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November 20, 2009

Commissioner Christopher F. Koller
Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

Subject: Filing of Subscription Rates for Class DIR

Dear Commissioner Koller:

This letter, together with the actuarial schedules enclosed, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs. This filing includes proposed rates to become effective April 1, 2010.

The rates proposed in this filing will affect the approximately 13,900 members enrolled as of September 2009 in Class DIR.

Definition of Class DIR

Class DIR is the rating classification for persons not eligible for employer-based (other than as a self employed individual), nor State or Federal programs. Enrollment is on a non-group basis either through direct application to the Plan or through conversion from prior group coverage. Two rating pools are employed in the Class -- the Basic Pool (Pool I) utilizing community rates and the Preferred Pool (Pool II) with rates determined based on the age and gender of the subscriber. It should be noted that we are proposing rate structure changes to Class DIR effective with this rate filing that would introduce age rating into Basic (Pool I). These rate structure changes are discussed further below. Group conversions occur monthly and an annual open enrollment period is conducted for the Basic Pool (Pool I), while enrollment in the Preferred Pool (Pool II) is available continuously throughout the year for applicants passing a health screening.

Benefit Changes Effective With This Filing

There are several product changes being proposed in conjunction with this filing. Briefly, we are proposing to increase the deductible on the HealthMate Coast-to-Coast Direct Plan 400/800 to $500 per individual and $1,000 per family. Also, the coinsurance for this product will be increased to 20% after the deductible. Finally, flat dollar prescription drug co-payments are being introduced after satisfaction of the deductible on the two HSA eligible products. The following Class DIR products will be available effective April 1, 2010:

- *HealthMate Coast-to-Coast Direct Plan 500/1000:* Includes a $500 per individual/$1,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, lab tests, and x-rays, $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid coinsurance of 20% generic/25% brand/50% non-preferred and $75 specialty

prescription drugs at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $2,500 per individual / $5,000 per family. In general, member cost share is greater at out-of-network providers.

- *HealthMate Coast-to-Coast Direct Plan 2000/4000:* This plan is comparable to HealthMate Direct 500/1000. The differences include the deductible and out of pocket maximums. The deductible is $2,000 per individual / $4,000 per family under HealthMate Direct 2000/4000, and the member paid coinsurance is 20% for in-network benefits. The out of pocket maximums for the HealthMate Coast-to-Coast Direct Plan 2000/4000 are $3,000 and $6,000 for individual and family respectively for in-network services. Pharmacy coverage does not apply toward the deductible. Members have the option of engaging in the Wellness Reward Program and may receive a reward equal to 10% of their annual paid premiums if they meet certain wellness requirements. In general, member cost share is greater at out-of-network providers.

- *HealthMate for HSA Direct Plan 3000/6000:* The HealthMate for HSA Direct Plan 3000/6000 includes deductibles of $3,000 per individual / $6,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs. For prescription drugs, members will pay co-payments of $7 for generic drugs, $30 for preferred brand-named drugs, $50 for non-preferred brand name drugs and $75 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $4,000 per individual and $8,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *HealthMate for HSA Direct Plan 5000/10000:* The HealthMate for HSA Direct Plan 5000/10000 is comparable to HealthMate for HSA Direct Plan 3000/6000. The only difference is the amount of the deductibles. The deductibles are $5,000 per individual / $10,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs. For prescription drugs, members will pay co-payments of $7 for generic drugs, $30 for preferred brand-named drugs, $50 for non-preferred brand name drugs and $75 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $5,950 per individual and $11,900 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

There are also a couple of minor benefit changes related to recently enacted mandated benefits. These are outlined in my prefiled testimony.

New Product Introduction

Effective July 1, 2010, Blue Cross is introducing a new plan, HealthMate Coast-to-Coast Direct Plan 1000/2000 (HealthMate Direct 1000) that we plan to launch in conjunction with Open

Enrollment. This plan will be based on our HealthMate PPO product with benefits designed to reduce barriers to care and align benefits with wellness programs and to provide incentives for participation in those programs. Contemporaneous with this rate filing, Blue Cross has filed with the OHIC a proposed contract form for this product. This proposed form provides a detailed description of the benefits and other terms of the subscriber agreement.

Rating Structure Changes Effective With This Filing

Effective April 2010, Blue Cross is proposing to introduce rate structure changes for Basic (Pool I) subscribers in order to make its rates more attractive in the market. Currently, all subscribers who fail medical underwriting pay the same individual or family rate for the same set of benefits, with the exception of subscribers ages 65 and older. Effective April 2010, Basic (Pool I) rates will vary by age category, similar to current Preferred (Pool II) rates. Rates for individual males and females, however, will be the same. We believe that by stratifying Basic (Pool I) rates by age, the relatively younger subscribers who are not able to pass medical underwriting will be more likely to purchase health insurance rather than going uninsured. Also, by reducing the health status adjustment for younger members, we believe the average age of the Basic pool should decline over time, helping to moderate future increases in health care costs. Finally, by having similar rate structures in both rating pools, there should be less rate shock to Direct Pay subscribers should pending health care legislation require the removal of rating by health status.

