

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

In Re: Blue Cross Blue Shield of Rhode Island)
Rates Filed May 15, 2015 for Individual Market Plans) OHIC-2014-1
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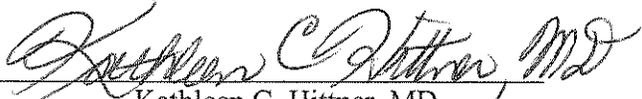
ORDER AND DECISION OF THE COMMISSIONER

Kathleen C. Hittner, MD, Commissioner of the Rhode Island Office of the Health Insurance Commissioner, hereby issues her Order and Decision with respect to the Rate Filing made by Blue Cross Blue Shield of Rhode Island for the Direct Pay line of business on May 15, 2014, after having carefully reviewed the Report and Recommendation of the Hearing Officer dated July 11, 2014, the testimony and exhibits entered into the record, the arguments of the parties, and the comments made by members of the public.

The Commissioner adopts and accepts the Report and Recommendation of the Hearing Office, including its Findings of Fact, and Conclusions of Law.

Wherefore it is hereby ORDERED that the modified rate increase recommended by the Hearing Officer is APPROVED, consistent with the Hearing Officer's Report.

Dated at Cranston, Rhode Island this 16 day of July, 2014.


Kathleen C. Hittner, MD
Health Insurance Commissioner

THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER**

IN RE: BLUE CROSS BLUE SHIELD OF : OHIC-2014-1
RHODE ISLAND RATES FILED :
MAY 15, 2014 FOR INDIVIDUAL :
MARKET PLANS :

REPORT AND RECOMMENDATION

I. INTRODUCTION

This Report and Recommendation is submitted to Commissioner Kathleen C. Hittner, M.D., Office of Health Insurance Commissioner (hereinafter “OHIC”), in connection with the Rate Request filed on May 15, 2014, by Blue Cross Blue Shield of Rhode Island (hereinafter “Blue Cross”). The Rate Request seeks approval of rates for subscribers in the individual or Direct Pay markets (“Filing”). The Filing originally sought an overall average rate increase of 12.3%. As discussed more fully below, the proposed rate increase was lowered by 4% as a result of several adjustments agreed upon by the parties.

This Report and Recommendation addresses the reasonableness of the requested rate increase. I am mindful of the legislative mandate that requires Blue Cross to provide “affordable and accessible health insurance to insureds,” R.I. Gen. Laws § 27-19.2-3(1), for a “comprehensive range of consumers, including business owners, employees and unemployed individuals.” R.I. Gen. Laws § 27-19.2-3(5). There is likewise a statutory mandate to ensure that Blue Cross remains financially sound. R.I. Gen. Laws § 42-14.5-2. Thus, the Filing brings into play two competing but valid interests, *i.e.*, the need to provide affordable health insurance to Rhode Islanders and to likewise ensure the financial viability of Blue Cross.

It is the role of the Commissioner to approve or modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6. When determining the appropriateness of

the rate, it is necessary to ensure that Blue Cross is providing affordable products and that it “has implemented effective strategies to enhance the affordability of its products.” OHIC Regulation 1, Section 9(b). The Commissioner must determine that Blue Cross has proven, by a preponderance of the evidence, that the Rate Request is consistent with the conduct of its business and in compliance with the interests of the public. *Blue Cross & Blue Shield of RI v. McConaghy*, PC No. 04-6806 (RI Super. 2005).

The Filing must also meet the requirements imposed by the Patient Protection and Affordable Care Act (hereinafter “ACA”). The Filing must comply with all requirements imposed by the ACA and imposes a number of restrictions on the setting of rates, including anti-discriminatory practices and rates that vary by gender or by health status.

II. THE HEARING

A. Jurisdiction

The Office of the Health Insurance Commissioner has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

B. Hearing Officer

On May 16, 2014, the Health Insurance Commissioner appointed Raymond A. Marcaccio, Esq. as the Hearing Officer for this matter. Hearing Officer Marcaccio was directed to make recommended Findings of Fact and Conclusions of Law to the Commissioner.

C. Notice of the Hearing

Pursuant to a Scheduling Order entered on May 27, 2014, this matter was scheduled for evidentiary hearings on June 19 and June 20, 2014. Likewise, the public was invited to appear

before the Hearing Officer to provide comments concerning the Blue Cross rate proposal on June 19 and June 20, 2014. The Filing was advertised, in accordance with applicable law and with the aforesaid Order, in a newspaper of general circulation, the *Providence Journal*, on June 9, 2014.

D. Pre-Filed Testimony, Exhibits and Witnesses

Prior to the commencement of the evidentiary hearing, the Attorney General and OHIC engaged in pre-hearing discovery with Blue Cross to determine the basis for Blue Cross' Rate Request. The Attorney General issued its First Set of Data Requests on May 19, 2014 and made subsequent data requests on May 21, 27, 30, and likewise on June 2 and June 3, 2014. OHIC issued its own discovery requests to Blue Cross on May 27 and 29, and also on June 9, 10 and 12, 2014.

Blue Cross submitted Exhibit 1, which is its Rate Filing dated May 15, 2014, as well as Exhibit 2, which is its proof and substance of the public notice to Direct Pay subscribers. At the conclusion of the hearing and in accordance with the Hearing Officer's Order dated June 25, 2014, Blue Cross submitted an additional exhibit which was entered and marked as AG-K-a. By agreement of the parties, and given the commercial and proprietary nature of the data contained therein, the exhibit was ordered to be sealed. That exhibit, along with AG-K – which also included commercial and proprietary information of Blue Cross – were the only two documents that were sealed during the hearing. All of Blue Cross' exhibits were admitted as full by agreement of the parties.

The Attorney General submitted the actuary report of Barbara Niehus, FSA, MAAA (hereinafter "Niehus"), who served as the expert actuary on behalf of the Attorney General. The report consisted of Exhibit A, with attachments AGBN-1 through AGBN-11. The Attorney

General also introduced AG-B through AG-T, each of which was admitted as full by agreement of the parties.

