STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATION

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE: BLUE CROSS & BLUE SHIELD :
OF RHODE ISLAND CLASS DIR :
NOVEMBER 20, 2009

PRE-FILED DIRECT TESTIMONY OF
JOHN LYNCH

I. INTRODUCTION

Q. Please state your name and professional qualifications.

A. My name is John Lynch. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Q. By whom are you employed?

A. I am employed by Blue Cross & Blue Shield of Rhode Island (Blue Cross).

Q. What is your title and area of specialization as an employee of Blue Cross?

A. My title is Chief Actuary and I oversee Blue Cross' actuarial and underwriting departments. A key responsibility of these areas is developing and maintaining premium rate structures that are actuarially sound, competitive in the marketplace, and meet the company's financial and operational goals. My duties also include setting claim reserve levels and overseeing all other actuarial and underwriting functions.

Q. How long have you been employed by Blue Cross in that capacity?

A. I have been employed in that capacity for the last 4 years. I was hired into this position on July 27, 2005.

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

A. Yes, for the last three years I have been accepted as an actuarial witness and testified as such at the rate hearings pertaining to Blue Cross' request to increase rates for class DIR. Additionally, numerous filings have been submitted to the OHIC over my signature during the last 4 years.

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

II. DESCRIPTIONS AND BACKGROUND INFORMATION.

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

A. Yes. This is a letter, dated November 20, 2009, that I wrote to the Health Insurance Commissioner notifying him of the filing of new subscription rates by Blue Cross for Class DIR and summarizing the content and purpose of the filing, which accompanied that letter.

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

A. Yes.

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

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

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

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

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

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

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

Q. Please describe the goal behind this rate structure.

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

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

A. Yes. Since the AccessBlue program was introduced to Preferred (Pool II) members in April 2007, the number of members enrolled in Preferred (Pool II) has steadily increased. In April 2007, there were approximately 13,900 members enrolled in Class DIR. Of these, approximately 7,400 were enrolled in Basic (Pool I) (53%) with 6,500 in Preferred (Pool II) (47%). In April 2008, the number of Preferred (Pool II) members had increased to approximately 6,900, with approximately 7,000 enrolled in Basic (Pool I). As of September 2009, the number of Preferred (Pool II) members has grown to approximately 7,400 members

(53%), while the number of Basic (Pool I) members has decreased to approximately 6,500 members (47%). Overall, the enrollment in Preferred (Pool II) has grown by approximately 1,000 members since April 2007, while the Basic (Pool I) enrollment has declined by approximately 900 members.

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

A. Assuring that Preferred (Pool II) is attractive in the market is critical to sustaining the Direct Pay market. The financial stability of the entire Class DIR is dependent to a significant degree on the continuing ability of Blue Cross to attract subscribers into Preferred (Pool II) since they help to subsidize Basic (Pool I). As a consequence, it is important that Preferred (Pool II) rates bear a reasonable relationship to the pool's own underlying experience level and not be higher than necessary, in order to balance attractiveness in the market with some continuing subsidy of Basic (Pool I). The entire Class DIR pool would be more financially sound if the Pool I subsidy could be generated from a smaller Pool II surcharge collected from a larger Pool II enrollment. Since the percentage of Pool II members in the Direct Pay population has increased from 47% at April 2007 to 53% at September 2009, it appears that the steps Blue Cross has taken in recent years to encourage Pool II enrollment are having their intended effects.

Q. What is Blue Cross' goal with regards to enrollment in its Direct Pay products?

A. Blue Cross' goal is to increase enrollment in both Basic (Pool I) and Preferred (Pool II), with enrollment in Preferred (Pool II) increasing at a faster rate.

Q. What is Blue Cross doing to address the decline in Basic (Pool 1) enrollment.

A. 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. This rate structure change will improve the financial equity between young and old Pool 1 subscribers and have favorable enrollment effects. We believe that by stratifying Basic (Pool I) rates by age, the relatively younger applicants who are not able to pass medical underwriting will be more likely to purchase health insurance rather than go 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.

Q. Would you please describe, in general terms, the products available to Class DIR in connection with the subscription rates developed in this filing?

A. Contemporaneous with this rate filing, Blue Cross has filed with the Office of the Health Insurance Commissioner (OHIC) proposed revisions to the contract forms for each of the four products currently available to Class DIR as well as a new product (HealthMate Coast-to-Coast Direct Plan 1000/2000). These proposed forms provide detailed descriptions of the benefits and other terms of the subscriber agreements. The four existing products, HealthMate Coast-to-Coast Direct Plan 400/800, HealthMate Coast-to-Coast Direct Plan 2000/4000, HealthMate for HSA Direct Plan 3000/6000 and HealthMate for HSA

Direct Plan 5000/10000 have been available to Direct Pay subscribers since April 1, 2006. Changes to these products have not been substantial since that date. However, in order to address the affordability of these products, Blue Cross has proposed the following changes:

HealthMate Coast-to-Coast Direct Plan 400/800:

- Increase the deductible to $500 per individual and $1000 per family
- Increase the coinsurance to 20% up to the current out of pocket maximum of $2500/5000

The HealthMate Coast-to-Coast Direct Plan 400/800 will also be renamed HealthMate Coast-to-Coast Direct Plan 500/1000.

HealthMate for HSA Direct Plan 3000/6000:

- Implement in-network post deductible prescription drug copays 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 copays after they satisfied the deductible until they satisfy the out of pocket maximum of $4000 per individual and $8000 per family.

HealthMate for HSA Direct Plan 5000/10,000:

- Implement in-network post deductible prescription drug copays 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 copays after they satisfied the deductible until they satisfy the out of pocket maximum of $5,950 per individual and $11,900 per family.

On all of our Class DIR plans we propose removing the limits from Mental Health and Chemical Dependency visits to be consistent with our Commercial Group plans and to

remove any perceived barriers to care. We also propose implementing the lifetime maximum of $100,000 on infertility services. The state infertility mandate allows for the introduction of this coverage maximum. Currently, there is no benefit maximum for infertility services.

In addition, we have filed a new plan, HealthMate Coast-to-Coast Direct Plan 1000/2000 (HealthMate Direct 1000) that we plan to launch effective July 1, 2010 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. The rate development for this new product is shown in Exhibit 3 and discussed in section IV of this testimony.

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

A. Yes. Effective April 1, 2008, the HealthMate Direct 2000 product was designated as a Wellness Health Benefit Plan. Subscribers who elect this plan option have the opportunity to receive a reward equal to 10% of paid premium if they meet the program requirements. Blue Cross has issued $34,716.93 in rewards to 55 subscribers who satisfied their wellness requirements between April and October 2009.

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

A. Yes. We are 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.

This rule has created administrative issues for Blue Cross and its members in our new claims processing system. Therefore, 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. In addition to the change in the way age categories are defined for family contracts, we are also modifying the rate relativities between products.

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

A. We determined the rate relationships by looking at base period and projected rate period loss ratios. Our goal was to adjust the rate relationships so that the rates for each product more closely aligned with the value of each of the benefit plans without causing major disruption to the rates.

Q. Please describe AccessBlue.

A. In 2006 Blue Cross launched AccessBlue, previously named the Direct Pay Premium Assistance Program, to help lower income subscribers and absorb some of the escalating costs of health insurance premiums. This program is a direct outreach activity, authorized by the Blue Cross Board of Directors to help improve the affordability of healthcare coverage in Rhode Island for eligible subscribers who have acted responsibly by purchasing their own Direct Pay coverage, but (1) are not eligible for either employer or government sponsored or assisted healthcare coverage plans (i.e., employer group coverage, other than a self-employed individual, and state or federal programs, including Medicare and Medicaid) and (2) have relatively low incomes (their annual gross household income is less than 350% of federal poverty levels (FPL)) with which to purchase coverage. A separate report discussing our experience to

date with AccessBlue has been submitted under separate cover to the OHIC contemporaneous with this filing.

Q. Is AccessBlue part of the rates?

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

Q. Why is Blue Cross offering the program?

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

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

A. There are two levels of assistance provided through AccessBlue. Subscribers with an annual household income less than or equal to 200% of the FPL qualify for Level 1 subsidy status. Over the course of the 12-month rating period beginning April 1, 2010, Level 1 will provide $984 for each eligible Direct Pay individual subscriber and $1,848 for each

eligible family subscriber. This equates to assistance ranging from 7% to 79% of the total proposed premium depending on the pool and the selected product.

Additionally, Direct Pay subscribers who have incomes between 201% and 350% FPL are eligible for Level 2. Over the course of the 12-month rating period, Level 2 will provide $648 for each eligible individual subscriber and $1,224 for each eligible family, on a monthly basis. This equates to assistance ranging from 5% to 52% of the total proposed premium depending on the pool and the selected product.

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

A. The 2010 federal poverty levels are expected to be released in February of 2010. Once released, Blue Cross intends to implement the new levels on the income guidelines for April 1, 2010. The 2009 federal poverty levels are as follows:

Family Size	100%	200%	350%
1	$10,830	$21,660	$37,905
2	$14,570	$29,140	$50,995
3	$18,310	$36,620	$64,085
4	$22,050	$44,100	$77,175

Approximately 7,600 or 80% of Direct Pay contracts are for individual coverage. With respect to family coverage, the average size family in Direct Pay is 3.3 persons.

