SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Filing at a Glance

Company: Blue Cross & Blue Shield of Rhode Island

Product Name: Direct Pay	SERFF Tr Num: BCBS-127815031	State: Rhode Island
TOI: H15I Individual Health - Hospital/Surgical/Medical Expense	SERFF Status: Assigned	State Tr Num:
Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense	Co Tr Num: DP 4-1-2012	State Status: Open-Pending Actuary Review
Filing Type: Rate		Reviewer(s): Adrienne Evans, Sandra West, Charles DeWeese, Herbert Olson, Maria Casale
	Authors: Monica Neronha, Scott Lucarelli, Jessie Knowles, Jeffrey McLane	Disposition Date:
	Date Submitted: 11/18/2011	Disposition Status:
Implementation Date Requested: 04/01/2012		Implementation Date:

State Filing Description:
Recd. 150.00 filing fee Assigned to Charlie Herb and Maria 11-21-11

General Information

Project Name: Direct Pay 2011 Filing	Status of Filing in Domicile: Not Filed
Project Number: DP 11-18-11	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact: 4.4%	Filing Status Changed: 11/21/2011
	State Status Changed: 11/21/2011
Deemer Date:	Created By: Jessie Knowles
Submitted By: Jessie Knowles	Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Filing Description:
The filing letter and the actuarial schedules, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island (“Blue Cross”) for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs.

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
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TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

This filing includes proposed rates to become effective April 1, 2012.

Company and Contact

Filing Contact Information

Scott Lucarelli, Team Leader, Individual/Senior Market	scott.lucarelli@bcbsri.org
500 Exchange Street	401-459-5429 [Phone]
Providence, RI 02903	401-459-5405 [FAX]

Filing Company Information

Blue Cross & Blue Shield of Rhode Island	CoCode: 53473	State of Domicile: Rhode Island
500 Exchange Street	Group Code:	Company Type: Health Insurance
Providence, RI 02903	Group Name:	State ID Number:
(401) 459-1000 ext. [Phone]	FEIN Number: 05-0158952	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	6 products, multiplied by $25 per product = $150.
Per Company:	Yes

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Blue Cross & Blue Shield of Rhode Island	$150.00	11/18/2011	53903702

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
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Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	Gus' Testimony	Jessie Knowles	11/28/2011	11/28/2011

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Amendment Letter

Submitted Date: 11/28/2011

Comments:

Attached as promised.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Gus' Testimony		New		Exhibit 8 - Gus Testimony.pdf
Exhibit 8 - Gus Testimony.pdf				

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 1.900%
Effective Date of Last Rate Revision: 04/01/2011
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Blue Cross & Blue Shield of Rhode Island	Increase	4.400%	4.400%		9,808		%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:		11,103			4,065			
Policy Holders:		7,033			2,775			

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
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TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Rate Review Details

COMPANY:

Company Name:	Blue Cross & Blue Shield of Rhode Island
HHS Issuer Id:	15287
Product Names:	VantageBlue Direct 1000 VantageBlue Direct 1500 HealthMate Coast-to-Coast Direct 2500 BlueSolutions for HSA Direct 3000 BlueSolutions for HSA Direct 5000 BlueValue Direct 2500
Trend Factors:	Individual Plan Allowed Trend (annual): Medical trend is 5.6%; Rx trend is 7.1%; overall trend is 5.9%

FORMS:

New Policy Forms:	FRONT DIRECT (04-12), SUMMARY DIRECT (04-12), INTRODUCTION DIRECT (04-12), ELIGIBILITY DIRECT (04-12), COVERED DIRECT (04-12), EXCLUSIONS DIRECT (04-12), APPEALS DIRECT (04-12), GLOSSARY DIRECT (04-12)
Affected Forms:	
Other Affected Forms:	PAYMENT DIRECT (07-10), COB DIRECT (07-10)

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Other
Member Months:	172,610
Benefit Change:	Decrease
Percent Change Requested:	Min: -10.2 Max: 21.7 Avg: 4.4

PRIOR RATE:

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Total Earned Premium:	61,922,009.00
Total Incurred Claims:	56,564,246.00
Annual $:	Min: 102.34 Max: 1,117.31 Avg: 546.80

REQUESTED RATE:

Projected Earned Premium:	69,240,362.00
Projected Incurred Claims:	60,487,829.00
Annual $:	Min: 102.00 Max: 1,012.38 Avg: 534.46

SERFF Tracking Number:	*BCBS-127815031*	*State:*	*Rhode Island*
Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
	Filing Letter	FRONT DIRECT (04-12), SUMMARY DIRECT (04-12), INTRODUCTION DIRECT (04-12), ELIGIBILITY DIRECT (04-12), COVERED DIRECT (04-12), EXCLUSIONS DIRECT (04-12), PAYMENT DIRECT (07-10), COB DIRECT (07-10), APPEALS DIRECT (04-12), GLOSSARY DIRECT (04-12)	New		Exhibit 1 - Filing Letter.pdf
	Filing Schedules		New		Exhibit 2 - Filing Schedules.pdf
	Health System Improvements		New		Exhibit 3 - Heatlh System

		Improvements.pdf
Jeff's Testimony	New	Exhibit 4 - Jeff Testimony.pdf
Budget Comparisons	New	Exhibits 5&6 - Budget Comparisons.pdf
Budget Narrative	New	Exhibit 7 - Budget Narrative.pdf
Kim's Testimony	New	Exhibit 9 - Kim Testimony.pdf
Gus' Testimony	New	Exhibit 8 - Gus Testimony.pdf

Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

November 18, 2011

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

Subject: Filing of Subscription Rates for Class DIR

Dear Commissioner Koller:

This letter, together with the actuarial schedules enclosed, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs. This filing includes proposed rates to become effective April 1, 2012.