OHIC submitted a report by its consulting actuary, Charles C. DeWeese, FSA, MAAA (hereinafter “DeWeese”), which was admitted in full as Exhibit 1, as well as Exhibits 1A, 2, 3A, 3B, 4A, 4B, 5, 6, 7A, 8A, 8B, 9, 10, 11, 13, 14, 16, 17, 19-34, each of which were marked as full by agreement of the parties. Likewise, OHIC introduced Exhibit 35 for identification only.

Over the course of the two-day evidentiary hearing, Blue Cross presented testimony from its actuary, Jeffrey McLane, FSA, MAAA (“McLane”); David Fogerty, managing Director of Financial Planning and Strategic Sourcing for Blue Cross; and Augustin Manocchia, M.D., Senior Vice President and Chief Medical Officer for Blue Cross. The Attorney General presented testimony from Ms. Niehus and OHIC presented testimony from Mr. DeWeese.

E. Public Comment

The public commented on the proposed rate increase through emails and letters and also through live testimony at the hearing. A number of the comments submitted were sobering. One self-employed businesswoman appeared on June 19 and state that her premiums for Advantage Blue Direct rose from \$547.21 per month to \$808.97 per month, an increase of 40%. In order to reduce the premium increases, she adjusted her co-pays. That resulted in a change to her co-pay for one drug to rise from \$2.00 per month to \$80.00 per month.

Other people shared similar stories of hardship from the dramatic rise in premiums last year. The comments were unanimous in expressing concern with the ability to provide health insurance coverage to themselves and their family members.

III. STANDARD OF REVIEW

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

IV. DISCUSSION

A. *Agreed Upon Adjustments to the 12.3% Proposed Rate Increase*

As stated above, the Filing originally requested 12.3% overall average rate increase with a corresponding 8.9% increase to the Essential Health Benefit (“EHB”)¹, or \$341.68 for the EHB Base Rate. Tr. I at 46, McLane Testimony.

The change to the EHB Base Rate will most closely translate to an equal change in the rate each subscriber will pay. Tr. II at 33, Niehus Testimony. The average change in the overall rates, initially proposed at 12.3%, will not measure the actual impact on any individual subscriber, whose rates may experience a greater or lesser change. *Id.*

Each of the actuary expert witnesses agree that the 12.3% proposed rate increase needs to be adjusted due to the following three factors: 1) additional revenues anticipated in 2015 from

¹ Essential Health Benefit is defined as: “A core package of items and services that must be covered under health plans offered in the individual and small group markets, both inside and outside of Health Insurance Exchanges beginning in 2014. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services, preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.” Blue Cross Glossary at 2.

the federal government, 2) a calculation error made to the projected reinsurance revenues, and 3) an adjustment to the costs associated with new enrollees due to age characteristics. By consensus, these three adjustments reduce the proposed rate increase by 4%. Each of these three factors is now discussed.

1. Anticipated Increase in the Transitional Reinsurance Program from the Federal Government for 2015.

The proposed rate for the 2015 Direct Pay market needs to be adjusted downward due to the anticipated change in the level of reimbursements to be provided by the federal government through the Transitional Reinsurance Program. Section 1341 of the ACA establishes the Transitional Reinsurance Program in order to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. Section 1341(b)(2) of the ACA directs the government to establish a formula for determining the amount of reinsurance payments to be made to health insurance issuers for high-risk individuals in order to provide for the equitable allocation of funds. Blue Cross is eligible for reinsurance payments for a portion of an enrollee's claims that exceed an "attachment point." An attachment point means the "threshold dollar amount for claims costs incurred by a health insurance issuer for an enrolled individual's covered benefits in a benefit year, after which threshold the claims costs for such benefits are eligible for reinsurance payments." 45 CFR § 153.20. Originally, the government set the attachment point at \$70,000. Blue Cross calculated a 5.5% credit to its allowed claims. Tr. I at 40, McLane Testimony. However, the parties now anticipate that the federal government will lower the attachment point to \$45,000, which will result in significantly more claims being covered under the Reinsurance Payment program. Tr. I at 40, McLane Testimony. With the lower attachment point, the credit for allowed claims is projected to rise from 5.5 to 8.3%. OHIC Exhibit 1, DeWeese Report at 10. This additional revenue will decrease Blue Cross' proposed rate increase

by approximately 3.2%. Tr. I at 40, McLane Testimony. Thus, the proposed 2015 Rate Request is significantly reduced from 12.3% to approximately 9-9.1% as a result of this single factor.

2. *Error in Calculating Reinsurance Credit.*

The Attorney General's actuary expert witness, Barbara Niehus, discovered an error in Blue Cross' calculation for the projected reinsurance credit. Blue Cross arrived at its calculation for the reinsurance credit by quantifying its 2013 large claims, adjusting them for its projected trends and arriving at its expected claims for 2015. Attorney General Exhibit A, Niehus Report at 4. However, when Ms. Niehus ran that calculation, she discovered that Blue Cross inadvertently omitted approximately 14,000 claim lines from its calculation. Tr. I at 41, McLane Testimony. With all of the claims data properly included, the calculation yields another .5% reduction to the proposed rates for 2015. Tr. I at 41, McLane Testimony.

3. *Population Risk/Morbidity Adjustment.*

An additional correction needs to be made to the proposed rate increase due to an agreed upon adjustment to the projected costs for new members, as a result of age characteristics. Blue Cross originally projected that new enrollees in 2015 will be relatively older than existing members and would be 2% more costly than the 2013 membership. Tr. I at 42, McLane Testimony; Tr. II at 112, DeWeese Testimony. Blue Cross assumed a 2% higher cost for those new members because of age characteristics. However, OHIC's actuary expert, Charles DeWeese, noted that such an assumption failed to recognize that older individuals will pay higher premiums, which will offset some or all of the anticipated increase in costs. OHIC Exhibit A, DeWeese Report at 6; Tr. II at 112, DeWeese Testimony. Blue Cross acknowledges that this offset is actuarially sound and has agreed to remove the 2% adjustment to that population factor. Tr. I at 42, McLane Testimony.

