 apply to Basic (Pool I) only. Are
10 there comparable schedules for Preferred (Pool II)?

11 A. Yes. They are schedules 33 through 36.

12 Q. Are there any differences between schedules 33 through 36 and schedules
13 29 through 32, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

14 A. No. The same calculations are carried out, and the same issues are
15 present.

16

17

18 **[Pages 35 to 37 are intentionally omitted as they have been filed**
19 **separately on a confidential basis under seal]**

1 Q. With regard to the utilization / mix trend factors shown in schedule 41,
2 you state that they were developed from an analysis by your staff of historical trends. Please
3 describe the nature of this analysis.

4 A. The utilization / mix trend analysis undertaken by my staff focused on
5 inpatient hospital days for the hospital inpatient line of business, and on allowed claims PCPM
6 that have been adjusted to a common price level, namely June 2005, for the hospital outpatient
7 and surgical / medical lines of business. For pharmacy, allowed claims PCPM without any price
8 adjustment were analyzed.

9 The data points used in this analysis were 12-month moving values, beginning
10 with the period ending May 2006. Twenty-five data points, which equates to three years of
11 experience, were looked at. The last fifteen points were used, rather than the traditional twenty-
12 five, to avoid the complications associated with mixing claims data from both before and after
13 the portfolio redesign effective April 2006. It is very well accepted that member cost sharing has
14 an impact on the utilization of medical services so the experience under the prior benefit plans is
15 not a reliable indicator of the utilization we should expect under the new plans. Trend lines were
16 fit to a number of sets of data points utilizing the method of linear least squares, a statistical
17 technique for quantifying trend levels. Following standard Blue Cross procedures, calculations
18 were made to determine the line that best fit the data points using the most recent 13 or more
19 data points, with a minimum R-squared value of 0.70 to help assure reasonable fit to the data
20 points.

21 The annual trend indicated by the least squares line producing the best fit under
22 this procedure is then selected as the basis for the trend assumption, provided the result is

1 acceptable actuarially. Adjustment or modification to this result, or substitution of an alternative
2 assumption, may occur if it is not reasonable or appropriate in our actuarial judgment.

3 Q. Could you please elaborate on the least squares calculation method?

4 A. This is the method that has been utilized and presented in past rate filings
5 for quantifying trends. It has been discussed extensively in previous rate hearings. Briefly, by
6 plotting a number of historical observations on a graph, the average change over a specified time
7 period may be calculated using a statistical technique referred to as the method of linear least
8 squares.

9 For the observations plotted on the graph, a general trend – either up, down or
10 neutral – may be observed by visual inspection of the line plotted on the graph. That is, it may
11 be possible to detect that a succession of points on the graph are generally higher than, lower
12 than, or about the same as the previous points. The method of linear least squares quantifies this
13 average change in values over time by use of a statistical computation.

14 The principle of least squares states that the line of best fit to a series of observed
15 values is the line where the sum of the squares of the deviations (the differences between the line
16 and the actual values) are minimal, or the least possible. While one may attempt to draw a
17 straight line through the observations by visual interpretation to denote a trend, the method of
18 least squares obtains that minimum sum of squared deviations necessary to give a best linear fit
19 of the data.

20 Q. Would you please describe the methodology in terms of the number of
21 data points used in order to find the best fit?

22 A. Yes. We considered a total of 15 monthly 12-month moving data points.
23 As I just mentioned, the use of more than 15 monthly 12-month moving data points would

1 involve including data prior to the portfolio redesign, which we wanted to avoid. The number of
2 data points consisting of the most recent 13 or more points that provide the best fit was
3 calculated, as I just described. There was no discretion in the selection of the number of data
4 points; it was mathematically determined. There is only one possible best fit, which is the
5 number of data points that produces the line with the highest R-squared value.

6 Once the number of 13 or more of the most recent data points that provides the
7 best fit is found, the trend indication based on those data points is what we utilize in the rate
8 calculations, provided that the best fit is actuarially acceptable. A trend line within an r-squared
9 value of 0.70 or higher is generally considered statistically acceptable to us; however,
10 information to the contrary, such as a non-credible experience base or an erratic or biased pattern
11 of data points, in addition to a low r-squared value, or when the result is unreasonable, may
12 provide reasons to utilize actuarial judgment in trend determination.

13 Q. In your opinion, is the use of less than 13 of the most recent monthly 12-
14 month data points appropriate as an actuarial method for quantifying utilization / mix?

15 A. No. In my opinion, fewer than 13 of these points do not provide sufficient
16 historical data from which to measure an underlying trend level.

17 Q. Does Blue Cross consistently use at least 13 monthly 12-month data points
18 in the calculation of the best fit whether or not it provides to Blue Cross a higher rate than some
19 other number of data points?

20 A. Yes, provided the best fit produces results that are actuarially acceptable.

21 Q. Is a good fit a valid measure of an underlying trend?

22 A. In the absence of information to the contrary, it normally is a reasonable
23 indicator.

1 Q. As a matter of statistical principle, is it correct that the better the fit, the
2 greater the validity of the trend measurement?

3 A. Yes.

4 Q. Is the choice of the best fit within a displayed number of data points
5 discretionary?

6 A. No. There is only one best linear fit. One cannot pick and choose best
7 fits.

8 Q. Would you briefly describe what utilization is and what mix is as these
9 terms have been used in the various schedules and in your testimony?

10 A. Utilization refers to the rate of use of covered services by subscribers.
11 Mix of services refers to the change in distribution of claims amounts by factors affecting the
12 amounts such as changes in the types of claims, procedures and services performed, providers
13 rendering service and other changes in the types of services used as opposed to the rate of use.

