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

IN RE: **BLUE CROSS & BLUE SHIELD OF RHODE ISLAND – CLASS DIR (Filed November 20, 2009)** **RH – 2010-01**

PRE-FILED DIRECT TESTIMONY OF BARBARA NIEHUS, FSA, MAAA

January 19, 2010

I. INTRODUCTION

Q. Please state your name, professional qualifications, and areas of responsibility.

A. My name is Barbara Niehus. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I serve as a consulting actuary on numerous issues arising in connection with life and health insurance.

Q. For how long have you been a consulting actuary?

A. I founded my firm, Niehus Actuarial Services, Inc. in February, 2001 which is when I began my consulting career.

Q. Prior to becoming a consulting actuary, what experience did you have with respect to life and health insurance?

A. From 1994 until February 2001 I was employed by CNA of Chicago. I served as Group Vice President and Senior Financial Officer of CNA's Group Operations Division from 1997 to 2001, and from 1994 to 1997 as Senior Vice President with responsibilities for pricing, product development, reserve reviews, and other actuarial and financial matters.

AG EXHIBIT A

From 1984 until 1994, I was employed in various capacities with Celtic Life Insurance Company of Chicago, Illinois, serving as Executive Vice President with overall profit and management responsibilities for its Small Group Division from 1988 to 1994. I was employed by Allstate Insurance Companies of Northbrook, Illinois, from 1972 until 1984 in various capacities involving the underwriting, pricing, reserve calculations, product development and other matters for their group life, health and disability insurance products. I began my career as an actuarial student for Montgomery Ward Life Insurance Company of Chicago, Illinois, where I was employed from 1970 to 1972.

Q. What actuarial activities are you involved in outside of your consulting responsibilities?

A. I have been an active member of the Society of Actuaries (SOA), and was elected in 2006 to a three-year term on the Health Section Council which I have just completed. I am serving as Chairperson for the SOA's 2010 Annual Health Meeting, to be held this June in Orlando, FL, where the SOA provides continuing education and networking opportunities for health actuaries. I have participated in the development of the syllabus and study materials for students seeking to become members of the SOA. I have also spoken at meetings, led seminars, and participated on the elections committee. Over the years, I have participated on various industry committees, especially in relation to the development of regulations affecting small group health insurance. I have also published articles and spoken in other insurance-related forums.

Q. Have you been qualified and been accepted as an expert on actuarial matters before?

A. I have served as an expert witness or expert consultant in the field of actuarial sciences in over 15 matters and have been accepted as an expert and testified both in federal court and in arbitration hearings in the field of actuarial sciences. I have also been accepted and testified as an expert in the field of actuarial sciences at each of the last three years' hearings in Rhode Island regarding the Blue Cross Class DIR rates.

Q. Please identify the document that has been marked as Attorney General Exhibit B for identification?

A. It is a copy of my Curriculum Vitae.

Ms. Niehus is offered as an expert in the field of actuarial sciences.

II. MATERIAL REVIEWED

Q. Ms. Niehus, did you review Exhibits 1-9 of the Filing of Subscription Rates for Class DIR submitted by Blue Cross Blue Shield of Rhode Island on November 20, 2009 for rates to become effective April 1, 2010 ("the Filing")?

A. Yes.

Q. Did you review any other materials that you used in reaching your conclusions and forming your opinions?

A. Yes, I reviewed all of the materials submitted in response to the Attorney General's questions submitted on December 4, 2009 (1st Set), December 8, 2009 (2nd Set), December 17, 2009 (3rd Set) and December 30, 2009 (4th Set). I also reviewed all of the materials submitted in response to the Hearing Officer's email dated December 7, 2009. In addition, I reviewed the Class DIR filings submitted by Blue Cross on November 20, 2006 ("2006 Class DIR filing"), November 15, 2007 ("2007 Class DIR filing") and November 21, 2008 ("2008 Class DIR filing") and related materials including data requests submitted by the Attorney General and the Office of the Health Insurance Commissioner ("OHIC"), responses to those data requests, pre-filed testimony, and the Final Orders.

III. FINDINGS - General

Q. Did you form any opinions to a reasonable degree of actuarial certainty regarding the Filing that affect the amount of the rates requested by Blue Cross?