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

A. In 2006, Blue Cross set aside $9 million to provide assistance through this program and in 2008 Blue Cross set aside an additional $2 million. Blue Cross' goal is to generate sufficiently favorable ongoing financial results so that a portion of the favorable results can continue to be available to fund worthy programs such as AccessBlue. This money was set aside solely to provide assistance to qualified Rhode Islanders and to ensure that assistance could

continue to be provided through this program during periods when Blue Cross' financial results may not enable a dividend, or return, in the form of additional funding.

Q. How long will Blue Cross continue AccessBlue?

A. AccessBlue is entering its fifth year and Blue Cross continues to study it, and adapt the program as its effectiveness and Blue Cross' means of support warrant. Underpinning the program's ongoing viability is the need for Blue Cross to be able to implement actuarially justified, adequate premium rates – for Direct Pay, as well as all other segments of business. The program is monitored closely by Blue Cross, and future funding, payment levels, and eligibility will be modified or terminated as appropriate. Based on the current expenditure level, funding for the program is expected to run out in 2012.

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

A. Blue Cross and its Board of Directors have taken pride in the fact the Direct Pay program is offered to anyone who wants it (who is not eligible for other employer or government provided coverage) and that, because of Blue Cross, there is no one who is uninsurable in the state of Rhode Island from an availability perspective. There are several ways to qualify for coverage. The most common way is through Rhode Island Gen. Laws § 27-18.5-3, which provides that coverage is guaranteed for our Pool 1 Basic rate for eligible individuals and families who have had creditable coverage that ended less than 63 days prior and was in force for 12 continuous months or was in force for 18 months with no breaks of more than 63 days. The Pool II plans are available to any eligible individual or family who can meet our medical underwriting guidelines throughout the year. Finally, Blue Cross also offers guaranteed coverage during open enrollment.

Q. Has Blue Cross recently conducted an open enrollment?

A. Yes. The last open enrollment was held between May 15, 2009 and June 15, 2009 for a July 1, 2009 effective date. Open enrollment was advertised on BCBSRI.com as well as in the Providence Journal on May 18, 2009 and during the week of May 27, 2009, in the Rhode Island Newspaper Group (RING) newspapers. Open enrollment was also promoted on eight local radio stations from May 11, 2009 through June 14, 2009. Lastly, individuals who applied and were not eligible to join throughout the year were sent a postcard reminding them about open enrollment.

As a result of this most recently completed open enrollment approximately 599 new applications were received with 64 for Basic rates (Pool I) and 535 for Preferred rates (Pool II). Subscribers who pass the health screen can enroll at any time during the year into Preferred rates (Pool II).

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

A. The last rate increase was effective April 1, 2008. This was the result of a filing for Class DIR that was submitted to the OHIC on November 15, 2007 and approved on February 15, 2008 with some modifications. Subsequently, a rate filing was submitted for Class DIR on November 21, 2008 for a rate increase effective 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.

Q. What was the basis for the denial of Blue Cross' rate filing effective April 2009?

A. The basis for the rate denial was twofold. First, OHIC rejected Blue Cross' argument that Direct Pay subscribers should contribute their fair share toward corporate reserves. Second, the OHIC accepted the Attorney General's argument that the claims trend

assumptions filed were too high due to an increase in the number of healthier Preferred (Pool II) members. The OHIC therefore concluded that no rate relief was required.

Q. Why is Blue Cross requesting rate relief for its Class DIR products at this time?

A. The rates currently in effect for Direct Pay products have been unchanged since April 2008 and are currently insufficient to cover claims and administrative expenses for Class DIR members. At March 31, 2008, the Class DIR reserve position was a negative ($6.4M). At March 31, 2009, the Class DIR reserve position had further declined to a negative ($6.9M). As of September 2009, the reserve position for Class DIR stands at a negative ($9.0M). Any further delay in implementing an increase in rates will further erode the reserve position of Class DIR and necessitate ever larger future increases to restore Class DIR rates to adequacy.

Q. What is the reserve contribution component being requested for Class DIR in the proposed filing effective April 2010?

A. Blue Cross is not asking for a reserve contribution in its proposed Direct Pay rates effective April 2010. Blue Cross and its Directors have historically 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. This over-arching long-term policy remains unchanged. However, Blue Cross is sympathetic to the current economic situation in Rhode Island and across the county, and the difficult financial situation many people are in. Therefore, Blue Cross is seeking an increase in its rates to cover only the cost of paying claims and administering the products. Blue Cross has made every effort to keep the required increase in

rates as low as possible. This includes making benefit changes and not seeking a reserve contribution from Direct Pay subscribers.

Q. You just mentioned that the denial of last year's rate filing was based, in part, on the assertion that Blue Cross had not properly reflected the favorable pool shifting in its trend assumptions. In your opinion, was this assertion actuarially justified?

A. No. In my opinion, this assertion was incorrect. First, the emerging experience suggests that Blue Cross' trend assumptions were not overstated. In fact, due to the denial of the rate increase requested for the current rate year, which began in April 2009, the result for the current rate year thus far (April 2009 through September 2009), is a negative amount of approximately $2,096,000, with a virtual certainty Blue Cross will lose money in Direct Pay during the current rate year.

Second, our trend methodology was actuarially sound and, although there was no explicit mention of a credit for the impact of the ongoing pool shifting towards the Preferred Rates (Pool II), this impact was implicitly accounted for within the trend calculations for each line of business. This was the case because pool shifting had been occurring throughout the experience period used in the trend calculations, and since trend was calculated on a combined pool basis, the pool shifting had a dampening effect on the calculated trends for each line of business.

In this filing, to clarify the impact of pool shifting, we have modified our trend methodology to explicitly show the credit given for continued pool shifting. Thus it was necessary to remove the implicit impact of pool shifting within each line of business by trending each pool separately. This has the additional benefit of grouping together similar risks, which generally produces a more consistent trend.

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

A. These are actuarial schedules that were enclosed with Exhibit 1 and submitted as support of the calculation of the required rates for both Basic (Pool I) and Preferred (Pool II) for the four existing benefit plans. They apply to Class DIR for the rate year commencing April 1, 2010. Blue Cross Exhibit 2 consists of schedules 1 through 47.

Q. I am showing you a document marked as Blue Cross Exhibit 3 for identification. Would you please identify it?

A. These are actuarial schedules that were enclosed with Exhibit 1 and submitted as support of the calculation of the proposed rates for both Basic (Pool I) and Preferred (Pool II) for the new HealthMate Direct 1000 plan to be effective July 1, 2010. Blue Cross Exhibit 3 consists of schedules 1A through 7A.

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

A. Blue Cross Exhibit 4 is entitled "Affordability Update Submitted in Conjunction with the Direct Pay Rate Filing Effective April 1, 2010." This exhibit lays out Blue Cross' strategy in regards to making improvements to the health care system, improve the health of our members, and slow down the increase in health care costs.

Q. Did you prepare or cause to be prepared Blue Cross Exhibit 1 for identification and the actuarial schedules attached thereto, marked as Blue Cross Exhibit 2 and Blue Cross Exhibit 3?

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

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

A. Yes.

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

A. The purpose of the filing is to seek approval of new subscription rates to be effective for the April 1, 2010 billing cycle as well as to introduce the new benefit plan outlined above. The filing schedules are intended to provide actuarial justification for the required rates needed by Blue Cross in order for the products to be financially self-supporting, both in the interest of its subscribers and its mission to provide quality health insurance programs.

The required subscription rates must provide for the expected costs of the products and contribute to the financial needs of Blue Cross. Such required rates are intended to provide sufficient income during the new rate period to cover the costs of subscribers' incurred claims for this period and to administer the programs.

Q. Did the Blue Cross Board of Directors authorize the rate increases reflected in this filing?

A. Yes. The Blue Cross Board of Directors met on October 8, 2009, at which time the rate increases reflected in this filing were considered, discussed, and approved for submission. The Directors' Finance Committee, which has primary oversight of all rate matters, also reviewed and authorized these rate increases at its meeting, held on September 24, 2009.

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

A. Schedules 1 through 3 constitute the table of contents for the actuarial schedules in Exhibit 2 that display and support the calculations of the required subscription rates for the April 1, 2010 billing cycle for the existing products within Class DIR. The actuarial schedules are grouped into sections, labeled as section I through section VII.

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

A. Section I consists of schedules 4 through 9, which summarize the calculations of the Basic (Pool I) monthly subscription rates for the April 2010 billing cycle. The monthly subscription rates for each of the Class DIR products for Basic (Pool I) subscribers are displayed separately by age and by individual vs. family contract type.

Section II consists of schedules 10 through 15, which summarize the calculations of the Preferred (Pool II) required monthly subscription rates for the April 2010 billing cycle. These schedules display the monthly subscription rates for each of the Class DIR products for Preferred (Pool II) subscribers by age, gender, and individual vs. family contract type.