14 Q. Were there any adjustments made to the data used for the trend analysis
15 you just described?

16 A. Yes. Certain adjustments were made to normalize for changes in benefits
17 or pricing policies that have occurred over the experience period used to measure trend. Also,
18 certain modest adjustments were made to the allowed claims PCPM under pharmacy, in order to
19 reflect global changes in the pricing, quantities, and over-the-counter dispensing of certain
20 specific prescription drugs.

21 Q. Are you satisfied with the appropriateness of these adjustments to the
22 data?

23 A. Yes.

1 Q. Please turn to schedule 42, and describe what is contained in that schedule.

2 Schedule 42 is entitled "Hospital Inpatient: Historical Days per 1,000 Members and Utilization
3 Trends." This schedule contains a graph displaying annual inpatient days per 1,000 members for
4 25 monthly 12-month moving periods or data points, for total Class DIR. The data points begin
5 with the 12-month period ending May 2006 and continue through the 12-month period ending
6 May 2008. As noted earlier, however, only the latest 15 points were considered for trend
7 evaluation.

8 Trend lines were fit to a number of sets of data points utilizing the method of
9 linear least squares, as I described earlier. Following standard Blue Cross procedures,
10 calculations were made to determine the line that best fit the data points with a minimum of the
11 most recent two years of data (the most recent 13 data points or more). As shown in schedule
12 42, the line with the best fit is based on the most recent 15 data points with an r-squared value of
13 0.9826 and an annual trend of -20.99%. Although the r-squared value met our minimum criteria
14 of 0.70, we do not believe that a -20.99% annual trend can reasonably be expected to continue.
15 Commercial Group inpatient trend factors, approved by the OHIC for groups renewing during or
16 after the fourth quarter 2008, imply an annual increase of 3.02% for utilization and mix. We
17 believe Group's inpatient trend is a reasonable proxy for future Class DIR inpatient trend.
18 However, it is reasonable to mitigate Group's experience in light of the downward Inpatient
19 trend observed for Class DIR. Therefore we selected a neutral 0.00% annual utilization/mix
20 trend for hospital inpatient. This annual trend assumption is documented in the footnotes
21 contained in schedule 41. It should be noted that Inpatient trends are generally less credible than
22 other lines of business due to the relatively low incidence of claim events. Also, since we are

1 projecting from a base period that consists of the twelve months ending May 2008, we are fully
2 recognizing the decreases in inpatient utilization that have occurred to date.

3 Q. Please turn to schedule 43, and describe what is contained in that schedule.

4 A. Schedule 43 is entitled "Hospital Outpatient: Historical Allowed Claims
5 PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims
6 per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The
7 data points begin with the 12-month period ending May 2006 and continue through the 12-month
8 period ending May 2008. Again, only the latest 15 points were considered credible, however. In
9 order to reflect only changes in utilization and mix of services, the allowed claims amounts have
10 been adjusted, or deprecised, to June 2005, so that intervening price increases have been removed
11 from the allowed claim PMPM values used.

12 Trend lines were fit to a number of sets of data points utilizing the method of
13 linear least squares referred to in describing schedule 42 earlier. Similarly, following standard
14 Blue Cross procedures, calculations were made to determine the line that best fit the data points
15 with a minimum of the most recent two years of data. As shown in schedule 43, the line with the
16 best fit is based on 14 data points, which has an r-squared value of 0.8511 and represents a
17 calculated annual trend of 7.21%. However, a utilization trend of 7.21% is somewhat higher
18 than we would anticipate going forward, and seems to be driven by a sharp increase in the most
19 recent points. Thus we weighted this number 50% with the commercial group fourth quarter
20 2008 approved trend of 1.93%, resulting in our filed annual utilization/mix trend of 4.57%. This
21 annual trend assumption is documented in the footnotes contained in schedule 41.

22 Q. Please turn now to schedule 44, and describe what is contained in that
23 schedule.

1 A. Schedule 44 is entitled “Surgical/Medical: Historical Allowed Claims
2 PMPM and Utilization / Mix Trends.” This schedule contains a graph displaying allowed claims
3 PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the
4 12-month period ending May 2006 and continue through the 12-month period ending May 2008.
5 As before, only the 15 data points representing claims data under the new product portfolio were
6 considered. In order to reflect only changes in utilization and mix of services, the allowed claims
7 amounts have been adjusted, or depriced, to June 2005, so that intervening price increases have
8 been removed from the allowed PMPM values used.

9 Again, trend lines were fit to a number of sets of data points utilizing the method
10 of linear least squares. Following standard Blue Cross procedures, calculations were made to
11 determine the line that best fit the data points with a minimum of the most recent two years of
12 data. As shown in schedule 44, the line with the best fit is based on 15 data points, which has an
13 r-squared value of 0.6146 and represents a calculated annual trend of 2.14%. Since the r-squared
14 value does not meet our minimum criteria of 0.70, we selected what we believe to be the most
15 appropriate trend choice, Commercial Group’s fourth quarter 2008 approved trend, which is
16 5.04%. Commercial Group utilization/mix trends for surgical/medical have been in the
17 neighborhood of 5% for the last several quarters. This annual trend assumption is documented in
18 the footnotes contained in schedule 41.