A. Yes.

Q. Please state those opinions.

A. I have determined that the rate increases requested in the Filing, in aggregate are excessive and are not consistent with the proper conduct of the business of Blue Cross or in the interests of the public.

Q. Please explain.

A. Blue Cross has requested rate increases averaging 10.2%. These rates include inappropriate charges which add to what would have been the appropriate premium increase. After removing these inappropriate charges, in my opinion a rate increase averaging 9.5% is appropriate. It is also my opinion that the age rating of Pool I recommended by Blue Cross should be modified.

Q. Have you reached any other opinions regarding the Filing?

A. Yes.

Q. What are those opinions?

A. As discussed further in my prefiled direct testimony, I have identified a number of areas that present opportunities for Blue Cross to better manage the Class DIR business to help assure its long-term viability and more appropriately serve its subscribers.

IV. FINDINGS – The Requested Rate Increase Is Too High

Q. You stated that it is your opinion that the requested rate increases in aggregate are excessive and not consistent with the proper conduct of the business of Blue Cross or in the interests of the public. What is the basis for your opinion?

A. Blue Cross's calculation of required rates inappropriately inflates the required rates in two areas.

Q. What are they?

A. First, Blue Cross has failed to adjust for the fact that some unusually large claims negatively impacted the experience in the time period used as the basis for Blue Cross's projections. Secondly, Blue Cross is unfairly charging excessive costs to Class DIR Subscribers related to Blue Cross's new building in Providence.

Q. Let's take those one at a time. Can you first discuss the impact of large claims?

A. Yes. Blue Cross determined its required rates relying on claim costs incurred during the experience period of June 1, 2008 through May 31, 2009. That period appears to have been impacted by a larger amount of "catastrophic" claims than in prior rating periods. Without some recognition of, and correction for, this anomaly, Blue Cross's claim projections in its filing are overstated.

Q. How can an unusually high amount of catastrophic claims impact Blue Cross's calculations?

A. It can cause the requested rate increase to be higher than necessary for two reasons. First, it overstates the true underlying level of costs in the base period. These base period costs are used for Blue Cross's claim projections as shown in Schedules 25 through 32 of Exhibit 2 of the Filing. Secondly, because trend is projected as a least squares fit, it can cause the trend to be overstated, since it can cause the more recent data points to be higher. The least squares approach fits a line to the observed points and measures the slope of that line. When the more recent points are overstated (because of an unusual amount of large claims), the steepness of the slope will increase, causing the trend to appear higher.

Q. What have you seen to indicate that there was an unusual amount of catastrophic claims?

A. In response to a request from Mr. Cogan, Blue Cross provided a history of large claim information (all claims over $100,000) for three experience years, beginning April 1, 2006, 2007 and 2008. Blue Cross's response did not specifically include the experience period beginning June 1, 2008, which was used as the basis for Blue Cross's rate calculations.

Q. How did you address this misalignment of data?

A. I used the data provided by Blue Cross in its response to Data Request AG1-2 to determine comparable numbers for the experience period beginning June 1, 2008. Attachment AGBN-1 presents that information and my analysis.

Q. Please describe Attachment AGBN-1

A. Attachment AGBN-1 is comparable to the exhibit that Blue Cross provided in response to Data Request OHIC1-2. The first three columns of numbers are the same numbers presented by Blue Cross in their response to Data Request OHIC1-2. The fourth column presents information (as determined from the data provided by Blue Cross in response to Data Request AG1-2) for the 12 months beginning June 1, 2008, which was the time period used for Blue Cross's rate calculations. Each column includes a list of each claim over $100,000 as well as total Class DIR claims for the time period indicated in the column heading (all reflecting allowed expenses on claims incurred).

In its response to Data Request OHIC1-2, Blue Cross stated: "Rationally, the definition of a large claims [sic] should also vary over time due to inflation. Assuming a modest trend of 5% a year, the definition of a large claim would be $100,000, $105,000, and $110,250 for the three years." To calculate the comparable large claim limit for the period beginning June 1, 2008, trend is applied for an additional two months to determine a limit of $111,150.

After determining the threshold for large claims, Blue Cross looked at the sum of all large claims (where large claims are those claims that exceed the claim limit, after considering trend) and then calculated the percentage they represented of all Class DIR claims for the same time period. I performed the same calculations in Attachment AGBN-1. The line toward the bottom of Attachment AGBN-1 labeled "Excess Claims" is the sum of all claims that exceed the corresponding claim limit for that period. The last line of numbers ("Excess claims – percent of total") shows the percent of all Class DIR claims that are represented by the large claims.