In addition to the change in rate structure for Basic (Pool I), Blue Cross is changing the way age categories are defined for family contracts. Currently, in a family with more than one adult, the age of the adult whose birth month and day fall earlier in the year is used to determine the age category for rating purposes. For new applications received on January 1, 2010 or later, the age of the adult listed as the subscriber on the application will be used to determine the age category for rating. Note that subscribers currently enrolled or applying prior to January 1, 2010 will still be subject to the current rule.

Reserve Contribution

Blue Cross is not requesting a reserve contribution component from Class DIR subscribers in this rate filing. Historically, Blue Cross and its Directors have taken the position that Direct Pay should recover not only its claims and administrative expenses, but it should contribute its fair share towards corporate reserves. Although Blue Cross has not changed its philosophical position in this regard, given the current economic conditions in Rhode Island, we are not asking Class DIR subscribers to contribute to corporate reserves at this time. It should be noted that as of September 30, 2009, Blue Cross corporate reserves were at 19% of annual premium, well below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium, and surplus levels are expected to decline further in the foreseeable future.

Required Rates

Blue Cross last filed rate changes for its Class DIR subscribers on November 21, 2008 for an effective date of April 1, 2009. In its decision rendered on February 19, 2009, The Office of the

Health Insurance Commissioner (OHIC) denied Blue Cross' request for rate relief in its entirety. As a result, the current rates for Class DIR have been in effect since April 2008.

The overall average required rate increase projected in this filing, exclusive of any Premium Assistance amounts, is 10.2%. All rates included in this filing will remain in effect for the twelve-month period commencing April 1, 2010, with the exception of the new HealthMate Direct 1000 product. Rates for HealthMate Direct 1000 will be in effect from July 1, 2010 through March 31, 2011. The Class DIR Basic (Pool I) required monthly rates and the Preferred (Pool II) required monthly rates for the four existing Direct Pay products as well as the new HealthMate Direct 1000 product are included in the following tables. Please note that all subscribers aged 65 and over receive the Basic (Pool I) rate. Rates for subscribers aged 65 and over are therefore not displayed in the table below for Preferred (Pool II) subscribers.

Class DIR Basic (Pool I)
Proposed Rates Effective April 1, 2010

		HM 500	HM 1000*	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Individual	$621.66	$555.12	$473.57	$405.39	$319.63
	Family	$1,242.40	$1,109.43	$946.45	$810.19	$638.80
25-29	Individual	$631.68	$564.07	$481.21	$411.93	$324.79
	Family	$1,268.84	$1,133.03	$966.59	$827.43	$652.39
30-34	Individual	$646.27	$577.10	$492.32	$421.44	$332.29
	Family	$1,283.42	$1,146.06	$977.70	$836.94	$659.89
35-39	Individual	$651.74	$581.98	$496.49	$425.01	$335.10
	Family	$1,298.00	$1,159.08	$988.81	$846.45	$667.39
40-44	Individual	$660.85	$590.12	$503.43	$430.95	$339.79
	Family	$1,304.39	$1,164.78	$993.67	$850.62	$670.67
45-49	Individual	$678.17	$605.59	$516.63	$442.25	$348.69
	Family	$1,318.97	$1,177.80	$1,004.78	$860.13	$678.17
50-54	Individual	$706.43	$630.82	$538.15	$460.68	$363.22
	Family	$1,352.70	$1,207.92	$1,030.47	$882.12	$695.51
55-59	Individual	$740.15	$660.94	$563.84	$482.67	$380.56
	Family	$1,390.98	$1,242.10	$1,059.64	$907.08	$715.19
60-64	Individual	$753.83	$673.14	$574.26	$491.59	$387.59
	Family	$1,422.88	$1,270.59	$1,083.94	$927.89	$731.59
65+	Individual	$1,185.89	$1,058.96	$903.40	$773.34	$609.74
	Family	$2,244.16	$2,003.97	$1,709.59	$1,463.46	$1,153.87