Section III consists of schedules 16 through 20, which summarize the calculation of the Basic (Pool I) and Preferred (Pool II) monthly base rates for each of the products. This includes the development of the required rates for the two pools within Class DIR on a full experience basis as well as on the current pool rate alignment basis.

Section IV consists of schedules 21 through 22, which summarize the claims impacts from state assessments. Schedule 22 shows the calculation of the claims impact from the child immunization, adult immunization, and children's health account.

Section V consists of schedules 23 through 32, which show the projected claims by plan for Direct Pay and calculate the rate period projected incurred claims expense for Basic (Pool I) and Preferred (Pool II) subscribers. Schedule 24 summarizes the projected claims expense by pool and plan for Direct Pay while schedules 25 through 32 calculate the projected claims expense by plan for Basic (Pool I) and Preferred (Pool II).

Section VI consists of schedules 33 through 34, providing the administrative expense estimates and calculations.

Section VII consists of schedules 35 through 47, and contains trends and projection factors.

Q. Let us turn now to Blue Cross Exhibit 3, namely the actuarial schedules displaying the calculation of the proposed rates for the new HealthMate Direct 1000 product. Please describe for us of what schedules 1A through 7A consist.

A. Schedule 1A constitutes the table of contents for the actuarial schedules in Exhibit 3 that display and support the calculations of the proposed subscription rates for the new HealthMate Direct 1000 product. Schedules 2A and 3A display the proposed subscription rates for Basic (Pool I) and Preferred (Pool II), respectively while schedules 4A through 7A constitute the supporting calculations.

III. RATING METHODOLOGY USED IN FILING

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

A. Yes. The actuarial development of required rates for this filing is similar to the methodology used last year. The basic approach was to begin with base period incurred allowed claims, separately for Basic (Pool I) and Preferred (Pool II) and by benefit plan. To avoid seasonality concerns we chose a twelve month base period which is our usual practice. We chose a base period that consists of allowed claims incurred over the June 1, 2008 to May 31, 2009 time period. These allowed claims, expressed on a per contract per month (PCPM) basis, were then projected to the rate period using projection factors which reflect anticipated trends in allowed claims levels and adjusted to reflect anticipated policy, contract, and other changes not reflected in either utilization or pure price trends. Finally, the projected rate period allowed claims were adjusted by a factor that represents the ratio of net claims paid to allowed claims for each benefit plan as well as a utilization adjustment factor to reflect anticipated changes in utilization of services due to changes in member cost sharing. The net-to-allowed factors were calculated based on the projected rate period claims so that the effect of trend leveraging would be accounted for. A more thorough description of trend leveraging is included later on in my testimony. This process produced projected paid claims PCPM for each of the products within Basic (Pool I) and Preferred (Pool II). The composite projected paid claims PCPM was then calculated for each pool.

The next major stage in the rate development was to determine the required monthly base rates for each of the four products within Basic (Pool I) and Preferred (Pool II).

This stage begins with the composite projected incurred claims expense PCPM for each pool, which I have just described. The impact of state assessments was then applied to the projected incurred claims cost. The detail behind the state assessments is in Section IV. Retention (administrative expense, investment income credit, new system expense, and taxes) was added to this expense to calculate required income PCPM by pool and then overall for Class DIR. Note that in this year's rate filing, we are not including a component to contribute to corporate reserves. Also, the tax liability component has been increased to 2.0% due to the newly revised state premium assessment. The increase in the premium assessment was enacted on April 10, 2009 with retroactive effect to January 1, 2009. Also, this year's filing includes a component intended to collect revenue to fund a new core system for claims payment and other business functions. The development of this new system is consistent with Blue Cross' goal to simplify and streamline systems and processes. Consistent with the required monthly income PCPM values, required loss ratios for each pool and overall for Class DIR are calculated.

The overall required income PCPM for Class DIR is the amount that must be produced by the base rates for Class DIR as a whole. The separate amounts PCPM for Basic (Pool I) and Preferred (Pool II) would be the amounts used in developing the base rates for each of the pools, respectively, if the separate experience of the two pools were to form the sole basis for rates. This experience has not been the basis used in the past, and we chose not to use it as the sole basis in this filing. Due to the uncertainty surrounding pending health care legislation, and the possibility of the elimination of rating by health status, we chose to maintain the current pool rate alignment in this rate filing.

The last step in calculating base rates was to apply rate relativity factors, by product, to the pool composite required base rate amounts PCPM. These calculations and results

are presented in the schedules contained in Section III. As mentioned previously, the rate relativity factors are being revised with this year's rate filing to more properly align the rate relationships amongst the products.

The final stage in the rate development was to apply age/gender, individual and family rate, and rate-tier normalization factors to the base rates, by product and pool in order to produce the monthly subscription rates. The age/gender and individual/family rate factors for Preferred (Pool II) are the same as those used in last year's rate filing. As discussed above, we are introducing age rating into Basic (Pool I) rates. Due to the uncertainty surrounding pending health care legislation, we are not introducing rating by gender into Basic (Pool I). The age factors for Basic (Pool I) were developed by starting with the current Preferred (Pool II) age factors and adjusting the slope to be twenty-five percent of the Preferred (Pool II) age slope for individual male, individual female, and family rate tiers. The individual male and individual female age factors were then averaged to arrive at the Basic (Pool I) individual age factors. The age slope being introduced for Basic (Pool I) is flatter than the existing age slope for Preferred (Pool II) to minimize rate shock for older subscribers.

It should be noted that there is no explicit rate component being added to the rates for organ transplant benefits as in previous filings. Blue Cross discontinued its reinsurance arrangement with BCS Insurance Group effective January 1, 2009. The costs for organ transplant benefits are included explicitly in the claims base used for the rate filing insofar as there are organ transplant claims incurred during that period. These calculations and results are presented in the schedules contained in sections I and II for Basic (Pool I) and Preferred (Pool II) respectively.

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

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

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

Q. In developing the required rates, you mention that base period allowed claims were projected to the rate period using projection factors which reflect anticipated trends in allowed claims levels. Are these projection factors the same for Basic (Pool I) and Preferred (Pool II)?

A. No. The projection factors are composed of anticipated price changes and projected changes in utilization and mix of services. The price component of the projection factors are identical for Basic (Pool I) and Preferred (Pool II) since the two populations utilize the same network of hospital and physician providers. In past filings it was our practice to develop utilization trend assumptions based on aggregated Basic (Pool I) and Preferred (Pool II) experience. The increasing mix of Pool II enrollment had the effect of depressing the trend factors produced by this methodology. With this filing we are developing separate utilization factors based on each pool's individual experience. This should modestly increase the trend factors developed. However, in determining our overall Class DIR revenue requirements we also, for the first time, include an explicit assumption relative to pool mix. In the aggregate, our new approach is the equivalent of our prior practice. We are just substituting an explicit pool mix assumption for an implicit one.

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

A. A claims adjustment factor was applied to the projected allowed claims to adjust for anticipated changes not related to utilization/mix of services or price increases. These include a change in the way Blue Cross reimburses pathologists, the impact of new mandated benefits, the impact of a contract with Wellpoint effective January 1, 2009, the impact of anticipated new brand name drugs being introduced to the market, and the anticipated availability of new generic drugs.

Blue Cross is changing the way it reimburses pathologists at certain hospitals. Previously, the pathologist payment was included in the reimbursement to the hospital. Blue Cross anticipates that, going forward, reimbursements will be sent directly to the pathologist, in accordance with our negotiated fee schedule. This change in payment policy impacted surgical/medical price factors in November 2008, April 2009 and October 2009.

Two coverage mandates also impact the claim projections in this rate filing. Coverage for Enteral Feeding (commonly called tube feeding) was mandated effective January 1, 2009 for individuals who have been diagnosed with certain inherited diseases of amino acids and organic acids or who have conditions of malabsorption. Covered oral enteral food includes nutritional liquids, such as Ensure and Boost, food products that have been modified to be low in protein, and formulas labeled for use by infants and children who have inborn errors of metabolism. This coverage mandate impacts the surgical/medical claims adjustment factor.

Also impacting the claims projections for Direct Pay is the federally mandated behavioral health parity law effective November 2009. Health plans are now required to cover unlimited visits for residential substance abuse and child & family intensive treatment programs (CFIT). The impacts of these mandates are reflected in the claims adjustment factors for inpatient and surgical/medical projections, respectively.

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

We also used net-to-allowed factors and utilization adjustment factors to adjust the projected allowed dollars to the claims level anticipated to be paid by Blue Cross under each benefit plan. Blue Cross used a re-adjudication process to develop net to allowed factors, which reflect the ratio of claims expense to allowed claims for the benefits under a given product. This methodology is consistent with last year's filing and similar to that employed by Blue Cross in the past to estimate the impact of changes in benefit costs. The first step in the calculation of net-to-allowed factors was to project incurred allowed claims for Class DIR from the twelve month period ending March 31, 2009 to the twelve month rate projection period ending March 31, 2011. The projected rate year allowed claims were then re-adjudicated to the payment level anticipated under each of the respective benefit plans. The ratio of the projected rate period claims at the level paid under the benefit provisions to the total allowed claims level is what we refer to as a net-to-allowed factor.