As a result of each of these adjustments, the proposed increase for the 2015 Direct Pay rates falls by a full 4% -- a change from 12.3% to an overall average proposed rate increase of approximately 8.3%. It is expected that the EHB base rate will fall from \$341.68 to \$329.66.

The anticipated changes to the rates will be calculated and verified by the parties once the Commissioner has issued her final Decision.

B. OHIC and Attorney General Challenges to the Filing

Both OHIC and the Attorney General contend that additional adjustments to the Filing are warranted which, if accepted, will further lower the proposed rate increase for 2015. The challenges are directed to: 1) certain utilization/mix trend factors (In-Patient Hospitalization and Other Medical/Services), 2) the population risk morbidity adjustment factor, 3) the financial impact from the retroactive changes to the federal Transitional Reinsurance Program for 2014, 4) the Blue Cross proposed contributions to reserves, 5) charges for abortion coverage, and 6) the diminishing deductible program. Each of these factors are now discussed.

1. Utilization/Mix Trend

The actuarial experts for OHIC and the Attorney General challenge certain claims trend factors. Claims trends are based upon 1) a utilization component, for the projected changes in the *number* of services utilized by covered members, 2) a mix component, for the projected changes in the *types* or severity of services used by covered members, and 3) a price component, for the projected changes in the *costs* of the services (“Utilization/Mix Trend”). *See*, Blue Cross Glossary at 1. A Utilization/Mix trend was developed for Hospital In-Patient, Outpatient, Other Medical/Surgical, and Prescription Drug Services. Blue Cross Exhibit 1, McLane Actuarial Memorandum at 5.

2. *In-Patient Hospital Utilization Trend*

Blue Cross factors in a 1% increase to its in-patient hospital utilization/mix trend for

2015. Mr. McLane explains how he reached this assumption:

For inpatient admissions per 1,000 members the total commercial data produced a best fit line at -1.9% and a latest 12 month trend of -0.7%. This best fit line was based on the latest 13 points of the regression period. When considering all 25 data points, the regression yielded a trend of 0.8%. Based on the fact that the utilization peaked in the middle of the regression period, began to drop and then increased toward the end, a decision was made to use a 1% trend for inpatient.

Blue Cross Exhibit 1, McLane Actuarial Memo at 6. Mr. McLane observed a “sharp increase in [in-patient] costs, followed by a decrease and then leveling off at the end” of the 36 month data period. Tr. I at 55, McLane Testimony. Mr. McLane did not find the sharp increase or decrease to be most accurate and, instead, concluded that a trend factor of .8% was the most appropriate statistical assumption, which he then rounded up to 1%. *Id.* Mr. McLane acknowledged that his regression analysis had a low correlation for reliability. As demonstrated in Exhibit C of the Blue Cross Filing, the regression analysis was based upon the entire commercial market (*i.e.*, Large Group, Small Group and Direct Pay markets) in an effort to produce a more statistically sound analysis. The Direct Pay market is not large enough to achieve that goal, given its low membership, particularly before the implementation of the ACA. *Id.* at 55-56.

In contrast to Blue Cross, both OHIC and the Attorney General opine that a zero percent trend assumption is more appropriate for the in-patient hospitalization factor. Ms. Niehus and Mr. DeWeese find such an assumption to be more consistent with their observations of the long-term trend derived from the data. Tr. II at 145, DeWeese Testimony. Mr. DeWeese observed that the long-term trend, even longer than the 36 month period used by Mr. McLane, demonstrates that there is no growth in the in-patient utilization factor. He observed that even over 36 months, it is “at about the level in the most recent month as it was in the beginning.” Tr.

II at 115. While the figures have moved both up and down, “there’s no clear trend longer than a period of a year or several months.” *Id.* at 115-116. The most recent trend moves in a downward direction. *Id.*

Ms. Niehus’ opinion is consistent with that of Mr. DeWeese. Her testimony focused on the use by Blue Cross of the linear least squared methodology to obtain a “best fit” for the data and the projected trend. The linear least squared methodology takes numerous data points (25) over a period of time (3 years) and “fits” them to a line in order to project future trends. When developing the “best fit” model, the actuary attempts to account for variances, so that s/he can achieve the most accurate outcome. The actuaries present an R-squared value which measures for the variances. Blue Cross applies an R-squared value as close to .7 as possible. Blue Cross Exhibit 1, McLane Actuarial Memorandum at 6. The principle of least squares states that the “line of best fit to a series of observed values is the line where the sum of the squares of the deviations (the difference between the line and the actual values) are minimal, or the least possible.” *Id.* A .7 R-squared value would account for 70% of the variance. A lower R-squared factor would account for a lower percentage of the variance and therefore be less reliable. The higher the R-squared value, the better the line fits the data. When Ms. Niehus used the Blue Cross data, she achieved a “best fit” with an R-squared value of 0.682 that yielded a negative 1.9% trend for in-patient hospitalizations. She likewise testified that Blue Cross’ projected trend of .8% yields a very unreliable R-squared value of 0.281. Tr. I at 160, Niehus Testimony. That means that over 70% of the variance is not accounted for under that model. Such a “very low R-squared value...[is] not a reliable fit.” *Id.* When Ms. Niehus reviewed Blue Cross’ regression analysis at Appendix C of its Filing, relating to utilization trends, including the graphs set forth

therein, she observed that the “numbers jump up and down...but they do hover around zero.” *Id.* at 161.

While Blue Cross’ trend factor of 1% is not unreasonable, I find it more appropriate to utilize a zero percent trend assumption for In-Patient Hospitalization Services. First, consistent with the actuarial testimony submitted by OHIC and the Attorney General, I do not find sufficient evidence to establish a long-term positive trend for In-Patient Hospitalization Services. I am persuaded that the data more closely tracks a neutral (0%) trend for In-Patient Hospitalization. Second, even if I found Blue Cross’ trend assumption equally plausible, I believe that it is appropriate to factor in the statutory mandate to provide affordable insurance to Blue Cross subscribers. That factor, mandated by our Legislature, moves the determination decidedly in favor of the opinion proffered by both OHIC and the Attorney General for zero percent growth for In-Patient Hospitalizations.

I anticipate that this adjustment will reduce both the average rate increase and ENB rate increase by 0.5%, with a corresponding reduction of \$1.43 to the EHB premium rate.