Q. Blue Cross performed an analysis in its response to Data Request OHIC1-2 and concluded that there was nothing unusual about the large claim activity. Why do you disagree?

A. Blue Cross's analysis failed to look at the actual experience period used in its pricing. Blue Cross's analysis calculated that on a trended basis, the large claims represented a percent of total claims that went from 12.2% to 11.9% to 12.1% over the three time periods they looked at and concluded that there was not significant variation over the time period. Had Blue Cross performed the calculation using the experience period beginning June 1, 2008 it would have calculated a comparable percentage of 12.7%, which is the result I calculated in Attachment AGBN-1. This percentage was at least one-half point greater than any of the three periods studied by Blue Cross.

Q. Do you believe some adjustment is required to the rate changes requested by Blue Cross to correct for this anomaly?

A. Yes.

Q. Please explain your proposed adjustment?

A. It is fair to Class DIR subscribers to allow some credit for the large claim activity that occurred during the experience period used for determining rates. Specifically, I

recommend reducing projected claim costs across the board by 0.5% in order to appropriately credit the subscribers in any rate changes approved by OHIC for Class DIR. This correction reverses the higher costs observed in the experience period beginning June 1, 2008 – the base period used by Blue Cross for pricing.

Q. Please explain your concerns regarding Blue Cross's charges related to its new building.

A. Blue Cross recently moved into a new building and it appears that the move has significantly increased Blue Cross's charges to Class DIR for facilities & occupancy.

Q. What is your concern regarding the expense projections?

A. I have provided the history of charges against Class DIR premiums related to facilities & occupancy over the past few years in Attachment AGBN-2. A review of that exhibit shows that charges increased substantially with this year's Filing, at the same time that Blue Cross was moving into its new building. Blue Cross was asked to explain the increase in charges and, in response to Data Request AG1-10, stated that 2009 expenses were low due to a one-time savings. This answer does not seem to hold up in light of the historical numbers presented in Attachment AGBN-2.

Q. Do you believe an adjustment should be made to Blue Cross's calculations?

A. Yes, in the current economy, I believe it is inappropriate to ask Class DIR subscribers to bear additional costs related to Blue Cross's new building. In order to make charges for facilities and occupancy more consistent with prior years, I believe that expenses charged to Class DIR in the approved rates should be reduced by an annual amount of $100,000.

Q. You mentioned you believe that Blue Cross's proposed age rates for Pool I should be modified. Please explain.

A. Blue Cross has introduced age rating to Pool I under age 65, an idea that I suggested at last year's rate hearing.

Q. Why did you suggest this change for Pool I for Class DIR last year?

A. I suggested it in order to help attract a greater number of younger, and generally lower-cost, subscribers, helping to keep rates more affordable for everyone.

Q. Then why do you disagree with the age rating suggested by Blue Cross to Pool I in the Filing?

A. Blue Cross's proposed age rating is more severe than I had suggested.

Q. Please explain what you mean.

A. I had suggested, by way of example, charging subscribers under age 40 an amount equal to 90% of the premium for subscribers 40 through 64. Blue Cross's Filing proposes rates varying by each 5-year category, with differential greater than I had suggested. For example, under Blue Cross's proposal, a 24-year-old pays about 82.5% of the rates for a 62-year-old.

Q. Why is that a cause for concern?

A. Under Blue Cross's approach, older subscribers would experience a larger percentage increase, while younger subscribers will actually experience decreases. Blue Cross's proposal has some subscribers seeing increases of up to 16%, while others see decreases of nearly 6%.

Q. Do you recommend an alternative approach?

A. Yes, I believe that Blue Cross can change its approach to age rating gradually over a few years, without causing quite as much disruption to rates as would occur if its current proposal were to be approved. Specifically, I recommend that rates for subscribers ages 40 through 49 be set at 95% of those 50 through 64, while subscribers under age 40 be charged 90%

of rates for subscribers 50 through 64. Under this approach, as discussed later in my testimony, no subscriber will see an increase in excess of 13%, and younger subscribers will see only minor rate changes, generally within 1%.