Utilization adjustment factors are also applied as part of the rate development to adjust for expected changes in utilization due to changes in member cost sharing amounts. Increases or decreases in member cost sharing are expected to influence the frequency of health care services utilized and the type of service used. For example, an increase in an emergency room copay would disincent members from using the emergency room in non-emergent situations. Similarly, an increase in the deductible amount could discourage members from getting an elective outpatient surgery since the member has more financial stake in the procedure. The utilization adjustment factors used in the Direct Pay filing are consistent with those Blue Cross uses for developing rates in the Commercial Group market.

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

A. Yes. Briefly, trend leveraging describes the phenomenon that for benefit plans with fixed-dollar cost sharing, claims on a net paid dollar basis increase at a faster rate than claims on an allowed dollar basis if the fixed-dollar cost sharing (i.e. deductibles and co-payments) does not change from year to year. For example, let's say that the underlying increase in medical costs (i.e. the trend in allowed claims) is ten percent annually. Let's further assume that in a given year, one hundred dollars of allowed claims is incurred. As mentioned earlier, the trend in allowed dollars is ten percent and one hundred ten allowed dollars are incurred in the following year. However, if we impose a fifty dollar deductible on the benefit plan, the net claims expense becomes fifty dollars ($100-$50) in the first year and sixty dollars in the following year ($110-$50). The annual trend in claims expense in this case has been leveraged to 20% ($60 divided by $50). The same phenomenon occurs in the Direct Pay products due to the upfront deductibles and other fixed-dollar co-payments in the benefit provisions. Since members do not utilize benefits consistently, the effect of trend leveraging is best handled by projecting and re-adjudicating claims at the member level. This is the process involved in the calculation of the net-to-allowed factors.

Q. You testified previously that over the last few years the number of members enrolled in Preferred (Pool II) has steadily increased. How was the impact of this shift in enrollment accounted for in the rate development?

A. Allowed claims PCPM were developed separately for Basic (Pool I) and Preferred (Pool II) and projected to the rate year using projection factors that were appropriate

for each pool. Next, contract months over the rate year were projected for each pool by looking at recent historical enrollment changes. The separate rate period claims expense PCPM for each pool were weighted together by the projected rate period contract months to arrive at a composite projected claims expense for Class DIR over the rate year. Similarly, present rate income PCPM was developed separately for Basic (Pool I) and Preferred (Pool II) and weighted by projected rate period contract months to arrive at composite present rate income PCPM for Class DIR. Finally, required income PCPM was calculated for each pool using the current pool rate alignment. These calculations are displayed on Schedules 19 and 20 of Exhibit 2. By projecting the claims costs and present rate income separately for the two pools and recalculating the composite based on the projected enrollment over the rate year, the issue of enrollment shifting amongst the pools is dealt with explicitly in the rating methodology.

Q. Can you please provide an overview of the approach used by Blue Cross to develop the proposed rates for the new HealthMate Direct 1000 product?

A. Yes. The first step in the basic approach was to start with projected allowed dollars for the HealthMate Direct 500 and HealthMate Direct 2000 product by pool from Blue Cross Exhibit 2. Only the claims experience from the HealthMate Direct products was used in the calculation since this population is representative of subscribers likely to enroll in the new HealthMate Direct 1000 plan. Next, a trend adjustment was made to account for the fact that the rate year for the new HealthMate Direct 1000 product begins July 1, 2010 versus April 1, 2010 for the existing products. Since the rate year for the HealthMate Direct 1000 starts July 1, 2010 and ends March 31, 2011, this adjustment is equivalent to one and one half months of trend. Next, net-to-allowed factors were applied which represent the ratio of paid claims to allowed dollars for the new HealthMate Direct 1000 plan. To be consistent with the experience used,

these factors were calculated based on the experience of the HealthMate Direct products. Finally, utilization adjustment factors were applied to adjust for the differences in utilization expected under the new product due to differing member cost sharing amounts versus the products used in the experience base. Applying these adjustments result in the projected paid claims PCPM. These projected paid claims PCPM amounts are shown in column (6) of schedule 6A of Blue Cross Exhibit 3 for Basic (Pool I) and column (6) of schedule 7A of Blue Cross Exhibit 3 for Preferred (Pool II).

Once the projected paid claims PCPM amounts for the HealthMate Direct 1000 product were calculated, the rest of the rate development is similar to that used for the existing products. The next major stage in the rate development was to determine the required monthly base rates for the HealthMate Direct 1000 product for Basic (Pool I) and Preferred (Pool II). This stage begins with the composite projected incurred claims expense PCPM for each pool, which I have just described. The impact of state assessments was then applied to the projected incurred claims cost. To this expense was added retention (administrative expense, investment income credit, new system expense, and taxes) to calculate required income PCPM by pool and then overall for the new product. The overall required income PCPM for HealthMate Direct 1000 was then allocated to Basic (Pool I) and Preferred (Pool II) using the same pool relationship present in the current Class DIR rates.

Once the required income PCPM is calculated, a rate discount factor of 0.9000 is applied to arrive at the proposed monthly base rate. This discount factor was chosen in order to align the HealthMate Direct 1000 product's rate to a desirable level relative to the existing products in Class DIR. This discount factor also recognizes the different onboarding process we will be using to enroll members in this product versus the existing product portfolio. This

different onboarding mechanism is expected to change the way we engage with our members in the new HealthMate Direct 1000 product. The behavioral changes we hope to instill in our members are expected to result in medical expense savings.

The final stage in the rate development was to apply age/gender, individual and family rate, and rate-tier normalization factors to the base rates, by product and pool in order to produce the monthly subscription rates. The rate tier normalization factors are identical to those used in Exhibit 2 for the existing Class DIR products.

IV. REQUIRED CLASS DIR BASIC (POOL I) AND PREFERRED (POOL II) MONTHLY SUBSCRIPTION RATES

Q. Please turn to schedule 24 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 24 is entitled "Calculation of Composite Paid Claims Expense Per Contract Month for April 1, 2010 Billing Cycle." The purpose of this schedule is to display the base period contract months and the projected incurred claims PCPM by pool and plan. It uses the projected claims expense for each product from schedules 25 through 28 for Basic (Pool I) and schedules 29 through 32 for Preferred (Pool II). Calculations are documented in the footnotes.

Q. Please turn to schedule 25 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 25 is entitled "Calculation of Projected Paid Claims per Contract Month for April 1, 2010 Billing Cycle for HealthMate Direct 500." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the projected paid claims PCPM for HealthMate Direct 500 for Basic (Pool I). Calculations are documented in the footnotes.

Q. How does schedule 25 compare with schedules 26 through 28?

A. Schedules 26 through 28 are comparable in nature. They also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas schedule 25 applies to HealthMate Direct 500.

Q. On a column-by-column basis, would you explain what is contained in schedules 25 through 28? Please note any relevant differences among them.

A. The first and second columns of each of these schedules show base period incurred allowed claims for each of the respective products. As indicated in the applicable footnotes, allowed claims were tabulated prior to the application of deductibles, coinsurance, or copayments. We used a base period for tabulating these allowed claims, and for the contract months underlying column (2), of June 2008 through May 2009. Incurred allowed claims amounts for this base period reflect actual claim submissions through July 2009, adjusted to a fully complete basis.

Column (3) shows the projection factors used to incorporate trends into the projection of allowed claims PCPM for the rate period. The projection factors are developed in schedule 36, as indicated in the footnotes. Consistent projection factors are used in all four schedules.

Column (4) shows a claims adjustment factor used to account for anticipated policy changes, contract changes, and one time claims impacts that are not reflected in utilization or pure price trends. These adjustments include enteral formulas, federal mental health parity, direct payments to pathologists, Wellpoint contract savings, and changes in the prescription drug market (such as brand drugs becoming generic).

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

Column (6) displays the Net-to-Allowed factors by benefit. These factors convert the projected allowed claims to paid claims for the rate year, including the pricing impact of the new benefit design. The factors are unique to each combination of pool and plan since these

factors are calculated using the actual claims experience for each pool and plan combination. Since the HealthMate Direct 500 and HealthMate Direct 2000 products have first dollar coverage for drug benefits (i.e. drug benefits are covered without members first having to meet a deductible), separate drug and non-drug net-to-allowed factors are calculated for these products. The HealthMate for HSA 3000 and HealthMate for HSA 5000 products cover drug benefits only after the deductible has been met. Therefore, net-to-allowed factors for these products are calculated in aggregate for drug and non-drug benefits.

Column (7) is the anticipated utilization change due to the redesigned benefits.

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

Q. You state that schedules 25 through 28 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 29 through 32.

Q. Are there any differences between schedules 29 through 32 and schedules 25 through 28, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

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

Q. Please turn to schedule 36 and describe that schedule.

A. Schedule 36 is entitled "Projection Factors for Allowed Claims for April 1, 2010 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the projection factors used to project base period allowed claims to the rate period. The base period for allowed claims is June 2008 through May 2009, while the rate period is April 2010 through March 2011. The difference between these two periods is 22

months. The projection factors reflect Blue Cross' expectation for cumulative trends over this 22-month period. These trends have a price component and a utilization and mix of services component. The calculations in schedule 36 are documented in the footnotes.