19 Q. Please turn to schedule 45, and describe what is contained in that schedule.

20 A. Schedule 45 is entitled “Pharmacy: Historical Allowed Claims PMPM
21 and Allowed Claims PMPM Trends.” This schedule contains a graph displaying allowed claims
22 PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the

1 12-month period ending May 2006 and continue through the 12-month period ending May 2008.

2 These values have not been deprecised, so their trends reflect both price and utilization/mix.

3 The line exhibiting the best fit, considering only the latest 15 points, produced an
4 annual trend of 5.25%. It consisted of 15 data points, with an r-squared value of 0.8384.

5 Actuarial judgment was exercised by Blue Cross, however. Visual inspection of the graph and
6 an analysis of annual trends by month suggest that the regression trend is dampened by an
7 aberrantly low last couple of data points. Therefore, the calculated trend prior to the last couple
8 of points of 7.00% was selected to minimize the impact of this aberration. It is also worth noting
9 that Commercial Group's \$0 copay pharmacy trend corresponding to their fourth quarter 2008
10 approved increase is 9.12%. This annual trend assumption is documented in the footnotes
11 contained in schedule 41.

12 Q. Would you turn now to schedule 46, and describe what is contained in that
13 schedule?

14 A. Schedule 46 is entitled "Point Values Utilized in Development of Trends."
15 This schedule displays the inpatient days per 1,000 members and allowed claims PMPM values
16 utilized to calculate trends in schedules 42 through 45. The first column shows the dates
17 applicable to each of the 25 monthly 12-month periods observed. Opposite each date are the
18 values reflected in the various graphs set forth in schedules 42 through 45 for each of the
19 applicable lines of business.

20 Q. With regard to the claims adjustment factor shown in column (4) of
21 schedules 29 through 36, could you please describe these factors?

22 A. As indicated in the footnotes, these factors are used to adjust claims
23 expenses for anticipated policy changes, contract changes, and one time claims impacts that are

1 not reflected in utilization or pure price trends. It should be noted that in previous rate filings,
2 these adjustments were already reflected in the base period allowed claims expense. They are
3 broken out and shown separately here.

4 Q. Turning back to schedules 29 through 36, column (6) shows net-to-
5 allowed factors. Could you please describe generally the method used to develop these net-to-
6 allowed factors?

7 A. Sure. To determine net-to-allowed factors, the allowed claims for each
8 Direct Pay member are re-adjudicated to simulate members having each of the current plan
9 designs for the rate year April 2009 to March 2010. The most recent full rate year, April 2007 to
10 March 2008, claims were broken out by each pool and product combination and each category
11 was used in the calculation of the net-to-allowed factor for that particular cohort. For example
12 the April 2007 to March 2008 claims for Basic (Pool I) HealthMate Direct 400 were re-
13 adjudicated in the calculation of the net-to-allowed factor applicable to that pool and product.
14 Since the period used begins in the middle of the calendar year and deductibles are aggregated on
15 a calendar year basis, a multi-step process was utilized to project and re-adjudicate the claims.

16 First, allowed claims for the period January 2007 through December 2007 were
17 projected to the period January 2009 through December 2009 and re-adjudicated to the net
18 payment level for the applicable benefit plan. Next, allowed claims for the period January 2008
19 through March 2008 were projected to the period January 2010 through March 2010 and re-
20 adjudicated to the net benefit level. This data were combined with the last nine months of
21 projected net claims data from the previous step to form the net claims for the rating period. The
22 net-to-allowed factor is then the ratio of the projected net claims expense to the projected rate
23 year allowed claims. The prescription drug net-to-allowed calculations for the HealthMate for

1 HSA 3000 and the HealthMate for HSA 5000 products are incorporated into the medical net-to-
2 allowed calculations, since prescription drug claims for these plans apply towards the deductible.

3 The prescription drug net to allowed calculations for the HealthMate Direct 400
4 and the HealthMate Direct 2000 products are separate from the medical net-to-allowed
5 calculations, since prescription drug claims for these plans do not apply towards the deductible.

6 Q. You have now described and explained the columns in schedules 29
7 through 36, along with the various schedules supporting them. You have stated that schedules
8 29 through 36 develop the projected paid claims PCPM for each of the current products. Now I
9 would like to turn to section III of the rate filing and the development of the monthly base rates.
10 Please turn to schedule 17 and describe that schedule.

11 A. Schedule 17 is entitled “Calculation of Required Monthly Base Rates for
12 April 1, 2009 Billing Cycle.” It applies to Basic (Pool I) only. The purpose of this schedule is to
13 display the calculation of the proposed monthly base rates for each of the products under Basic
14 (Pool I). Calculations are documented in the footnotes.

15 Q. On a column-by-column basis, please explain what is contained in
16 schedule 17.

17 A. Column (1) contains the number of contract months by product. It is used
18 for weighting various amounts.

19 Column (2) shows the composite required monthly base rate for Basic (Pool I).
20 This value represents the projected overall average rate required from Basic (Pool I) subscribers.
21 As indicated in the footnotes, this PCPM value is developed in schedule 19.

22 Column (3) contains the current plan relativity factors for each of the current
23 products.

1 Column (4) shows the Basic (Pool I) current plan relativity monthly base rate for
2 each of the four products. These are the base rates, by product, that correspond to the plan
3 relativities prior to modification which are shown in column (3). This column is shown for
4 informational purposes only. Calculations are documented in the footnotes.

5 Column (5) shows a redistribution factor for each plan. These factors are
6 multiplied by the current plan relativity factor in column (3) to produce the proposed plan
7 relativity factor shown in column (6). The factors were chosen to reduce the cross subsidy
8 between the non-HSA plans and the HSA plans, with the target of a 0% increase, or no overall
9 change, for the HealthMate for HSA 5000 product for Preferred (Pool II) subscribers.