3. *Utilization Trend Assumptions for Other Medical/Surgical Services*

Blue Cross next assumes a 1% trend factor for its Other Medical/Surgical claims. That assumption was derived from historical claims data for Blue Cross’ entire commercial market, *i.e.* the Large Group, Small Group and Direct Pay. The trend analysis is found at Appendix C of the Blue Cross Filing. Mr. McLane determined that the regression analysis produced a “best fit” trend of 0.9%, using 25 data points. Mr. McLane then rounded up his assumption figure to a positive 1% trend. Tr. I at 56, McLane Testimony. Mr. McLane recognized that this analysis produced an R-squared value of .582, which is below the Blue Cross benchmark of .7 for purposes of reliability. Tr. I at 57, McLane Testimony.

OHIC does not challenge the 1% trend assumption for Other Medical/Surgical claims. However, the Attorney General reaches a different conclusion, finding that it would be more appropriate to use an Other Medical/Surgical trend assumption of negative 1%. Ms. Niehus approaches the issue by calculating the utilization trend based upon the Direct Pay market data exclusively (rather than the entire Blue Cross commercial market). She obtained a high R-squared value of 0.872 when performing her regression analysis on the Direct Pay data alone, thereby establishing reliability. However, her analysis resulted in a negative 5.2% trend, which even Ms. Niehus acknowledges is not sustainable. Tr. II at 163, 165, Niehus Testimony. To compensate for this, Ms. Niehus adjusts her negative 5.2% calculation for Other Medical/Surgical to a negative 1%. She testified that it would be consistent with actuarial standards of practice to perform this trend analysis on Direct Pay market data, while nonetheless selecting the data for all other commercial markets to perform the other trend assumptions. Tr. II at 60-62, Niehus Testimony.

While I find Ms. Niehus' argument and analysis to be reasonable, I do not find it to be so persuasive that it rebuts the analysis performed by Blue Cross. I believe that Blue Cross has met its burden of proof by a preponderance of the evidence with respect to the use of a positive 1% trend factor for other medical/surgical claims.

4. Population Risk Morbidity Adjustment Factor

The Attorney General also challenges Blue Cross' assumption relating to the morbidity rate for new enrollees, opining that new enrollees will be 3% healthier than the average Direct Pay subscriber in 2013. Tr. II at 6, Niehus Testimony. Morbidity refers to the incidence and severity of sickness in a defined class or classes of persons. Blue Cross Glossary at 3. Blue Cross and OHIC both assume that the morbidity rate for new members will be similar to existing

members. The Attorney General anticipates better health among new enrollees, reasoning that the primary barrier in Rhode Island to health insurance coverage has historically been cost, not health status. Ms. Niehus observed that in Rhode Island, Blue Cross is required to accept all applicants. Tr. II at 7, Niehus Testimony. In years past, prior to the ACA, there was an open enrollment period, without the need to satisfy underwriting standards. *Id.* at 7. This population of insureds was commonly referred to as Pool I. *Id.* at 8. Lower rates were historically charged to subscribers who met underwriting standards, referred to as Pool II. *Id.* at 8. Ms. Niehus acknowledges that Pool I enrollees historically did have access to subsidies under Access Blue, but the subsidies afforded under that program were not as generous as what is now afforded under the ACA. Tr. II at 9. Thus, in Ms. Niehus' view, the health status barrier lifted by the ACA did not have a significant impact in Rhode Island, since Blue Cross historically offered insurance to Rhode Islanders, regardless of health status. In summary, the primary barrier to Rhode Islanders was the financial costs of insurance. Tr. II at 41.

In 2014, with the implementation of the ACA, approximately 12,000 people (as of April of 2014) are now enrolled, 83% of whom are receiving federal subsidies. Tr. II at 13, Niehus Testimony. This compares with Direct Pay subscribers who continued from 2013, only approximately 25% of whom received subsidies. *Id.* Ms. Niehus reasons that with increased subsidies, the financial barrier is now lifted, and many more healthy people are entering the market. *Id.* As the Attorney General explains, "if the barrier to coverage for the newly enrolled members was cost, rather than underwriting, it is then logical to expect that the people most in need of the insurance would have worked hardest to find a way to afford insurance and would already have been covered in 2013." Attorney General Post-Hearing Memorandum at 15.

5. *Financial Impact From Retroactive Changes to the Federal Transitional Reinsurance Program for Rate Year 2014*

Blue Cross estimates that it will receive an additional \$5.7 million in reinsurance payments for rate year 2014 due to anticipated federal adjustments. The question is what should be done with these additional monies that will be collected in 2015, but relate to the 2014 rate year? Blue Cross intends to accrue the payments for the 2014 rate year. Tr. I at 73, McLane Testimony. However, even with the anticipated additional monies, Blue Cross still projects a loss in 2014. Tr. I at 86. Mr. David Fogerty, Managing Director of Financial Planning, quantified the anticipated adjusted loss to be approximately \$1 million for 2014. Tr. I at 128, Fogerty Testimony. Furthermore, from an accounting perspective, Blue Cross finds that it is more appropriate to adjust the entries to the 2014 Rate Filing, booking the receipt of the monies as an offset to claims incurred in that year, rather than creating a book entry for a subsequent year. *Id.*; *see also*, Tr. I at 73, McLane Testimony.

OHIC ultimately does not challenge Blue Cross' methodology for accounting for this increase in federal government monies. Tr. II at 123, DeWeese Testimony. However, the Attorney General expresses concern that, in the event that these federal transitional monies result in a net gain to Blue Cross for the 2014 rate year, it will constitute a "windfall" to the company. Tr. II at 31, Niehus Testimony. Given these concerns, and consistent with the Attorney General's recommendation, I find it appropriate to order Blue Cross to report on these adjusted reinsurance recovery payments as part of the 2016 rate review process. Blue Cross should fully account for these additional monies so that OHIC, the Attorney General, and the public can assess its financial impact. Given the uncontradicted testimony of Blue Cross, I do not anticipate that these monies will do anything more than reduce the losses that will be sustained by Blue Cross for the 2014 rate year.