Q. On a column-by-column basis, would you please explain what is contained in schedule 36?

Column (1) of schedule 36 shows the price trend factor components of the projection factors. These price trend factors apply to the 22-month projection period from the base period to the rate period. They were provided by Blue Cross' Contract Support Department, based on actual unit cost increases, estimates of price increases based on negotiated prices, and any planned or estimated increases and adjustments.

Column (2) contains the Basic (Pool I) utilization / mix trend factor components of the Basic (Pool I) projection factors. These utilization / mix trend factors also apply to the 22-month projection period from the base period to the rate period. They were developed from an analysis of Basic (Pool I) historical claims trends. For Basic (Pool I), the graphs and corresponding data points displayed in schedules 38 through 41 formed the foundation for this analysis, along with actuarial judgment. The footnotes in schedule 36 document the annual trend assumptions for utilization / mix selected by Blue Cross, along with the computational steps necessary to calculate the 22-month utilization / mix trend factors contained in column (2).

Column (3) contains the projection factor. This is simply the product of columns (1) and (2).

Q. Was any recognition of leveraging of trend factors caused by the HealthMate deductibles needed? If so, please explain how this was handled.

A. The term leveraging, when used in the context of price trend factors, refers to the fact that deductibles or other fixed dollar subscriber cost-sharing generally causes price

trends in benefit claims expense to be greater than the underlying price trends in allowed claims. The materiality of such leveraging depends on the proportionate magnitude of the deductible or other fixed dollar cost sharing provisions; relatively large deductibles and fixed co-payments have greater leveraging impact on benefit claims expense trends than relatively small cost sharing amounts. The materiality of leveraging also depends on the magnitude of the underlying price trends in allowed claims; relatively higher price trends in allowed claims generally have a greater leveraging impact on benefit claims expense trends than lower price trends.

The projection factors developed in schedule 36 reflect trends in allowed claims, rather than benefit claims expense. They are then applied to base period allowed claims, to produce projected allowed claims. As a result, trend leveraging is not a factor affecting the price trend factor in column (1). It should be noted that the net-to-allowed factors contained in column (6) of schedules 25 through 28, for Basic (Pool I), and Schedules 29 through 32 for Preferred (Pool II), deal with the changing impact over time of deductibles and fixed dollar co-payments. These net-to-allowed factors address the impact of the deductibles and fixed dollar co-payments by re-adjudicating allowed claims that have already been projected. This direct treatment avoids the need for leveraged trend factors.

Q. You state that schedules 36 and 38 through 41 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 37 and 42 through 45, respectively.

Q. Are there any differences between schedules 36 and 38 through 41 and schedules 37 and 42 through 45, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

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

Q. With regard to the utilization / mix trend factors shown in schedules 36 and 37, you state that they were developed from an analysis by your staff of historical trends. Please describe the nature of this analysis.

A. The utilization / mix trend analysis undertaken by my staff focused on allowed claims PCPM that have been adjusted to a common price level, namely June 2006, for the hospital inpatient, hospital outpatient, and surgical / medical lines of business. For pharmacy, allowed claims PCPM without any price adjustment were analyzed.

The data points used in this analysis were 12-month moving values, beginning with the period ending May 2007. Twenty-five data points, which equates to three years of experience, were looked at. Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, a statistical technique for quantifying trend levels. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points using the most recent 13 or more data points, with a minimum R-squared value of 0.70 to help assure reasonable fit to the data points.

The annual trend indicated by the least squares line producing the best fit under this procedure is then selected as the basis for the trend assumption, provided the result is acceptable actuarially. Adjustment or modification to this result, or substitution of an alternative assumption, may occur if it is not reasonable or appropriate in our actuarial judgment.

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

A. This is the method that has been utilized and presented in past rate filings for quantifying trends. It has been discussed extensively in previous rate hearings. Briefly, by

plotting a number of historical observations on a graph, the average change over a specified time period may be calculated using a statistical technique referred to as the method of linear least squares.

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

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 differences between the line and the actual values) are minimal, or the least possible. While one may attempt to draw a straight line through the observations by visual interpretation to denote a trend, the method of least squares obtains that minimum sum of squared deviations necessary to give a best linear fit of the data.

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

A. Yes. We considered a total of 25 monthly 12-month moving data points. The number of data points consisting of the most recent 13 or more points that provide the best fit was calculated, as I just described. There was no discretion in the selection of the number of data points; it was mathematically determined. There is only one possible best fit, which is the number of data points that produces the line with the highest R-squared value.

Once the number of 13 or more of the most recent data points that provides the best fit is found, the trend indication based on those data points is what we utilize in the rate

calculations, provided that the best fit is actuarially acceptable. A trend line with an r-squared value of 0.70 or higher is generally considered statistically acceptable to us; however, information to the contrary, such as a non-credible experience base or an erratic or biased pattern of data points, in addition to a low r-squared value, or when the result is unreasonable, may provide reasons to utilize actuarial judgment in trend determination.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

A. Yes.

Q. Please turn to Schedule 38, and describe what is contained in that schedule.

A. Schedule 38 is entitled "Class DIR Basic Rate (Pool I): Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points, for Class DIR Basic (Pool I). The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May

2009. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, as I described earlier. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent 13 data points or more). As shown in schedule 38, the line with the best fit is based on all 25 data points with an r-squared value of 0.9189 and an annual trend of -11.67%. Although the r-squared value met our minimum criteria of 0.70, we do not believe that a -11.67% annual trend can reasonably be expected to continue. In addition, there are typically only about 125 Pool I hospital inpatient admissions per 12 month period so we do not consider this data to be fully credible. Commercial Group inpatient trend factors, which were filed on May 15, 2009 and subsequently withdrawn, imply an annual increase of 1.00% for utilization and mix. We believe Group's inpatient trend is a reasonable proxy for future Class DIR inpatient trend. This annual trend assumption is documented in the footnotes contained in schedule 36. Since we are projecting from a base period that consists of the twelve months ending May 2009, we are fully recognizing the decreases in inpatient utilization that have occurred to date.

Q. Please turn to schedule 39, and describe what is contained in that schedule.

A. Schedule 39 is entitled "Class DIR Basic Rate (Pool I); Hospital Outpatient: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending

May 2007 and continue through the 12-month period ending May 2009. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 38 earlier. Similarly, following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 39, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.6781 and represents a calculated annual trend of 7.43%. However, the r-squared value does not meet the minimum criteria of 0.70. Also, the more recent data points show that the trend is moderating. Thus, to recognize the general increase in utilization shown in schedule 39, we chose an annual utilization/mix trend of 4.00%. This trend assumption is modestly lower than the outpatient utilization/mix trend factor filed for in our most recent Commercial Group filing of 5.3% for groups renewing in the second quarter of 2010. This annual trend assumption is documented in the footnotes contained in schedule 36.

Q. Please turn now to schedule 40, and describe what is contained in that schedule.

A. Schedule 40 is entitled "Class DIR Basic Rate (Pool I): Surgical/Medical: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. In order to reflect only changes in utilization and mix of

services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed PMPM values used.

Again, trend lines were fit to a number of sets of data points utilizing the method of linear least squares. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 40, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.7892 and represents a calculated annual trend of 3.15%. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 3.15%. This annual trend assumption is documented in the footnotes contained in schedule 36.

Q. Please turn to schedule 41, and describe what is contained in that schedule.

A. Schedule 41 is entitled "Class DIR Basic Rate (Pool I): Pharmacy: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. These values have not been depriced, so their trends reflect both price and utilization/mix.

The line exhibiting the best fit produced an annual trend of 15.02%. It consists of 13 data points, with an r-squared value of 0.9890. Actuarial judgment was exercised by Blue Cross, however. We chose to utilize the trend calculated on all 25 12-month moving points of 10.32%. This trend is a more reasonable indication and more closely aligns with drug trends we have been observing in the Commercial Group market. Also, using all 25 points of data produce a still valid r-squared value of 0.9678, which indicates the best fit line if more than 15 data points

are considered. We believe that, in this case, using more data points produce a more reliable result. This annual trend assumption is documented in the footnotes contained in schedule 36.

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

A. Schedule 46 is entitled "Class DIR Basic Rate (Pool I): Point Values Utilized in Development of Trends." This schedule displays the allowed claims PMPM values utilized to calculate trends in schedules 38 through 41. The first column shows the dates applicable to each of the 25 monthly 12-month periods observed. Opposite each date are the values reflected in the various graphs set forth in schedules 38 through 41 for each of the applicable lines of business.