10 Column (6) displays the proposed plan relativity factor for each plan. These are
11 used to distribute the Pool I rate need across plans.

12 Column (7) calculates the proposed monthly base rates for each plan. These are
13 the base rates, by product, that correspond to the plan relativities after modification which are
14 shown in column (6).

15 Q. You state that schedule 17 applies to Basic (Pool I) only. Is there a
16 comparable schedule for Preferred (Pool II)?

17 A. Yes. It is schedule 18.

18 Q. Are there are differences between schedule 18 and schedule 17, other than
19 applying to Preferred (Pool II) vs. Basic (Pool I)?

20 A. No.

21 Q. With regard to the composite required monthly base rate in column (2) of
22 schedules 17 and 18, you refer to their development in schedule 19. Could you please turn to
23 schedule 19 and describe that schedule?

1 A. Schedule 19 is entitled “Calculation of Composite Required Monthly Base
2 Rates for April 1, 2009 Billing Cycle.” This schedule applies to both Basic (Pool I) and
3 Preferred (Pool II). Its purpose is to display the calculation of the composite required monthly
4 base rate, by pool. Calculations are documented in the footnotes.

5 Q. On a column-by-column basis, would you please explain what is
6 contained in schedule 19?

7 A. Column (1) contains the number of contract months for each pool, and
8 column (2) contains the projected incurred claims including mandates for each pool. The
9 sources of these values are documented in the footnotes. Note that the values in column (2) are
10 from schedule 21.

11 Column (3) shows the required loss ratio, full experience basis for Basic (Pool I)
12 and Preferred (Pool II). These ratios are the required loss ratios by pool that would be
13 appropriate for use in developing the composite required monthly base rate if the separate
14 experience for each of the two pools were to be fully used as the basis for developing the
15 respective monthly subscription rates. The Required Loss Ratios, Full Experience Basis in
16 column (3) are developed in schedule 21.

17 Column (4) shows the required loss ratio, current pool rate alignment basis for
18 Basic (Pool I) and Preferred (Pool II). These ratios are the required loss ratios by pool that
19 would be appropriate for use in developing the composite required monthly base rates if the
20 current rate relationships or alignment for the two pools were to be fully maintained as the basis
21 for developing the respective monthly subscription rates. The required loss ratios, current pool
22 rate alignment basis in column (4) are developed in schedule 20.

1 Column (5) shows the required loss ratio, experience adjusted basis for Basic
2 (Pool I) and Preferred (Pool II). These are required loss ratios by pool that are appropriate for
3 use in developing the composite monthly base rates in order to incorporate partial recognition of
4 the separate experience for each of the two pools, along with partial recognition of the current
5 pool rate alignments. For Basic (Pool I), a 6.8% rate increase was targeted to produce the
6 required loss ratio, experience adjusted basis. The corresponding value for Preferred (Pool II) is
7 then calculated so as to retain unchanged the composite value for the pools combined. Column
8 (6) contains the composite required monthly base rate for Basic (Pool I) and Preferred (Pool II).
9 These two PCPM values incorporate the new rate alignment between pools, consistent with
10 partial recognition of the separate experience of the two pools, as reflected by the required loss
11 ratios, experience adjusted basis in column (5). Note that the composite Class DIR required loss
12 ratio remains unchanged through this rate re-alignment process.

13 Q. With regard to the required loss ratios, full experience basis, you refer to
14 their development in schedule 21. Could you please turn to schedule 21 and describe that
15 schedule?

16 A. Schedule 21 is entitled “Calculation of Required Loss Ratios on Full
17 Experience Basis for April 1, 2009 Billing Cycle.” It applies to both Basic (Pool I) and Preferred
18 (Pool II). The purpose of the schedule is to display the calculation of the required loss ratios, full
19 experience basis for each of the two pools. Calculations are documented in the footnotes.

20 Q. On a column-by-column basis, would you explain what is contained in
21 schedule 21?

22 A. Column (1) of schedule 21 shows the contract months for Basic (Pool I)
23 and Preferred (Pool II).

1 Column (2) shows the projected incurred claims expense PCPM. As indicated in
2 the footnotes, these amounts come from schedule 28.

3 Column (3) shows the state assessments impact. As indicated in the footnote, this
4 factor comes from schedule 23.

5 Column (4) shows the projected incurred claims expense PCPM including the
6 impact of state assessments for each of the two pools. This is the product of columns (2) and (3).
7 The sources of these values are documented in the footnotes.

8 Column (5) contains the administrative expense PCPM for the rate period. As
9 indicated in the footnotes, the value contained in column (5) is developed in schedule 38.

10 Column (7) contains the investment income credit PCPM amounts. The
11 investment income credit is the amount by which required subscription income is reduced due to
12 anticipated earnings from invested funds.

13 The investment income credit is calculated by looking at three values that
14 generate funds used to produce investment earnings, namely, the reserve level of the Class in
15 question, prepaid subscriptions, and claim reserves. These amounts, after adjusting for only
16 those funds that will be available for investment, are used to generate earnings. Based on a
17 projection of such amounts, a determination was made of the appropriate investment income
18 credit factor, expressed as a percent of projected incurred claims and administrative expense.
19 This calculation produced the investment income credit factor of 0.19% indicated in the
20 footnotes to schedule 21. This investment income credit factor was then used to calculate the
21 “Investment Income Credit PCPM” shown in Column (7) of schedule 21.