Blue Cross disagrees with the Attorney General's position. It observes that, despite the open enrollment under Pool I, a number of people first enrolled under the new High Risk Pool, when it became available a few years ago. Tr. II at 43. Enrollees only qualified for the High Risk Pool program if they did not have insurance during the previous six months. Tr. II at 42-43. Thus, the introduction of the High Risk Pool caused more unhealthy people to enter the market, despite the previously available open enrollment under Pool I. From that, Blue Cross reasons that there was still a demand for insurance from people who were significantly less healthy than the average enrollee, despite the existence of Pool I. Blue Cross thus concludes that there is no reason to project that the 2015 enrollees will be any healthier than the existing members of the Direct Pay market.

I am persuaded by Blue Cross' reasoning. I find its assumption on morbidity to be statistically appropriate. While Ms. Niehus' argument is logical, it simply is not supported by adequate statistical data. We are presently confronted with a very large new enrollment population who are entering the insurance market with no claims history. There is very limited claims experience due to the prolonged open enrollment period, with membership phasing in during the first five months of 2014. Blue Cross Exhibit 1, Actuarial Memorandum at 5. No one can project the morbidity rate, with any level of statistical certainty, for these new enrollees. This uncertainty exposes Blue Cross to significant financial risk. When coupled with the fact that the Direct Pay market sustained a loss of \$14 million between 2010 and 2013 (Blue Cross Exhibit 1, McLane Narrative at 2), I find it appropriate to adopt the neutral morbidity assumption proposed by Blue Cross and supported by OHIC.

6. *Contribution to Reserves or Surplus*

As with its 2014 Rate Filing, Blue Cross requests at 2.34% contribution to its reserves and a .5% contribution for payments of the federal income tax liability. Included within the 2.34% figure is a .34% contribution to amortize costs associated with the automated Blue TransIt claims system. Tr. I at 75, McLane Testimony.

OHIC and the Attorney General ultimately consent to the proposed contribution to reserves as well as the contribution for the payment of the federal income tax liability on said reserves. However, the Attorney General argues that there needs to be a better description relating to reserves, which would disclose to the public that the reserves are in the nature of a “profit charge.” Tr. II at 21, Niehus Testimony. Both OHIC and the Attorney General testified that the federal income tax component should be stated more explicitly.

I find that the Blue Cross request for a contribution to reserves to be appropriate. While every effort must be made to make health insurance as affordable as possible, the Commissioner is likewise compelled by statute to protect the financial stability of Blue Cross. I am mindful of the repeated financial losses sustained by Blue Cross with the Direct Pay market. Blue Cross Exhibit 1, McLane Letter to Dr. Kathleen C. Hittner at 2. Likewise, as of March 2014, the Blue Cross reserve level was at 17.4% of its premium, which is below the recommended reserve level of 23%. *Id.* These weaker financial underpinnings must be viewed in the context of a significantly larger population of subscribers who are now provided coverage under the ACA. These new enrollees enter the market with no known claims history and at considerable financial risk to Blue Cross. Adequate reserves are needed to protect Blue Cross against adverse financial events and thus, insure its ability to pay its financial obligations. To achieve these important

goals, I find it appropriate to make the contribution to reserves in the amount 2.34%, as well as a contribution for the anticipated federal tax liability of .5%, for a total of 2.84%.

In order to address the concerns expressed by the Attorney General, I also recommend that OHIC provide guidance to Blue Cross as to how best to report each of the three components that constitute the reserves calculation, in order to ensure compliance with common reporting standards and also to ensure transparency.

7. *Elective Abortion Coverage Charge*

This Filing revisits the method by which Blue Cross attempts to comply with the Elective Abortion Coverage provisions of the ACA. The Filing includes a separate premium charge of \$1 per enrollee per month (“PMPM”) for every Direct Pay enrollee, whether or not the enrollee receives federal subsidies and whether or not s/he enrolls through the HealthSource Rhode Island Exchange. Tr. II, 134-135, 137. Blue Cross imposes this additional premium charge of \$1 PMPM in its effort to comply with the federal mandate that no federal subsidy be used to pay for elective abortions. Blue Cross acknowledges that this will result in excess charges for such services, but it proposes that such excess monies be transferred to its reserves. Blue Cross Post-Hearing Memorandum at 16-17.

OHIC opposes the additional premium charge, noting that the actual costs associated with abortion related services are approximately \$0.03 PMPM. Tr. I at 77, Tr. II at 132-142. Thus, the collection of \$1 PMPM from all Direct Pay subscribers far exceeds the actual costs relating to the services and, in the view of OHIC, are “inherently excessive.” OHIC Post-Hearing Memorandum at 8.

In order to assess the merits of these competing positions, it is necessary first to review the interplay between the provisions of the ACA and the long-standing federal prohibition against using public monies for funding abortions. As the President noted in an Executive Order:

It is necessary to establish an adequate enforcement mechanism to insure that federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a long-standing federal statutory restriction that is commonly known as the Hyde Amendment.

75 F.R. 15599 (March 24, 2010). The Executive Order directed federal agencies to develop a model set of segregation guidelines for state health insurance commissioners to be used in determining whether exchange plans comply with the ACA's segregation requirements, set forth in § 1303 of the ACA. *Id.* Such segregation requirements are directed toward "enrollees receiving federal financial assistance." *Id.*

Federal regulations were subsequently promulgated. Nothing under the ACA "shall be construed to require a QHP [Qualified Health Plans] issuer to provide coverage of services [for abortion] as part of its essential health benefits..." 45 CFR 156.280(c). If the health plan issuer does provide coverage of abortion services, it must not use any amount attributable to either the credits afforded under the ACA or toward any cost-sharing reduction under the ACA. 45 CFR 156.280(e)(1). Blue Cross must submit a plan that details its process and methodology for meeting the requirements of the "abortion exclusion provision and such plan must be submitted to the health insurance commissioner." 45 CFR 156.280(e)(5)(ii). The federal regulations make clear that the carriers must estimate the basic per enrollee, per month cost, for coverage of abortion services and "may not estimate such a cost at less than \$1 per enrollee, per month." 45 CFR 156.280(e)(4). The Act and regulations also require the carrier to "collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate

payment” which is to be deposited into a separate allocation account. 45 CFR 156.280(e)(2)(i) (emphasis provided).