Q. You state that schedules 38 through 41 and 46 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 42 through 45 and 47, respectively

Q. Are there any differences between schedules 38 through 41 and 46 and schedules 42 through 45 and 47, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

A. Yes. The data used is applicable to Preferred (Pool II) versus Basic (Pool I) and trend selections vary.

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

A. Schedule 42 is entitled "Class DIR Preferred Rate (Pool II): Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points, for Class DIR Preferred (Pool II). The data points begin

with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 38 earlier. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent 13 data points or more). As shown in schedule 42, the line with the best fit is based on the last 22 data points with an r-squared value of 0.9309 and an annual trend of 42.46%. Although the r-squared value met our minimum criteria of 0.70, we do not believe that a 42.46% annual trend can reasonably be expected to continue. In addition, there are typically fewer than 50 Pool II hospital inpatient admissions per 12 month period so we do not consider this data to be fully credible. Commercial Group inpatient trend factors, which were filed on May 15, 2009 and subsequently withdrawn, imply an annual increase of 1.00% for utilization and mix. We believe Group's inpatient trend is a reasonable proxy for future Class DIR inpatient trend. This annual trend assumption is documented in the footnotes contained in schedule 37.

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

A. Schedule 43 is entitled "Class DIR Preferred Rate (Pool II); Hospital Outpatient: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. In order to reflect only

changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 38 earlier. Similarly, following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 43, the line with the best fit is based on the last 13 data points, which has an r-squared value of 0.9238 and represents a calculated annual trend of 12.69%. Even though the r-squared value meets our minimum criteria of 0.70, because of the unreasonableness of the trend indication, we chose to utilize an annual trend of 4.00%, the same trend utilized in Basic (Pool I). This annual trend assumption is documented in the footnotes contained in schedule 37.

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

A. Schedule 44 is entitled "Class DIR Preferred Rate (Pool II): Surgical/Medical: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2006, so that intervening price increases have been removed from the allowed PMPM values used.

Again, trend lines were fit to a number of sets of data points utilizing the method of linear least squares. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 44, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.8884 and represents a calculated annual trend of 4.74%. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 4.74%. This annual trend assumption is documented in the footnotes contained in schedule 37.

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

A. Schedule 45 is entitled "Class DIR Preferred Rate (Pool II): Pharmacy: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2007 and continue through the 12-month period ending May 2009. These values have not been depriced, so their trends reflect both price and utilization/mix.

The line exhibiting the best fit produced an annual trend of 9.21%. It consists of 13 data points, with an r-squared value of 0.9621. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 9.21%. This annual trend assumption is documented in the footnotes contained in schedule 37.

Q. Would you turn now to schedule 47, and describe what is contained in that schedule?

A. Schedule 47 is entitled "Class DIR Preferred Rate (Pool II): Point Values Utilized in Development of Trends." This schedule displays the allowed claims PMPM values utilized to calculate trends in schedules 42 through 45. The first column shows the dates applicable to each of the 25 monthly 12-month periods observed. Opposite each date are the values reflected in the various graphs set forth in schedules 42 through 45 for each of the applicable lines of business.

Q. With regard to the claims adjustment factor shown in column (4) of schedules 25 through 32, could you please describe these factors?

A. As indicated in the footnotes, these factors are used to adjust claims expenses for anticipated policy changes, contract changes, and one time claims impacts that are not reflected in utilization or pure price trends. I have discussed these factors in more detail earlier in my testimony.

Q. Turning back to schedules 25 through 32, column (6) shows net-to-allowed factors. Could you please describe generally the method used to develop these net-to-allowed factors?

A. Sure. To determine net-to-allowed factors, the allowed claims for each Direct Pay member are re-adjudicated to simulate members having each of the plan designs for the rate year April 2010 to March 2011. The most recent full rate year claims, April 2008 to March 2009, were broken out by each pool and product combination and each category was used in the calculation of the net-to-allowed factor for that particular cohort. For example the April 2008 to March 2009 claims for Basic (Pool I) HealthMate Direct 400 were re-adjudicated in the calculation of the net-to-allowed factor applicable to Basic (Pool I) HealthMate Direct 500.

Since the period used begins in the middle of the calendar year and deductibles are aggregated on a calendar year basis, a multi-step process was utilized to project and re-adjudicate the claims.

First, allowed claims for the period January 2008 through December 2008 were projected to the period January 2010 through December 2010 and re-adjudicated to the net payment level for the applicable benefit plan. Next, allowed claims for the period January 2009 through March 2009 were projected to the period January 2011 through March 2011 and re-adjudicated to the net benefit level. This data were combined with the last nine months of projected net claims data from the previous step to form the net claims for the rating period. The net-to-allowed factor is then the ratio of the projected net claims expense to the projected rate year allowed claims. The prescription drug net-to-allowed calculations for the HealthMate for HSA 3000 and the HealthMate for HSA 5000 products are incorporated into the medical net-to-allowed calculations, since prescription drug claims for these plans apply towards the deductible.

The prescription drug net to allowed calculations for the HealthMate Direct 500 and the HealthMate Direct 2000 products are separate from the medical net-to-allowed calculations, since prescription drug claims for these plans do not apply towards the deductible.

Q. Turning back again to schedules 25 through 32, column (7) shows utilization adjustment factors. Could you please describe generally the method used to develop these utilization adjustment factors?

A. As discussed previously in my testimony, these factors are applied to adjust for expected changes in utilization due to changes in member cost sharing amounts. For each change in subscriber cost sharing being proposed in this rate filing, a corresponding assumption is made regarding a change in the rate of use of that particular service by subscribers.

These utilization factors are based on those used in rating Blue Cross' Commercial Group line of business.

Q. You have now described and explained the columns in schedules 25 through 32, along with the various schedules supporting them. You have stated that schedules 25 through 32 develop the projected paid claims PCPM for each of the current products. Now I would like to turn to section III of the rate filing and the development of the monthly base rates. Please turn to schedule 17 and describe that schedule.

A. Schedule 17 is entitled "Class DIR Basic Rate (Pool I): Calculation of Required Monthly Base Rates for April 1, 2010 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the proposed monthly base rates for each of the products under Basic (Pool I). Calculations are documented in the footnotes.

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

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

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

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

Column (4) shows the Basic (Pool I) current plan relativity monthly base rate for each of the four products. These are the base rates, by product, that correspond to the plan

relativities prior to modification which are shown in column (3). This column is shown for informational purposes only. Calculations are documented in the footnotes.

Column (5) shows a redistribution factor for each plan. These factors are multiplied by the current plan relativity factors in column (3) to produce the proposed plan relativity factors shown in column (6). We are reducing the relativity factor applicable to the HealthMate Direct 500 plan to recognize that the subscribers covered under this plan will be experiencing a larger increase in member cost sharing than will other Class DIR subscribers.

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

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

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

A. Yes. It is schedule 18.

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

A. No.

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

A. Schedule 19 is entitled "Calculation of Required Loss Ratios on Current Pool Rate Alignment Basis for April 1, 2010 Billing Cycle." It applies to both Basic (Pool I) and

Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss ratio, current pool rate alignment basis for each of the two pools. Calculations are documented in the footnotes.

The overall Class DIR required income PCPM is developed in schedule 20. The same overall Class DIR required income PCPM is preserved in schedule 19. The respective amounts by pool, however, differ between schedule 20 and 19. In schedule 20, the required Income PCPM amounts by pool directly reflect the separate experience of each pool. Schedule 19 develops required income PCPM amounts by pool which reflect the current alignment of rates by pool, rather than pool experience. In both cases, schedules 20 and 19, the composite average required income PCPM must remain the same.

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

A. Column (1) of schedule 19 shows the projected contract months for Basic (Pool I) and Preferred (Pool II). As discussed earlier in my testimony, projected contract months by pool were used in weighting various amounts in order to directly deal with the impact of enrollment changes over time. Column (2) shows the projected incurred claims including mandates amounts for each of the two pools. The sources of these values are documented in the footnotes.

Column (3) contains the composite required income PCPM amount for Class DIR as a whole. This amount is developed in schedule 20.

Column (4) contains the present rate income PCPM (PRI) amounts on an average basis for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The composite average

PRI for all of Class DIR is the weighted average of the PRI amounts for Basic (Pool I) and Preferred (Pool II), as documented in the footnotes.

Column (5) contains the current pool rate alignment basis required income PCPM amounts for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The calculations are documented in the footnotes. The Class DIR composite in column (5) is required to be the same as in column (3). The respective required income PCPM amounts by pool in column (5) are calculated to maintain the same proportionate relationship as the PRI values in column (4), i.e., no re-alignment in rates between pools. For this filing, these are the composite required monthly base rates used in developing the proposed monthly base rates for each product, by pool.

Column (6) contains the required loss ratios calculated for Basic (Pool I) and Preferred (Pool II), on a current pool rate alignment basis. This means that the Basic (Pool I) and Preferred (Pool II) values would retain the same relationship in required rates as is reflected in the present rates. Due to the uncertainty surrounding pending health care legislation, and the possibility of the elimination of health status rating, we are not changing the current pool rate alignment in this year's filing.

Q. With regard to the required income PCPM, you refer to the development in schedule 20. Could you please turn to schedule 20 and describe that schedule?

A. Schedule 20 is entitled "Calculation of Required Loss Ratios on Full Experience Basis for April 1, 2010 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss ratios, full experience basis for each of the two pools. Calculations are documented in the footnotes.

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

A. Column (1) of schedule 20 shows the projected contract months for Basic (Pool I) and Preferred (Pool II).

Column (2) shows the projected incurred claims expense PCPM. As indicated in the footnotes, these amounts come from schedule 24.