22 Column (8) contains the rating component for the new core system. Like last
23 year, Blue Cross intends to continue to collect the revenue required to implement the new claims

1 payment system by way of a charge on rates. This year the rates contain a factor equal to 0.33%
2 of premium. The new system expenses will be amortized across all lines of business, including
3 self-insured accounts, over the expected lifetime of the system. Since we expect to collect the
4 same flat dollar amount per year, it is anticipated that this rate inclusion will decline over time as
5 a percent of premium. Calculations are documented in the footnotes.

6 Column (9) contains the contribution to reserve/ tax liability PCPM values for the
7 rate period. The contribution to reserve and tax liability component is the amount requested by
8 Blue Cross to include in the Class DIR subscription rates in order to contribute to the
9 establishment and maintenance of reserves maintained by Blue Cross for the protection of its
10 subscribers. As mentioned earlier, the contribution to reserve/tax liability component includes
11 1.75% for the recently increased state premium tax assessment on health insurance premiums.
12 The tax is levied pursuant to P.L. 2008, ch. 100, as enacted by House Bill 7390 Substitute A as
13 amended, as enacted by Article 32 Substitute A as amended, which amended in relevant parts
14 R.I.G.L. § 27-20.1-2 and § 44-17-1. This bill (i.e. the budget) was enacted on June 26, 2008,
15 with Article 32 becoming effective January 1, 2009.

16 The factor used to calculate column (9) is based on the requested contribution to
17 reserve as a percentage of income plus one quarter of the amount for federal income taxes plus
18 an additional 1.75% for the aforementioned state premium assessment. Thus, in this case, the
19 contribution to reserve of 2% requires 0.5% for federal taxes (20% of the pre-tax gain). The
20 combined contribution to reserve and tax PCPM is then calculated using a factor of 0.9575.

21 The remaining columns in schedule 21 are calculated using the values I just
22 described. These calculations are documented in the footnotes. Column (11) then contains the
23 required loss ratios calculated for Basic (Pool I) and Preferred (Pool II), on a full experience

1 basis. That means that the Basic (Pool I) value reflects the projected required loss ratio based
2 fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

3 Q. You mention a state assessments impact factor in column (3) of schedule
4 21. Could you please explain the calculation of this factor.

5 A. Of course. Section IV shows the development of this factor. Section IV
6 starts with schedule 23. Schedule 23 is titled "Calculation of Claims Impact of State
7 Assessments" and illustrates the different assessments that have an impact on the rates being
8 filed for Class DIR. The total impact of these is also shown at the bottom. The detail behind
9 each of these calculations is supplied in schedules 24 through 26. The total impact of these
10 elements is 1.01% to claims expense.

11 Q. Can you please run through each of the schedules 24 through 26 that you
12 just mentioned and describe those for us?

13 A. Schedule 24 is titled "Calculation of Claims Impact of Child
14 Immunization Assessment". This assessment will be made as a percentage of premium at an
15 estimated rate of 0.50%, which we translate into a factor equal to 0.51% of projected claims.

16 Schedule 25 is titled "Calculation of Claims Impact of Adult Immunization
17 Assessment". This assessment will be made as a percentage of premium at an estimated rate of
18 0.15%, which we translate into a factor equal to 0.15% of projected claims.

19 Schedule 26 is titled "Calculation of Claims Impact of CEDARR, CIS, and Home
20 Services". This assessment will be made as a percentage of premium at an estimated rate of
21 0.345%. This has an overall impact on Class DIR projected claims of 0.35%.

22 Q. Have State Assessments of the above sort been included in Class DIR
23 rates in the past?

1 A. Yes. These State Assessments were included in the Class DIR rate filing
2 effective April 1, 2008.

3 Q. Is it appropriate to include these assessments in the rate calculations for
4 the Class DIR line of business?

5 A. Yes. The determination of these assessments to Blue Cross is based on
6 premium reported on annual financial statements, including premium for the Class DIR line of
7 business. As such, we do not believe we can absorb these costs in our other lines without
8 threatening our competitive standing in those market segments. We believe that the only
9 appropriate way of insulating DIR from these costs (if indeed the Legislature wishes to so
10 insulate DIR) is to define future bases for assessments in such a way as to exclude DIR business.

11 Q. With regard to the administrative expense PCPM shown in column (5) of
12 schedule 21, you refer to its development in schedule 38. Could you please turn to schedule 38
13 and describe that schedule?

14 A. Schedule 38 is entitled “Calculation of Administrative Expense per
15 Contract Month for April 1, 2009 Billing Cycle.” It applies to both Basic (Pool I) and Preferred
16 (Pool II). The purpose of this schedule is to weight together Blue Cross’ administrative expense
17 PCPM amounts for 2009 and 2010 from schedule 39, to produce an appropriate amount for the
18 April 1, 2009 billing cycle.

19 Q. Would you please turn to schedule 39 and explain what that is?

20 A. Schedule 39 is entitled “Calculation of Calendar Year 2009 and Calendar
21 Year 2010 Administrative Expense per Contract Month.” It applies to both Basic (Pool I) and
22 Preferred (Pool II). Schedule 39 displays the calendar year 2009 and 2010 administrative
23 expense budget amounts, in aggregate and PCPM.

1 Q. What is the basis of the projections for the values utilized for operating
2 expense for Class DIR?

3 A. A large portion of Class DIR operating expenses is allocated rather than
4 direct. Consequently, in order to project operating expenses on their own merit, independent of
5 increases in health care costs, the provision of operating expenses in this filing is based upon
6 expense budgets for CY2008, CY2009, and CY2010 developed internally by Blue Cross for
7 Class DIR.