Q. Will changing the age factors change the amount of rate increase requested by Blue Cross?

A. No, total projected premiums across all subscribers would remain the same. As I have testified in last year's Class DIR rate hearing, Blue Cross's rates for Class DIR subscribers include a variety of subsidies from one group of subscribers to another. These subsidies are important to the long-term viability of Class DIR products, but the level of subsidy needs to be regularly reviewed and adjusted as appropriate.

Q. You've talked about three adjustments to Blue Cross's rate calculations, including the adjustments for large claims, a reduction to charges for facilities & occupancy, and modification of the Pool I age rating. Have you formed an opinion, to a reasonable degree of actuarial certainty, as to what rates are appropriate for the April 1, 2010 Billing Cycle if these adjustments are made?

A. Yes.

Q. What is that opinion?

A. In my opinion, Blue Cross's requested rates should be reduced. The appropriate average increase is 9.5% compared to Blue Cross's request of 10.2%.

Q. Please explain how you reached that conclusion.

A. The calculation is presented in Attachment AGBN-3 to my testimony.

Q. Please explain how you have constructed AGBN-3.

A. In Attachment AGBN-3, I have included all of the schedules from Exhibit 2 of the Filing that are affected by the Attorney General's proposed changes. That includes Schedules 5 through 9, 11 through 14, 17 through 20, and 34. Note that in Attachment AGBN-3, numbers that are *shaded* represent my changes to input values on the corresponding Blue Cross Filing Schedule, while numbers in ***bold italics*** represent my revised calculations based on my new inputs in those filing Schedules. The credit for large claims is reflected as an adjustment in column 3.1 of Schedule 20. The reduction to expense related to facilities & occupancy is in column 2 of Schedule 34. The change to Pool I age factors is introduced in Schedule 9. These changes flow through all the other schedules, with the final rates being calculated in Schedules 5 through 8 and 11 through 14.

Q. How did you determine the Pool I age factors shown in Schedule 9?

A. I used the same age factors used by Blue Cross in last year's filing, but reduced the factor for age categories 40 through 49 by 5% and for age categories under age 40 by 10%.

Q. Have you prepared a summary of recommended rates?

A. Yes, Attachment AGBN-4 presents current rates, Blue Cross's requested rates and rates recommended by the AG, as well as showing the corresponding rate increases.

Q. How have you determined the rates for the new HealthMate 1000 plan?

A. Based on Blue Cross's Filing and its response to Data Request AG1-26, I have set those rates to equal 89% of the HealthMate 500 rates.

V. FINDINGS – Management Opportunities

Q. You stated earlier that you have identified a number of areas that present opportunities for Blue Cross to better manage the Class DIR business to help assure its long-term viability. Can you identify those opportunities?

A. Yes. After reviewing Blue Cross's calculations and methodology, I noted certain issues that, although not affecting this year's recommendations, may become important in the future.

Q. What is the first area of opportunity for Blue Cross to better manage the Class DIR business you have identified?

A. In general, as has been stated by the Attorney General in previous years, Blue Cross needs to make sure that administrative costs are properly managed and allocated on a basis that is fair to Class DIR subscribers. I have already noted concerns about charges related to facilities & occupancy. I will also note that Class DIR subscribers, along with all other Blue Cross customers, are paying costs related to Blue Cross's new "core system." Hopefully, all subscribers will see some benefit from that new system in terms of increased efficiencies, better management of claim costs, or both. I would hope to see some savings flow through as lower administrative costs in the future.

Q. What is the next area of opportunity that you have identified?

A. The next area I have identified is related to plan design.

Q. Please explain.

A. In previous years, I recommended that Blue Cross consider incremental changes to its Class DIR plan designs to avoid major disruptions similar to what occurred in 2006 when

the entire portfolio of products was replaced. Specifically, last year I suggested making some modifications to the HealthMate 400 plan and/or introducing a new plan.

Q. How did Blue Cross respond to your recommendations?

A. This year's filing incorporated both of those suggestions, changing the HealthMate 400 plan to HealthMate 500 and introducing a new HealthMate 1000 plan. Although these types of changes do not need to be made every year, Blue Cross should continue to review its portfolio of products to assure that they are designed to do the best job of meeting the needs of Class DIR subscribers, balancing cost against benefit design.