The Act and regulations do not require an additional, separate premium. Instead, it calls for a payment of the existing premium to be cabined for the purpose of providing the abortion services. That separate payment cannot be made from federal subsidies. The federal regulations require Blue Cross to collect a separate payment of at least \$1 PMPM for those plans offered on the Exchange and only for those enrollees who receive federal subsidies. 45 CFR 146.280(e)(5)(ii)(A). The \$1 PMPM must be deposited into a separate insurer account and abortion services can only be paid from that segregated account. There is no federal law or regulation that requires a separate payment of \$1 PMPM or the use of segregated accounts for those enrollees who are in plans offered off the Exchange and without federal subsidies. Thus, I find that there is no legal requirement for Blue Cross to collect a separate \$1 PMPM from any subscribers other than those receiving a federal subsidy.

As presently proposed, Blue Cross is obtaining \$1 PMPM from all enrollees, which far exceeds the anticipated costs for abortion services of \$0.03 PMPM. Thus, Blue Cross is collecting such additional monies from all enrollees, rather than simply from those enrolling on the Exchange and receiving federal subsidies and also collecting far more than will be necessary to pay for the services. Admittedly, Blue Cross has done so in an effort to comply with federal mandate and with the previous Decision and Order rendered for the 2014 Filing.

Mr. DeWeese testified that it would be “inappropriate for the [abortion coverage] provision to be a license for insurance companies just to charge extra and keep the balance.” Tr. II at 136, DeWeese Testimony. OHIC proposes that no additional premium be collected from the enrollees. Rather, OHIC recommends that a separate payment of \$1 PMPM be deposited

into a segregated account from those enrollees who receive either federal tax credits or subsidies. No other enrollee will have a separate \$1 PMPM collected.

OHIC, as the state health insurance regulator, has determined that a protocol can be followed that both complies with the federal mandate and also ensures that excessive premiums are not unnecessarily collected from other Direct Pay enrollees. Blue Cross can fund the \$0.97 PMPM from their reserves during the 2015 plan year and it can then “be made whole by a true-up at appropriate times during or after the plan year.” OHIC Post-Hearing Memorandum at 8. The adjustment process would have no impact on premiums.

I find that deference should be afforded to OHIC, as the regulatory agency, with respect to the interpretation and application of the ACA provisions. Further, the ACA mandates that the carrier “comply with the efforts or direction of the state health insurance commissioner to insure compliance with this section through the segregation of QHP funds...” 45 CFR 156.280(e)(5)(i). As such, I find the approach proposed by OHIC to be more appropriate than the current method utilized by Blue Cross.

It is anticipated that the change to the method by which the elective abortion charge is collected will reduce the average rate increase by 0.2% and the EHB premium by \$0.02. There is no anticipated percentage change to the EHB rate.

8. *Challenge to the Legality of the Diminishing Deductible*

As in the past few rate year filings, some of the Blue Cross plans include a diminishing deductible formula which:

allows members who do not reach their deductible in a given year to receive a credit in the following year. Each subsequent year that they do not reach their deductible results in an increased credit for the following year. The one year credit is 20%, the two year credit is 40% and the credit for three or more years is 50%.

Blue Cross Exhibit 1, Actuarial Memorandum at 7. Under the diminishing deductible program, a subscriber can qualify for up to a 50% reduction to his or her deductible for members who do not exceed their deductible in a given rate year. Tr. I at 79-80, McLane Testimony. If a subscriber does use extensive health services and exceeds his or her deductible, they will not qualify for the diminished deductible program. *Id.* at 80. An extra 2% is built into the benefits factors for 2015 rates in order to subsidize the cost of this deductible feature. Tr. II at 129, DeWeese Testimony.

The question is whether the deductible formula runs afoul of the anti-discrimination provisions of the ACA. Blue Cross contends that the program is not tied to the health status of the insureds and therefore is not discriminatory. Tr. I at 81, McLane Testimony. For example, a person can be chronically ill and not exceed his or her deductible for one or more years. Tr. I at 81, McLane Testimony. However, Blue Cross' example is not the statistical norm. Rather, the use of benefits "is a very reliable indicator of health status, and the correlation is enormous." Tr. II at 130, DeWeese Testimony. Moreover, prior to the implementation of the ACA, when health status was allowed as an explicit rating factor, Blue Cross routinely relied upon the use of benefits as a "measure for determining who to give a higher rate to or a lower rate." *Id.* As Mr. DeWeese explained, while:

people of different health status, as evidenced by their past healthcare utilization, are not charged different premium rates, under the diminishing deductible plan they are required to pay different cost sharing. People who used their benefit plans in a prior year are being asked to pay a higher rate to cover the cost of enhanced benefits for people who didn't use benefits in a prior year.

OHIC Exhibit 1, DeWeese Report at 14. Thus, all insureds are funding a deductible program that will only benefit the healthier population of subscribers. All subscribers pay 2% more so that certain people who have "histories of low utilizations could get better benefits." Tr. II at 129, DeWeese Testimony. Thus those subscribers "who have exhibited some favorable health

status get a better deal.” Tr. II at 131, DeWeese Testimony. While the program may be neutral in its motive, it negatively impacts the less healthy population of subscribers in a far greater proportion than the healthier population. The correlation leads me to conclude that the impact is discriminatory in effect towards less healthy insureds who are statistically more likely to exceed their annual deductible. I find that it violates the anti-discrimination provisions of the ACA. The rate should be recalculated without the 2% cost associated with the deductible program. The program should not be implemented in the 2015 rate year.

It is anticipated that the disallowance of the deductible program will reduce the average rate increase by 1.9%.

V. ADDITIONAL OBSERVATIONS AND RECOMMENDATIONS

There are several other observations and recommendations presented by the Attorney General which I will now address in summary form. While these observations and recommendations do not directly impact the proposed increase in rates, they do deserve further consideration in an effort to ensure that costs are controlled to the furthest extent possible.