8 Q. How are the 2008, 2009, and 2010 Class DIR operating expense budget
9 amounts determined?

10 A. In preparation for this Class DIR filing, we developed estimated budgets
11 for Class DIR calendar years 2008, 2009, and 2010. Attached hereto as Blue Cross Exhibit 5 is a
12 document entitled “Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of
13 CY09 Budget to CY08 Projected Actual by Natural Account.” Blue Cross Exhibit 5 compares by
14 natural account (1) 2008 Projected Operating Expenses to (2) the 2009 Operating Expense
15 Budget. The CY08 Budget is based on actual reported expenditures in 2008, with an estimate for
16 the remainder of the year. The CY09 amounts reflect the budget for the calendar year. The third
17 column of Blue Cross Exhibit 5 shows the dollar increase or decrease between CY08 Projected
18 and CY09 Budget. The fourth column shows the percentage increase or decrease. As stated at the
19 bottom of Blue Cross Exhibit 5, the methodology used to create the 2009 budget was to estimate
20 the Class DIR operating expenses for 2008 by category and then adjust for inflation and certain
21 other factors.

22 For purposes of this filing, the calendar year 2009 budget results in a total
23 budgeted amount for Class DIR of \$6,178,686, as reflected in column 1 of schedule 39 of Blue

1 Cross Exhibit 2. This in turn was divided by total projected Class DIR contract months for 2009
2 of 117,528 for a projected total Class DIR operating expense per contract month figure of \$52.57
3 for calendar 2009. See column 3 of schedule 39 of Blue Cross Exhibit 2.

4 For 2010 attached hereto as Blue Cross Exhibit 6 is a document entitled “Blue
5 Cross & Blue Shield of Rhode Island Direct Pay – Comparison of CY10 Budget to CY09 Budget
6 by Natural Account.” Exhibit 6 employs the same format as exhibit 5, except that it compares
7 CY10 to CY09. The CY10 budget amount of \$6,400,134 as reflected in column 1 of schedule 39
8 of Blue Cross Exhibit 2 is divided by the total projected Class DIR contract months for 2010 of
9 117,528, for a projected total Class DIR operating expense per contract month figure of \$54.46.
10 The methodology involves a projected no change in enrollment for volume sensitive departments
11 and items for 2010 over 2009.

12 Attached hereto as Blue Cross Exhibit 7 is a detailed narrative breaking down the
13 administrative expenses for the Direct Pay budget.

14 Q. Blue Cross recently announced it laid off 41 employees and cut 33 vacant
15 positions. How does that impact the budget numbers contained in exhibits 5, 6, and 7.

16 A. The budget numbers reflected in the referenced exhibits were developed
17 assuming that corporate enrollment would be essentially unchanged from 2008 and before the
18 decision was made to layoff 41 employees and eliminate 33 vacant positions. While the total
19 corporate expense budget was reduced by the staffing reductions (and other budget cuts) our
20 projected enrollment will be 10% lower in 2009 than in 2008. The result of the effect of the
21 enrollment decline exceeding the expense budget reduction is that the resulting PMPM operating
22 expense for all remaining enrollment would increase. Considering the late developments in the

1 rate filing process Blue Cross has made a policy decision to not increase the Direct Pay expense
2 budget which would have increased the required rate increase.

3 Q. Please turn back to schedule 21. In your testimony regarding column (9)
4 of this schedule, you described the nature of the contribution to reserve / tax liability PCPM and
5 its calculation. You also indicate that a factor of .9575 was used, in order to produce an after-tax
6 contribution to reserve of 2% of subscription income. Is that correct?

7 A. Yes.

8 Q. Why is an after-tax contribution to reserve of 2% appropriate for this line
9 of business?

10 A. A recent financial forecast analysis concluded that with the continued use
11 of reserve contribution factors currently approved by OHIC (1.35% for large group business,
12 1.33% for small group business, 0.35% for Direct Pay, 1.33% for Plan 65 non-group, and 1.33%
13 for Plan 65 group), Blue Cross' surplus levels as a percent of annual premium are projected to
14 fall below 23% of annual premium (the minimum of the Blue Cross surplus range recommended
15 by the Lewin report) by the end of calendar year (CY) 2009. Given current claims cost trends,
16 and the amortization of the new computer system costs, a reserve contribution level of 2% (in
17 addition to the new system provision) will be necessary to return Blue Cross' reserves to 23% of
18 annual premium by the end of CY 2013.

19 Q. What is the reserve status of Class DIR?

20 A. The Class DIR reserve position at September 30, 2008 was \$(5,255,982),
21 or (1.15) months in reserve. The Class DIR reserve position at March 31, 2009 is projected to be
22 approximately \$(4.8) million. These reserve positions are indicated on a Statutory Accounting
23 Principles (SAP) basis and assume no unrealized capital gains or losses.