Column (3) shows the state assessments impact. As indicated in the footnote, this factor comes from schedule 22.

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

Column (5) contains the administrative expense PCPM for the rate period. As indicated in the footnotes, the value contained in column (5) is developed in schedule 34.

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

The investment income credit is calculated by looking at three values that generate funds used to produce investment earnings, namely, the reserve level of the Class in question, prepaid subscriptions, and claim reserves. These amounts, after adjusting for only those funds that will be available for investment, are used to generate earnings. Based on a projection of such amounts, a determination is made of the appropriate investment income credit factor, expressed as a percent of projected incurred claims and administrative expense. Due to the accumulation of losses in Class DIR over the last year, the sum of the three values that generate funds for investment earnings is in a negative position for Direct Pay. Therefore, no

projected investment income earnings have been allocated to Class DIR for the rate year. As such, the investment income credit factor is 0.00%, as indicated in the footnotes to schedule 20.

Column (8) contains the rating component for the new core system. Like last year, Blue Cross intends to continue to collect the revenue required to implement the new claims payment system by way of a charge on rates. This year the rates contain a factor equal to 0.34% of premium. The new system expenses will be amortized across all lines of business, including self-insured accounts, over the expected lifetime of the system. Calculations are documented in the footnotes.

Column (9) contains the contribution to reserve / tax liability PCPM values for the rate period. The contribution to reserve and tax liability component is the amount requested by Blue Cross to include in the Class DIR subscription rates in order to contribute to the establishment and maintenance of reserves maintained by Blue Cross for the protection of its subscribers. As mentioned earlier, the contribution to reserve/tax liability component includes 2% for the recently increased state premium tax assessment on health insurance premiums. Section 9 of Chapter 5 of the Rhode Island Public Laws of 2009, enacted April 10, 2009, increased the premium tax assessment from 1.75% to 2.00% retroactively to January 1, 2009.

The factor used to calculate column (9) is based on the requested contribution to reserve as a percentage of income plus one quarter of the amount for federal income taxes plus an additional 2% for the aforementioned state premium assessment. For the reasons discussed earlier, Blue Cross is not requesting a contribution to reserve component for Class DIR rates effective April 2010. Thus, in this case, the combined contribution to reserve and tax PCPM is calculated using a factor of 0.98.

The remaining columns in schedule 20 are calculated using the values I just described. These calculations are documented in the footnotes. Column (11) then contains the required loss ratios calculated for Basic (Pool I) and Preferred (Pool II), on a full experience basis. That means that the Basic (Pool I) value reflects the projected required loss ratio based fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

Q. You mention a state assessments impact factor in column (6) of schedule 22. Could you please explain the calculation of this factor?

A. Of course. Section IV shows the development of this factor. Section IV consists of only schedule 22. Schedule 22 is titled "Calculation of Claims Impact of State Assessments" and illustrates the different assessments that have an impact on the rates being filed for Class DIR. These three assessments will be made as a percentage of premium at an estimated rate of 0.73% for the Child Immunization Assessment, 0.10% for the Adult Immunization Assessment, and 0.418% for the CEDARR, CIS, and Home Services Assessment, for a a total of 1.248%. This translates to 1.26% of projected claims.

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

A. Yes. These State Assessments were included in the last several Class DIR rate filings.

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

A. Yes. The determination of these assessments to Blue Cross is based on premium reported on annual financial statements, including premium for the Class DIR line of business. As such, we do not believe we can absorb these costs in our other lines without

threatening our competitive standing in those market segments. We believe that the only appropriate way of insulating DIR from these costs (if indeed the Legislature wishes to so insulate DIR) is to define future bases for assessments in such a way as to exclude DIR business.

Q. With regard to the administrative expense PCPM shown in column (5) of schedule 20, you refer to its development in schedule 34. Could you please turn to schedule 34 and describe that schedule?

A. Schedule 34 is entitled "Calculation of Administrative Expense per Contract Month for April 1, 2010 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). This schedule displays Blue Cross' administrative expense budget amounts for calendar years 2010 and 2011, in aggregate and PCPM. Then the PCPM amounts for 2010 and 2011 are weighted together to produce an appropriate amount for the April 1, 2010 billing cycle.

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

A. A large portion of Class DIR operating expenses is allocated rather than direct. Consequently, in order to project operating expenses on their own merit, independent of increases in health care costs, the provision of operating expenses in this filing is based upon expense budgets for CY2009, CY2010, and CY2011 developed internally by Blue Cross for Class DIR.

Q. How are the 2009, 2010, and 2011 Class DIR operating expense budget amounts determined?

A. In preparation for this Class DIR filing, we developed estimated budgets for Class DIR calendar years 2009, 2010, and 2011. Attached hereto as Blue Cross Exhibit 6 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of

CY10 Budget to CY09 Projected Actual by Natural Account." Blue Cross Exhibit 6 compares by natural account (1) 2009 Projected Operating Expenses to (2) the 2010 Operating Expense Budget. The CY09 Budget is based on actual reported expenditures in 2009, with an estimate for the remainder of the year. The CY10 amounts reflect the budget for the calendar year. The third column of Blue Cross Exhibit 6 shows the dollar increase or decrease between CY09 Projected and CY10 Budget. The fourth column shows the percentage increase or decrease. As stated at the bottom of Blue Cross Exhibit 6, the methodology used to create the 2010 budget was to estimate the Class DIR operating expenses for 2009 by category and then adjust for inflation and certain other factors.

For purposes of this filing, the calendar year 2010 budget results in a total budgeted amount for Class DIR of $6,425,429, as reflected in column 2 of schedule 34 of Blue Cross Exhibit 2. This in turn was divided by total projected Class DIR contract months for 2010 of 120,018 for a projected total Class DIR operating expense per contract month figure of $53.54 for calendar year 2010. See column 4 of schedule 34 of Blue Cross Exhibit 2.

For 2011 attached hereto as Blue Cross Exhibit 7 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of CY11 Budget to CY10 Budget by Natural Account." Exhibit 7 employs the same format as Exhibit 6, except that it compares CY11 to CY10. The CY11 budget amount of $6,645,268 as reflected in column 2 of schedule 34 of Blue Cross Exhibit 2 is divided by the total projected Class DIR contract months for 2011 of 121,404, for a projected total Class DIR operating expense per contract month figure of $54.74. Attached hereto as Blue Cross Exhibit 8 is a detailed narrative breaking down the administrative expenses for the Direct Pay budget.

Q. Please turn back to schedule 20. In your testimony regarding column (9) of this schedule, you described the nature of the contribution to reserve / tax liability PCPM and its calculation. You also indicate that a factor of .98 was used, in order to produce an after-tax contribution to reserve of 0% of subscription income. Is that correct?

A. Yes.

Q. Why is an after-tax contribution to reserve of 0% appropriate for this line of business?

A. Although we believe that the Direct Pay population should contribute their fair share to reserves, given the current economic climate and other considerations we have chosen to not require a contribution to reserves at this time. In the future, we do intend to require a contribution to reserves from this population particularly because Blue Cross' surplus levels as a percent of annual premium are currently 19% of annual premium, well below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium.

Q. What is the reserve status of Class DIR?

A. The Class DIR reserve position at September 30, 2009 was $(9,028,034), or (1.78) months in reserve. The Class DIR reserve position at March 31, 2010 is projected to be approximately $(10.9) million. These reserve positions are indicated on a Statutory Accounting Principles (SAP) basis. Projected reserve positions assume no change in unrealized capital gains or losses.

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

A. Blue Cross' reserve position at September 30, 2009 was $327,681,664, or 2.19 months in reserve, on a SAP basis.

Q. What is the reserve target for Blue Cross?

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

Note that Blue Cross of Rhode Island was ranked 26th out of 37 Blue Cross Plans nationally in health risk-based capital, as of June 30, 2009.

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

A. Yes. Assuming the requested rates are implemented as filed it is projected that at the end of the rate year (March 31, 2011), Class DIR will still have a projected negative reserve balance of ($11.8) million. Note that our Class DIR reserve position will continue to deteriorate even if the proposed rates are approved in full due to excess expenses related to our core system replacement and Integrated Health Management that are not included in the rate development.

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

A. Schedule 5 is entitled "Calculation of HealthMate Direct 500 Required Monthly Subscription Rates for April 1, 2010 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the monthly subscription rates for individual and family subscribers in Basic (Pool I) by age category. Monthly subscription rates in schedule 5 are shown separately on a required rate basis. Calculations are documented in the footnotes. Note that effective April 2010, Blue Cross is proposing to introduce rating by age category into Basic (Pool I). The Basic (Pool I) age categories are identical to the Preferred (Pool II) age categories with the exception of an age 65 and older category for Basic (Pool I). In addition, proposed rates for Basic (Pool I) do not vary by gender. The rationale for this rate structure was discussed previously in my testimony.

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

A. Schedules 6 through 8 are comparable in nature. They also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas schedule 5 applies to HealthMate Direct 500.

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

A. Row (i) contains the monthly base rate for each of the corresponding products for Basic (Pool I). As indicated in the footnotes, the monthly base rates for Basic (Pool I) are developed in schedule 17.