With its new HealthMate 1000 plan, Blue Cross has also discussed a new "onboarding process" for enrollees which it describes in response to Data Request AG2-10. This process is designed with the intention of assisting subscribers to better manage their health. It will be important for Blue Cross to monitor the costs and success of this approach and expand its use, if it is successful or consider alternative approaches, if it is not.

Q. What is the next area of opportunity for Blue Cross to better manage the Class DIR business you have identified?

A. Blue Cross set forth numerous Affordability Initiatives in a 2006 Report that it submitted to the Office of the Health Insurance Commissioner ("OHIC") on April 21, 2006. When this report was initially released, the Attorney General expressed significant concerns regarding these proposed initiatives, particularly raising concerns that there was no accountability of any expenditures made to implement these initiatives, no targets for determining whether the initiative had been achieved, and no triggers to cease unsuccessful initiatives. Since that time, OHIC and Blue Cross have modified the approach to reporting on

these initiatives. While this year's information better highlighted major priorities, there is still room for improvement in the monitoring and reporting of these initiatives.

Q. What are your concerns with regard to the current reporting?

A. My concerns are twofold: first, the reports do not provide any look-back, to determine whether prior years' issues were addressed or whether the chosen priorities were successfully acted upon. It is not clear whether previous programs were determined to be successful or unsuccessful, and are being terminated, modified, or merely continued. Secondly, there is still minimal information being provided regarding actual dollars spent or actual/anticipated savings.

Q. Can you give an example of where you feel the look-back information is deficient?

A. Yes. In the 2008 Annual Affordability Report, Blue Cross identified five projects ranked as priority level 1. These included Specialty Pharmacy, Aligning Benefits to Promote Member Engagement, CSI-RI, HealthMate Direct 2000, and Replacement of Core Processing System. Except for some limited information received through responses to the AG Data Requests, we are aware of no information being provided that indicates what progress was made on those priorities, how much was spent, or the status of ongoing efforts.

Q. Are there other examples of how Blue Cross reporting of Affordability Initiatives can be enhanced?

A. Yes, more information could be provided regarding the amount of money Blue Cross is investing in its initiatives. As requested by OHIC, Blue Cross now files its update on Affordability Initiatives as part of its rate filing, in this case, Exhibit 4 to the Filing (see Blue Cross's response to Data Request AG4-2). The five most significant initiatives are provided,

beginning on page 3 of Exhibit 4 and an estimated return on investment is provided. However, no information is provided regarding the amount of the investment – is it $10,000 or $10,000,000? Some additional information should be provided regarding the nature of the investment, and an idea of the magnitude of the investment, as well as an expected pay-back period.

Q. In the course of your review of the Filing, did you also review the progress of the AccessBlue Program?

A. Yes.

Q. Do you have any opinions regarding this Program?

A. Yes.

Q. What are they?

A. I note that the AccessBlue Program has continued to grow and is a very meaningful and successful effort. It benefits those subscribers in financial need, but it also appears to benefit all subscribers by encouraging more healthy people to join the program, keeping rates lower for everyone.

Q. Do you have any concerns regarding the reporting related to the AccessBlue Program?

A. Yes, I saw some inconsistencies in the numbers reported by Blue Cross.

Q. Please explain what you mean by inconsistencies.

A. Blue Cross indicates in its response to Data Request AG1-12 (b) that the average amount paid out under AccessBlue for the six months ending August 2009 was $224,958. Blue Cross also provided enrollment counts in its response to Data Request AG1-12 (a) and subsidy amounts were reported on page 2 of the AccessBlue report provided to OHIC on November 20,

2009. Multiplying enrollments times subsidy amounts produced an average monthly payout amount of only approximately $199,000, lower by more than 12% than the amount reported by Blue Cross. Since Blue Cross has allocated a fixed amount of money to cover AccessBlue Costs, it is important that the accounting be done accurately.

Q. Is it your opinion, to a reasonable degree of actuarial certainty, that the Attorney General's proposed rates in Attachment AGBN-4 to become effective April 1, 2010 (representing a 9.5% average increase rather than Blue Cross's proposed rates averaging a 10.2% increase) are within the proper conduct of the business of Blue Cross and in the interests of the public?

A. Yes.

Q. Are all of the opinions you have expressed in your prefiled testimony and attached schedules made to a reasonable degree of actuarial certainty?

A. Yes.

Q. Does this conclude your testimony at this time?

A. Yes.