1 Q. What is the corporate reserve status of Blue Cross?

2 A. Blue Cross' reserve position at September 30, 2008 was \$443,807,205, or
3 3.15 months in reserve, on a SAP basis.

4 Q. What is the reserve target for Blue Cross?

5 A. Blue Cross' reserve target is a range of 25% to 35% of annual insured
6 premium. This target is a result from a review of our reserve requirements conducted by
7 Milliman USA ("Milliman"), our consulting actuaries, in early to mid 2000 (updated in 2003).
8 The purpose of the review was to determine the appropriate level of reserves in order to provide
9 Blue Cross and its subscribers with the financial stability necessary to avoid a financial crisis
10 such as that experienced by Blue Cross in 1996 through 1998 (the third such loss cycle
11 experienced by Blue Cross since 1980). The 1996 through 1998 loss cycle not only endangered
12 the future of Blue Cross as an independent, nonprofit, locally controlled Blues Plan, but also
13 caused the liquidations of Harvard Pilgrim Health Care of New England, Inc. and Tufts Health
14 Plan of New England, Inc. which had been doing business at the time in Rhode Island. The
15 Milliman study set our target range for corporate reserves at 25% to 35% of annual insured
16 premium. A second opinion on our reserve requirement was sought from the actuarial consulting
17 firm of Reden and Anders. The results of that study confirmed the validity of Milliman's reserve
18 range. Additionally in 2006, pursuant to a legislative directive, the OHIC conducted a study to
19 evaluate the reserve requirements of Rhode Island's domestically located health insurers. The
20 report of the Lewin Group recommended a reserve level ranging from 23% to 31% of insured
21 premium for Blue Cross. In our view, the Lewin Report validated the necessity of adequate
22 reserves and the reasonableness of our established reserve target.

1 Note that Blue Cross of Rhode Island was ranked 21st out of 36 Blue Cross Plans
2 nationally in health risk-based capital, as of June 30, 2008.

3 Q. Are reserves for Class DIR projected to be below the 25% to 35% of
4 annual premium current target range during the rate period for which rates are sought?

5 A. Yes. Assuming the requested rates are implemented as filed it is projected
6 that at the end of the rate year (March 31, 2010), Class DIR will still have a projected negative
7 reserve balance of (\$4.3) million.

8 Q. Please turn back to schedule 19. In your testimony pertaining to schedule
9 19, you describe three required loss ratio bases. Is that correct?

10 A. Yes.

11 Q. The first of these three required loss ratio bases you describe is the full
12 experience basis in column (3), which you describe in your testimony pertaining to schedule 21.
13 Is that also correct?

14 A. Yes.

15 Q. The second of these three required loss ratio bases you describe is the
16 current pool rate alignment basis in column (4), which you indicate is developed in schedule 20.
17 Is that correct?

18 A. Yes.

19 Q. Please turn to schedule 20 and describe that schedule.

20 A. Schedule 20 is entitled "Calculation of Required Loss Ratios on Current
21 Pool Rate Alignment Basis for April 1, 2009 Billing Cycle." It applies to both Basic (Pool I) and
22 Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss

1 ratio, current pool rate alignment basis for each of the two pools. Calculations are documented
2 in the footnotes.

3 The overall Class DIR required income PCPM is developed in schedule 21. The
4 same overall Class DIR required income PCPM is preserved in schedule 20. The respective
5 amounts by pool, however, differ between schedule 21 and 20. In schedule 21, the required
6 Income PCPM amounts by pool directly reflect the separate experience of each pool. Schedule
7 20 develops required income PCPM amounts by pool which reflect the current alignment of rates
8 by pool, rather than pool experience. In both cases, schedules 21 and 20, the composite average
9 required income PCPM must remain the same.

10 Q. On a column-by-column basis, would you explain what is contained in
11 schedule 20?

12 A. Column (1) of schedule 20 shows the contract months for Basic (Pool I)
13 and Preferred (Pool II). Column (2) shows the projected incurred claims including mandates
14 amounts for each of the two pools. The sources of these values are documented in the footnotes.

15 Column (3) contains the composite required income PCPM amount for Class DIR
16 as a whole. This amount is developed in schedule 21, which I described earlier in my testimony.

17 Column (4) contains the present rate income PCPM (PRI) amounts on an average
18 basis for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The composite average
19 PRI for all of Class DIR is the weighted average of the PRI amounts for Basic (Pool I) and
20 Preferred (Pool II), as documented in the footnotes.

21 Column (5) contains the current pool rate alignment basis required income PCPM
22 amounts for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The calculations are
23 documented in the footnotes. The Class DIR composite in column (5) is required to be the same

1 as in column (3), as I just discussed in my testimony. The respective required income PCPM
2 amounts by pool in column (5) are calculated to maintain the same proportionate relationship as
3 the PRI values in column (4), i.e., no re-alignment in rates between pools.

4 Column (6) contains the required loss ratios calculated for Basic (Pool I) and
5 Preferred (Pool II), on a current pool rate alignment basis. This means that the Basic (Pool I) and
6 Preferred (Pool II) values would retain the same relationship in required rates as is reflected in
7 the present rates.

8 Q. Please turn back to schedule 19 once again. You have now described the
9 development of the required loss ratios, full experience basis in column (3) and the required loss
10 ratios, current pool rate alignment basis in column (4). Is that correct?

11 A. Yes.

12 Q. The third of the three required loss ratio bases, shown in column (5) of
13 schedule 19, is labeled "Required Loss Ratio, Experience Adjusted Basis." You explain this
14 third set of required loss ratios in your testimony as being based on a blending of the preceding
15 two sets of required loss ratios. You state that the required loss ratio, experience adjusted basis in
16 column (5) was then used by Blue Cross in calculating the composite required monthly base
17 rates in column (6). Is all this correct?