Row (ii) is labeled "Rate Tier Normalization Factor." This is the normalization factor that corrects any imbalance in the rate factors contained in columns (1) and (3) of schedules 5 through 8, determined across the entire pool. The rate tier normalization factor is developed in schedule 9.

Row (iii) is simply row (i) divided by row (ii).

Column (1) contains the individual rate factors, and column (3) contains the family rate factors. These are the factors needed to convert the normalized monthly base rate for the product and pool to monthly subscription rates for individual and family contracts and, within each, by age category. As explained elsewhere in my testimony the rate factors used were developed by flattening the slope of the Preferred (Pool II) rate factors. The Preferred (Pool II) rate factors are the same factors that were used in last year's rate filing.

Column (2) contains the monthly subscription rates for individual subscribers, and column (4) contains the monthly subscription rates for family subscribers. The calculations are documented in the footnotes.

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

A. Schedule 9 is entitled “Calculation of Rate Tier Normalization Factor”. Column (1) is the “Rate Factor” that converts monthly normalized base rates to monthly subscription rates for individuals and families, by age category

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

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

Lines (1) through (21) simply represent the enrollment by tier category and in total.

Row (22) represents the proposed rate relativity factors for each plan that are calculated on schedule 17, as mentioned in the footnote.

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

Q. Please turn back now to schedule 5. You described the calculations involved in columns (2) and (4) of schedule 5. The result is what is shown in these two columns as the Basic (Pool I) monthly subscription rates for HealthMate Direct 500. Is that correct?

A. Yes. The resulting monthly subscription rates are contained in column (2) for individual subscribers and column (4) for family subscribers.

Q. Schedule 5 applies to the HealthMate Direct 500 product under Basic (Pool I). You testify that schedules 6 through 8 are comparable, for the other three product rates for Basic (Pool I). Is that also correct?

A. Yes.

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

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

Q. Please turn to schedule 11. Are the same calculations carried out for the HealthMate Direct 500 product in schedule 11 for Preferred (Pool II) as in Schedule 5 for Basic (Pool I)?

A. The same types of calculations are carried out in schedule 11 for Preferred (Pool II) as in schedule 5 for Basic (Pool I). I would note that the format and structure of schedule 11 differs slightly from schedule 5; labeling and rate development is consistent, however. The structural difference occurs since Preferred (Pool II) does not have rates for subscribers age 65 and over, but does have separate individual rates for male vs. female subscribers.

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

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

Q. Please turn now to schedule 6A of Blue Cross Exhibit 3 and describe that schedule.

A. Schedule 6A of Blue Cross Exhibit 3 is titled "Calculation of Projected Paid Claims Per Contract Month for July 1, 2010 Billing Cycle for HealthMate Direct 1000." This schedule displays the calculation of projected paid claims PCPM for the new HealthMate Direct 1000 product. This schedule applies to Basic (Pool I) only.

Q. On a column-by-column basis, would you explain what is contained in schedules 6A?

A. The first column of this schedule shows base period contract months for HealthMate Direct 500 and HealthMate Direct 2000. The second column shows the projected allowed claims per contract per month values for the respective products. As indicated in the footnotes, the values in these columns come from Blue Cross Exhibit 2.

Column (3) shows the trend adjustment factors used to adjust the claims projection to be applicable to the nine months beginning July 1, 2010.

Column (4) displays the Net-to-Allowed factors for the HealthMate Direct 1000 product. These factors convert the projected allowed claims to paid claims for the rate year. They are based on claims experience for the HealthMate Direct products only.

Column (5) is the anticipated utilization change due to differences in the member cost sharing provisions.

Column (6) is the product of columns (2) through (5). Column (6) represents the projected paid claims PCPM for the HealthMate Direct 1000 product.

Q. You state that schedule 6A applies to Basic (Pool I) only. Is there a comparable schedule for Preferred (Pool II)?

A. Yes. It is schedule 7A.

Q. Are there any differences between schedule 7A and schedule 6A, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

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

Q. Please turn to schedule 5A of Blue Cross Exhibit 3 and describe that schedule.

A. Schedule 5A is entitled "Calculation of Required Loss Ratios on Full Experience Basis for July 1, 2010 Billing Cycle for HealthMate Direct 1000." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss ratios, full experience basis for each of the two pools for the HealthMate Direct 1000 product. This schedule is identical to schedule 20 of Blue Cross Exhibit 2 with the exception of applying to the HealthMate Direct 1000 product only. Calculations are documented in the footnotes.

Q. Please turn to schedule 4A of Blue Cross Exhibit 3 and describe that schedule.

A. Schedule 4A is titled "Calculation of Required Loss Ratios on Current Pool Rate Alignment Basis for July 1, 2010 Billing Cycle for HealthMate Direct 1000." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the required income PCPM and the required loss ratio based on the current pool rate alignment for each of the two pools for the HealthMate Direct 1000 product. This schedule is identical to schedule 19 of Blue Cross Exhibit 2 with the exception of applying to the HealthMate Direct 1000 product only. Calculations are documented in the footnotes.

Q. Please turn now to schedule 2A and describe that schedule.

A. Schedule 2A is entitled "Calculation of HealthMate Direct 1000 Required Monthly Subscription Rates for July 1, 2010 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the monthly subscription rates for

individual and family subscribers in Basic (Pool I) by age category. Calculations are documented in the footnotes.

Q. On a column-by-column basis, would you explain what is contained in schedule 2A?

A. Row (i) contains the required monthly base rate for the HealthMate Direct 1000 product. As indicated in the footnotes, the required monthly base rate for Basic (Pool I) is developed in schedule 4A.

Row (ii) is labeled "Rate Reduction Factor". This is the factor that reduces the required monthly base rate to arrive at the proposed monthly base rate. This discount recognizes the behavioral changes we hope to see in HealthMate Direct Plan 1000 members. With the introduction of this product, Blue Cross will be piloting a new onboarding process. After members enroll in this plan they will receive a welcome call from an engagement specialist who will review benefit information, encourage members to complete a PHA and enroll in health management programs, when appropriate. They will also receive a personalized welcome kit via mail or email depending on the member's communication channel preference.

It is our hope that the changes in the member enrollment and onboarding process, together with the benefit design changes that reduce financial barriers to high value care, will improve the way members manage their health and interact with the healthcare system. This we believe should lead to better outcomes and ultimately reduce medical expenses.

Another very practical reason for the rate discount is to make the pricing of this product attractive. It is a pilot program and we need to attract enrollment in order to test our hypotheses. We will be studying the developing experience and will make adjustments to the program and/or our pricing as necessary.

Row (iii) is the proposed monthly base rate. This is the product of rows (i) and (ii).

Row (iv) is labeled "Rate Tier Normalization Factor." This is the normalization factor that corrects any imbalance in the rate factors contained in columns (1) and (3) of schedule 2A, determined across the entire pool. The rate tier normalization factor is developed in schedule 9 of Blue Cross Exhibit 2.

Row (v) is simply row (iii) divided by row (iv).

Column (1) contains the individual rate factors, and column (3) contains the family rate factors. These are the factors needed to convert the normalized proposed monthly base rate for the product and pool to monthly subscription rates for individual and family contracts and, within each, by age category.

Column (2) contains the monthly subscription rates for individual subscribers, and column (4) contains the monthly subscription rates for family subscribers. The calculations are documented in the footnotes.

Q. You state that schedule 2A applies to Basic (Pool I), for the HealthMate Direct 1000 product. Is there a comparable schedule for Preferred (Pool II)?

A. Yes. Schedule 3A corresponds to schedule 2A, for Preferred (Pool II) versus Basic (Pool I).

Q. Please turn to schedule 3A. Are the same calculations carried out for the HealthMate Direct 1000 product in schedule 3A for Preferred (Pool II) as in schedule 2A for Basic (Pool I)?

A. The same types of calculations are carried out in schedule 3A for Preferred (Pool II) as in schedule 2A for Basic (Pool I). I would note that the format and structure of

schedule 3A differs slightly from schedule 2A; labeling and rate development is consistent, however. The structural difference occurs since Preferred (Pool II) does not have rates for subscribers age 65 and over, but does have separate individual rates for male vs. female subscribers.

V. CONCLUSION

Q. Are the rates developed in Exhibit 2 and Exhibit 3 and displayed in schedules 5 through 8, 11 through 14, 2A, and 3A consistent with rates presented in your letter dated November 20, 2009 and included as Blue Cross Exhibit 1?

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

Q. Were Blue Cross Exhibit 2, schedules 1 through 47 and Blue Cross Exhibit 3, schedules 1A through 7A prepared by you or under your direction and supervision?

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

Q. Were Blue Cross Exhibit 2, schedules 1 through 47 and Blue Cross Exhibit 3, schedules 1A through 7A prepared using generally accepted actuarial principles and were those principles consistently applied?

A. Yes.

Q. Is it your opinion, to a reasonable degree of actuarial certainty, that Blue Cross Exhibit 2, schedules 1 through 47 and Blue Cross Exhibit 3, schedules 1A through 7A reflect fair, accurate and reasonable computations of required and proposed rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

A. Yes.