A. Incentive Payments

Incentive payments made to providers are a significant part of the cost trend. Tr. II at 23-24, Niehus Testimony. The Blue Cross projected costs assume that the hospitals are going to meet 100% of the scores necessary to achieve full incentive payment. Tr. II at 89, Manocchia Testimony. However, Dr. Manocchia testified that not all of the incentives are actually met. *Id.* This is significant since the hospital incentive payments represented 5.2% of total spent in 2013 and an increase expected for 2014 to 6.1%. *See*, Attorney General Exhibit L. Based upon historical increases, it is expected that about one-third of the 2015 hospital price increase will be applied to incentive payments. *Id.* The Attorney General suggests that it would be more

appropriate to have Blue Cross' projected incentive payments to actually reflect the reduced amount of actual historical payments, rather than a presumed 100% payment for such incentive programs. The Attorney General also recommends that OHIC review the Blue Cross contracting conditions to insure that its incentives are actually achieving their intended purpose of decreasing costs.

B. Key Drivers

The Attorney General also expressed concern with the letter that was sent to all subscribers, which explained the reason for the proposed rate increase and referenced key drivers at the beginning of its narrative. These five key drivers for medical expense increases include:

- A 23% increase in specialty pharmacy drug claims;
- A 7% increase in mental health/substance abuse admissions;
- A 22% increase in outpatient mental health/substance abuse visits;
- While overall emergency room utilization is flat there is an 8% increase in emergency room costs due to increased severity of cases; and
- A 4.8% increase in specialist office visits.

However, in response to questions submitted by the Attorney General, Blue Cross acknowledged that it has not actually determined what financial impact these key drivers have had on the Direct Pay market. *See*, Attorney General Exhibit F. While the Attorney General does not object to the use of key drivers, it does advise that the list of such drivers be relevant to the Direct Pay subscribers. Tr. II at 46-47, Niehus Testimony.

C. Subscriber Notification

The Attorney General also expressed concern with one of the new plans being introduced for 2015 called VantageBlue Select. That plan offers four tiers of providers with subscriber costs changing, depending on which provider they see in any particular tier. The Attorney General would like to see Blue Cross assist its subscribers in determining which provider is available for which tier in order to lessen the likelihood of penalties being imposed for using a provider

outside of the lower cost tier. Tr. II at 99, Niehus Testimony. The Attorney General recommends that Blue Cross provide adequate notice to its Direct Pay subscribers when a provider is no longer available in a particular tier and/or network so that the subscriber is not penalized with a higher cost by unwittingly using that provider. Tr. II at 100. Blue Cross acknowledges that it would be appropriate to assist subscribers to find the right provider in the lowest cost tier in order to reduce subscriber costs. Tr. II at 102, Manocchia Testimony.

VI. FINDINGS OF FACT

Based upon the evidence submitted, I hereby make the following proposed Findings of Fact with respect to the 2015 Direct Pay Filing:

1. The preceding Sections I through IV of this Report and Recommendation are incorporated into these Findings of Fact.
2. On May 15, 2014, Blue Cross submitted a Rate Filing for the Direct Pay market with the Health Insurance Commissioner seeking an overall average rate increase of 12.3%.
3. On May 16, 2014, Commissioner Hittner appointed Raymond A. Marcaccio, Esq. as the Hearing Officer in this matter.
4. The Filing was properly advertised in the *Providence Journal* on June 9, 2014.
5. In accordance with R.I. Gen. Laws §§ 27-20-6(a) and 29-19-6(a), Blue Cross mailed written notice of the proposed rate increase for the Direct Pay class to its members. Said notice was mailed at least 10 days prior to the commencement of the evidentiary hearings.
6. In accordance with an Order entered by Hearing Officer Marcaccio, the matter was scheduled for evidentiary proceedings on June 19 and 20, 2014 which were transcribed

and open to the public. The hearing was conducted in accordance with the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

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

8. Members of the public submitted comments to OHIC and the Hearing Officer prior to the hearing through correspondence and emails. Members of the public likewise provided comments in person at the public hearings conducted on June 19 and 20, 2014. The public comments indicated that the current premiums are not affordable and additional increases will cause economic hardships.

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

10. In support of its requested increase, Blue Cross submitted its Rate Filing, (BC Exhibit 1) on May 15, 2014. Blue Cross also introduced BC Exhibit 2 providing proof and substance of the public notice.

11. In support of its opposition to Blue Cross' requested increase, the Attorney General submitted the report of Barbara Niehus, FSA, MAAA, the Attorney General's consulting actuary, along with schedules supporting her conclusions (AG Exhibit A with Attachments AGBN-1 through AGBN-11), which were admitted in full at the public hearing. The Attorney General also submitted Exhibits AG-B through AG-T, each of which were admitted as full exhibits at the public hearing.

12. The Office of Health Insurance Commissioner submitted the report of Charles W. DeWeese, FSA, MAAA, and Exhibits 1, 1A, 2, 3A, 3B, 4A, 4B, 5, 6, 7A, 8A, 8B, 9, 10 11, 13, 14, 16, 17, 19-34, each of which were admitted in full as OHIC Exhibit 1 at the public hearing. OHIC also submitted Exhibit 35, which was marked for identification only.

13. At the commencement of the evidentiary hearing on June 19, 2014, the following stipulations were entered by agreement:

Notice of the public hearing was published and mailed to all Direct Pay subscribers in accordance with statutory requirements and applicable law;

The Hearing Officer and the Health Insurance Commissioner have jurisdiction to hear and set the rates for the Direct Pay market; and

The three actuarial witnesses presented by the parties were qualified as experts in the field of actuarial science.

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

15. As a result of an anticipated increase in Transitional Reinsurance Program revenues, the proposed overall rate increase of 12.3% is reduced by approximately 3.2%.

16. An error in the calculation for the Transitional Reinsurance credit was discovered by the Attorney General's actuary expert, Barbara Niehus, during the rate review process. With all of the claims data properly included in the analysis, the calculation yields an additional .5% reduction to the proposed Rate Request.