18 A. Yes.

19 Q. Please turn now to schedule 5 and describe that schedule.

20 A. Schedule 5 is entitled "Calculation of HealthMate Direct 400 Required
21 Monthly Subscription Rates for April 1, 2009 Billing Cycle." It applies to Basic (Pool I) only.
22 The purpose of this schedule is to display the calculation of the monthly subscription rates for
23 individual and family subscribers in Basic (Pool I), separately for subscribers under age 65

1 versus age 65 and over. Monthly subscription rates in schedule 5 are shown separately on a
2 required rate basis. Calculations are documented in the footnotes.

3 Q. How does schedule 5 compare with schedules 6 through 8?

4 A. Schedules 6 through 8 are comparable in nature. They also apply to Basic
5 (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000,
6 HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas schedule 5
7 applies to HealthMate Direct 400.

8 Q. On a column-by-column basis, would you explain what is contained in
9 schedules 5 through 8?

10 A. Column (1) contains the monthly base rate for each of the corresponding
11 products for Basic (Pool I). As indicated in the footnotes, the monthly base rates for Basic (Pool
12 I) are developed in schedule 17.

13 Column (2) is labeled “Rate Tier Normalization Factor.” This is the
14 normalization factor that corrects any imbalance in the rate factors contained in columns (4) and
15 (6) of schedules 5 through 8, determined across the entire pool. The rate tier normalization
16 factor is developed in schedule 9.

17 Column (3) is simply column (1) divided by column (2).

18 Column (4) contains the individual rate factors, and column (6) contains the
19 family rate factors. These are the factors needed to convert the normalized monthly base rate for
20 the product and pool to monthly subscription rates for individual and family contracts and,
21 within each, for under age 65 and age 65 and over subscriber rating categories. The rate factors
22 used are the same factors that were used in last year’s rate filing for class DIR.

1 Columns (5) and (7) contain the monthly subscription rates for the individual and
2 family subscriber categories, respectively. The calculations are documented in the footnotes.

3 Q. With regard to the rate tier normalization factor in column (2) of schedules
4 5 through 8 you refer to its development in schedule 9. Could you please turn to schedule 9 and
5 describe that schedule?

6 A. Schedule 9 is entitled “Calculation of Rate Tier Normalization Factor”.
7 Column (1) is the “Rate Factor” that converts monthly normalized base rates to monthly
8 subscription rates for individual, family, under 65, and ages 65 and over rating categories. These
9 are the same factors used in last year’s filing.

10 Columns (2), (3), (4), and (5) represent the base period contract months for each
11 of the current products.

12 Column (6) is just an aggregation of the four preceding columns.

13 Lines (1) through (5) simply represent the enrollment by tier category and in total.

14 Row (6) represents the proposed rate relativity factors for each plan that are
15 calculated on schedule 17, as mentioned in the footnote.

16 The remaining lines show the computational steps, as explained in the footnotes.

17 Q. Please turn back now to schedule 5. You described the calculations
18 involved in columns (5) and (7) of schedule 5. The result is what is shown in these two columns
19 as the Basic (Pool I) monthly subscription rates for HealthMate Direct 400. Is that correct?

20 A. Yes. The resulting monthly subscription rates are contained in columns
21 (5) and (7) for individual and family subscribers, respectively.

1 Q. Schedule 5 applies to the HealthMate Direct 400 product under Basic
2 (Pool I). You testify that schedules 6 through 8 are comparable, for the other three product rates
3 for Basic (Pool I). Is that also correct?

4 A. Yes.

5 Q. You state that schedules 5 through 8 apply to Basic (Pool I), for each of
6 the four products being offered. Are there comparable schedules for Preferred (Pool II)?

7 A. Yes. Schedules 11 through 14 correspond to schedules 5 through 8, for
8 Preferred (Pool II) versus Basic (Pool I). Schedule 15 also corresponds to schedule 9.

9 Q. Please turn to schedule 11. Are the same calculations carried out for the
10 HealthMate Direct 400 product in schedule 11 for Preferred (Pool II) as in Schedule 5 for Basic
11 (Pool I)?

12 A. The same types of calculations are carried out in schedule 11 for Preferred
13 (Pool II) as in schedule 5 for Basic (Pool I). I would note that the format and structure of
14 schedule 11 differs slightly from schedule 5; labeling and rate development is consistent,
15 however. The structural difference occurs since Preferred (Pool II) has separate individual rates
16 for male vs. female subscribers, and has rates for subscribers under age 65 that vary by age band.

17 Q. You state that schedules 11 through 14 for each of the Preferred (Pool II)
18 products correspond to schedules 5 through 8 for Basic (Pool I). You have just described
19 schedule 11. Are there any differences between schedules 12 through 14 and schedule 11, other
20 than applying to the other products under Preferred (Pool II)?

21 A. No. The same calculations are carried out, and the same issues are
22 present.

1 **V. CONCLUSION**

2 Q. Are the rates developed in exhibit 2 and displayed in schedules 5 through
3 8 and 11 through 14 consistent with rates presented in your letter dated November 21, 2008 and
4 included as Blue Cross Exhibit 1?

5 A. Yes, the rates in these two documents are the same.

6 Q. Were Blue Cross Exhibit 2, schedules 1 through 46 prepared by you or
7 under your direction and supervision?

8 A. Yes. These schedules were prepared by my staff in the Actuarial and
9 Statistical Analysis Department of Blue Cross.

10 Q. Were Blue Cross Exhibit 2, schedules 1 through 46 prepared using
11 generally accepted actuarial principles and were those principles consistently applied?

12 A. Yes.

13 Q. Is it your opinion, to a reasonable degree of actuarial certainty, that Blue
14 Cross Exhibit 2, schedules 1 through 46, reflect fair, accurate and reasonable computations of
15 required rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

16 A. Yes.