*** This Plan will be effective July 1, 2010**

Class DIR Preferred (Pool II)
Proposed Rates Effective April 1, 2010

		HM 500	HM 1000*	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Male	$202.82	$179.88	$154.51	$132.26	$104.28
	Female	$283.59	$251.51	$216.04	$184.94	$145.81
	Family	$679.57	$602.70	$517.70	$443.16	$349.40
25-29	Male	$224.33	$198.95	$170.89	$146.29	$115.34
	Female	$321.35	$285.00	$244.80	$209.56	$165.22
	Family	$761.23	$675.12	$579.90	$496.41	$391.38
30-34	Male	$255.50	$226.60	$194.64	$166.61	$131.36
	Female	$381.93	$338.73	$290.95	$249.06	$196.37
	Family	$807.32	$716.00	$615.02	$526.47	$415.08
35-39	Male	$292.37	$259.30	$222.73	$190.66	$150.32
	Female	$378.86	$336.00	$288.61	$247.06	$194.79
	Family	$852.10	$755.71	$649.13	$555.67	$438.10
40-44	Male	$312.57	$277.21	$238.11	$203.83	$160.71
	Female	$414.42	$367.54	$315.70	$270.25	$213.07
	Family	$870.98	$772.45	$663.51	$567.98	$447.81
45-49	Male	$377.98	$335.22	$287.94	$246.49	$194.34
	Female	$459.19	$407.25	$349.81	$299.45	$236.09
	Family	$917.95	$814.11	$699.29	$598.61	$471.96
50-54	Male	$478.95	$424.77	$364.86	$312.33	$246.25
	Female	$536.46	$475.77	$408.67	$349.83	$275.82
	Family	$1,022.43	$906.77	$778.89	$666.75	$525.68
55-59	Male	$613.72	$544.30	$467.53	$400.22	$315.54
	Female	$612.41	$543.13	$466.53	$399.36	$314.87
	Family	$1,144.47	$1,015.01	$871.86	$746.33	$588.43
60-64	Male	$656.31	$582.06	$499.97	$427.99	$337.44
	Female	$656.31	$582.06	$499.97	$427.99	$337.44
	Family	$1,243.69	$1,103.00	$947.44	$811.03	$639.44

*** This Plan will be effective July 1, 2010**

Filing Schedules

Schedules displaying the required rates and detailed actuarial schedules documenting the calculation of the required rates are enclosed as Blue Cross Exhibit 2 for the existing products, and Blue Cross Exhibit 3 for the new HealthMate Direct 1000 product.

The underlying actuarial methodology used in the preparation of the required rates in this filing is similar in nature to the previous Class DIR rate filing submitted to the OHIC. The filing schedules and supporting actuarial pre-filed testimony detail the rating methodology.

Pre-Filed Testimony

With this filing, we are submitting the pre-filed testimony of Augustine Manocchia, MD, Chief Medical Officer, who will be Blue Cross' witness with regards to medical management issues, and myself, who will be Blue Cross' actuarial and policy witness at the upcoming rate hearing on this matter. We believe submitting the pre-filed testimony contemporaneously with the rate filing will make the discovery process more efficient and decrease the length of time of all aspects of the hearing process.

Affordability as Addressed in the Rate Filing

In consideration of previous rate decisions issued by the OHIC, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Specifics of these programs are detailed in the pre-filed testimonies of Dr. Manocchia and me. In addition, along with this rate filing, we are submitting as Exhibit 4 an update to our 2009 affordability plan. Exhibit 4 outlines Blue Cross' strategies regarding improving the overall affordability of health care in Rhode Island.

Conclusion

The development of the actuarial assumptions has been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

In accordance with the filing fee requirements contained in section 42-14-18 of the General Laws of Rhode Island, a filing fee of $125 ($25 per each policy) has been included with this submission via electronic funds transfer (EFT). This filing pertains to the following policy form numbers which have been submitted to the Department under separate cover:

- DIRECTAMEND 500/1000 (04-10) - amends HMC2C DIRECT 400/800 (04/09)
- DIRECTAMEND 2000/4000 (04-10) – amends HMC2C DIRECT 2000/4000 (04/09)
- DIRECTAMEND HSA 3000/6000 (04-10) – amends HM HSA DIRECT 3000/6000 (04/09)
- DIRECTAMEND HSA 5000/10000 (04-10) – amends HM HSA DIRECT 5000/10000 (04/09)
- HMC2C DIRECT 1000/2000 (04-10)

We respectfully ask for your timely approval of this filing as submitted. Blue Cross & Blue Shield of Rhode Island believes that the proposed rates are in the interest of both the public and the Corporation.

As always, we shall be pleased to provide any additional information that you may require.

Sincerely,

John Lynch, F.S.A., M.A.A.A.
Chief Actuary

JL/swl

Enclosures

cc: Mr. Normand G. Benoit, Esquire
Ms. Genevieve M. Martin, Esquire