17. Blue Cross originally projected that new enrollees in 2015 would be relatively older than existing members and would be 2% more costly than the 2013 Direct Pay membership. However, OHIC's actuary expert, Charles DeWeese, noted that the Blue Cross assumption failed to recognize that older individuals will pay higher premiums, which will offset

the anticipated increase in costs. Blue Cross acknowledges that this offset is actuarially sound, thereby resulting in the removal of the 2% adjustment for this population factor.

18. As a result of the 1) the higher revenues anticipated in 2015 Transitional Reinsurance Program, 2) a calculation correction to the original projected reinsurance revenues, and 3) an adjustment to the costs associated with new enrollees due to age characteristics, the Blue Cross proposed 2015 overall rate increase is reduced by 4% -- a change from 12.3% to an overall average proposed rate increase of approximately 8.3%. It is estimated that the EHB rate will fall from \$341.68 to \$3209.66 or, from 8.9% to 5%.²

19. Blue Cross has not met its burden of proof, by a preponderance of the evidence, to support its In-Patient Hospital Utilization trend assumption of 1%. OHIC and the Attorney General have effectively rebutted this trend factor and I conclude that the In-Patient Hospital Utilization trend assumption should be reduced to zero for the 2015 Rate Filing. It is expected that the 0% assumption will reduce the average rate increase in the EHB base rate by 0.5% and likewise reduce the EHB premium by \$1.43.

20. I find that Blue Cross has met its burden of proof in establishing that the use of a positive 1% trend assumption for the Other Medical/Surgical Utilization/Mix trend is appropriate for the 2015 Rate Filing.

21. Blue Cross' assumption of a neutral (0%) population risk morbidity adjustment factor is statistically sound and hereby adopted for this Filing.

22. It is appropriate for Blue Cross to accrue in rate year 2014 any additional monies that it receives from the federal government as a result of the anticipated adjustments in revenue from the Federal Transitional Reinsurance Program. Blue Cross must file an accounting of these

² The estimated change to the EHB rate will be subject to the recalculations to be run by the parties based upon each of the adjustments required by the Commissioner's final Decision.

additional monies as part of its 2016 rate review. The accounting should set forth how the monies were accrued by Blue Cross and explain what financial impact said additional monies had on the 2014 Rate Filing year.

23. The evidence supports a finding that Blue Cross is entitled to a contribution to reserves in the amount of 2.34%, including a .34% component that constitutes a charge in the rates for the Blue TransIt computer system. An additional .5% for the payment of anticipated federal income tax liability is recommended. I further find it appropriate and therefore recommend that OHIC provide guidance to Blue Cross, prior to the 2016 Rate Filing, as to how Blue Cross should report each of these three components of its reserves figure, *i.e.*, reserves, amortization of the automated Blue TransIt claims system, and the anticipated federal tax component. The components should be appropriately categorized in order to ensure that common reporting standards are met and to likewise ensure transparency.

24. I find that the diminishing deductible program implemented by Blue Cross violates the anti-discriminatory provision of the ACA. The program improperly factors in the health status of the subscriber. The subscribers must fund a program that will benefit the healthier population, who are more likely to not reach their deductible in a given year and thereby obtain a reduced deductible in the following year. The program adversely impacts the less healthy population of subscribers in a greater proportion than the healthier subscribers, since the unhealthy population is more likely to exceed their deductible. The 2015 rates should be recalculated without the 2% cost associated with the deductible program. It is anticipated that the disallowance of this deductible program will reduce the average rate increase by 1.9%.

25. I find that the provisions of the ACA do not require a separate premium charge of \$1 PMPM from every Direct Pay subscriber for elective abortion services. I further find that

Blue Cross is required to collect a separate payment of \$1 PMPM only for those plans offered on the Exchange and for those enrollees who receive federal subsidies. The payment of the \$1 PMPM cannot be made from federal subsidies. Those monies must be deposited into a separate insurer account and abortion services can only be paid from that account. Given that the actual cost for these services is approximately \$0.03 PMPM, Blue Cross will fund the \$0.97 PMPM from their reserves during the 2015 plan year and then be made whole by appropriate adjustments during or after the plan year. It is anticipated that the change to the collection of the elective abortion services will reduce the average rate increase by 0.5% and the EHB premium by \$0.02.

VII. CONCLUSIONS OF LAW

1. The preceding Sections I through VI of this Report and Recommendation are incorporated herein into these Conclusions of Law.
2. OHIC has jurisdiction to hear and decide this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.5-1 *et seq.*, 27-19-6 and 27-20-6.
3. This hearing was conducted in compliance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*
4. All of the procedural prerequisites for the conduct of the hearing have been followed.
5. In accordance with applicable statutes, OHIC has the jurisdiction and authority to determine whether or not the proposed rates for the Direct Pay plans satisfy each of the legal mandates, including the requirement that Blue Cross provide rates that are affordable and also provide access to healthcare coverage. R.I. Gen. Laws §§ 27-19.2-3(1) and (5).

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

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

8. Blue Cross’ Direct Pay Rate Filing for 2015 is also governed by the implementation of the Patient Protection and Affordable Care Act (“ACA”), Pub. L. 111-148, 124 Stat. 119.

9. The Commissioner, through her Hearing Officer, Raymond A. Marcaccio, Esquire, has jurisdiction in this proceeding to conduct the hearings for purpose of considering whether Blue Cross’ proposals contained in its Filing of May 15, 2014 are consistent with the proper conduct of Blue Cross’ business and also in the interest of the public. R.I. Gen. Laws §§ 27-19-1 *et seq.*, 27-20-1 *et seq.*, 42-14.5-1 *et seq.*, and 42-14-1 *et seq.*

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

11. Blue Cross has not satisfied its burden of proving that the modified proposed rate increase of 8.3% is consistent with the proper conduct of its business and also in the interest of providing affordable health insurance coverage to the public.

12. A modification to the overall rate increase and EHB rate shall be calculated in accordance with the final Decision of the Commissioner.

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

Respectfully submitted to Commissioner Kathleen C. Hittner, M.D., this 21st day of July, 2014.

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke at the end, positioned above a horizontal line.

Raymond A. Marcaccio, Hearing Officer