The rates proposed in this filing will affect the approximately 15,200 members enrolled in Class DIR as of September 2011.

Definition of Class DIR

Class DIR is the rating classification for persons not eligible for employer-based (other than as a self-employed individual), nor State or Federal programs. Enrollment is on a non-group basis either through direct application to Blue Cross or through conversion from prior group coverage. Group conversions occur monthly and an annual open enrollment period is conducted for the Basic Pool (Pool I), while enrollment in the Preferred Pool (Pool II) is available continuously throughout the year for applicants passing a health screening. Two rating pools are employed in the Class -- the Basic Pool (Pool I) with rates determined based on the age of the subscriber and the Preferred Pool (Pool II) with rates determined based on the age and gender of the subscriber. It should be noted that we are proposing rate structure changes to the Class DIR Basic Pool (Pool I) effective with this rate filing that would increase the rate differential between young and old subscribers, with the exception of subscribers over the age of 65. These rate structure changes are discussed further below.

Benefit Changes and New Product

Effective April 1, 2012, Blue Cross is proposing to make changes to its existing products (including renaming several) and to introduce a new product into the individual market. These changes are intended to increase member choice while improving affordability of the products. Another goal of the updates is to standardize the benefit structure both within the individual market and across market segments. This should make it easier for members to understand how their benefits work and allow for an easier transition when members change plans within Direct Pay and convert from group coverage. These

updates are further explained in my pre-filed testimony and detailed in the policy forms filed contemporaneously with this rate filing. Contingent upon approval of this rate filing, the following Direct Pay products will be available effective April 1, 2012:

- *VantageBlue Direct 1000/2000 (Formerly HealthMate Coast-to-Coast Direct 500/1000):* Includes a $1,000 per individual/$2,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of $10/$35/$60/$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $3,000 per individual / $6,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *VantageBlue Direct 1500/3000 (Formerly HealthMate Coast-to-Coast Direct 1000/2000):* Includes a $1,500 per individual/$3,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of $10/$35/$60/$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $4,500 per individual / $9,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *HealthMate Coast-to-Coast Direct 2500/5000 (Formerly HealthMate Coast-to-Coast Direct 2000/4000):* Includes a $2,500 per individual/$5,000 per family deductible, 20% member paid coinsurance in-network for hospitalization, outpatient hospital services, lab tests, and x-rays (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy), $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid co-payments of $10/$35/$60/$100 for tier 1, tier 2, tier 3, and specialty prescription drugs, respectively, at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $7,500 per individual / $15,000 per family. The out of pocket maximum includes the deductible. Members have the option of engaging in the Wellness Reward Program and may receive a reward equal to 10% of their annual paid premiums if they meet certain wellness requirements. In general, member cost share is greater at out-of-network providers.

- *BlueSolutions for HSA Direct 3000/6000 (Formerly HealthMate for HSA 3000/6000):* The BlueSolutions for HSA Direct 3000/6000 Plan includes deductibles of $3,000 per

individual / $6,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is also applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 80% for all covered services except prescription drugs (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). For prescription drugs, members will pay co-payments of $10 for tier 1 drugs, $35 for tier 2 drugs, $60 for tier 3 drugs, and $100 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $6,000 per individual and $12,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *BlueSolutions for HSA Direct 5000/10000 (Formerly HealthMate for HSA 5000/10000):* The BlueSolutions for HSA Direct 5000/10000 Plan includes deductibles of $5,000 per individual / $10,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is also applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). For prescription drugs, members will pay co-payments of $10 for tier 1 drugs, $35 for tier 2 drugs, $60 for tier 3 drugs, and $100 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $6,050 per individual and $12,100 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *BlueValue Direct 2500:* The BlueValue Direct 2500 plan will be available on an individual basis only (no family coverage) and includes a deductible of $2,500. Most services are covered at 50% after satisfaction of the deductible up to an out of pocket maximum of $7,500 (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy). The out of pocket maximum includes the deductible. Certain physician visits and emergency room visits, however, are covered pre-deductible. The first two visits to a primary care physician or specialist are covered with a $30 co-payment pre-deductible. Subsequent visits are covered at 50% after satisfaction of the deductible. Likewise, the first visit to an emergency room is covered with a $200 co-payment pre-deductible, with subsequent visits subject to the deductible and 50% coinsurance. A separate $500 deductible is applicable to tier 2, tier 3, and specialty drugs. Tier 1 drugs are covered pre-deductible with a $4 co-payment. Tier 2 and tier 3 drugs are covered at 50% after satisfaction of the deductible. Specialty drugs are also subject to the deductible with a $200 co-payment. BlueValue Direct 2500 also covers 1 annual dental cleaning and 1 set of bitewing X-rays per year with no member cost sharing. Finally, an annual fitness reimbursement of $100 toward a gym membership is available with this plan.

Effective April 1, 2012, we are also introducing an innovative new program that reduces the deductible over time. This program will be available with all of our Direct Pay plans and helps to address affordability by reducing the deductible amount in the following calendar year for those subscribers who do not meet their deductible. The deductible continues to be reduced so long as the subscriber does not meet the deductible in any given calendar year until the fourth year, or until the deductible is 50% of the original amount. After the fourth year, the reduced deductible is maintained as long as the deductible is not met. If the deductible is met in any year, the deductible resets to the original amount the following year. After reset, the subscriber can begin to earn the reduced deductible again as long as insurance coverage is maintained. Subscribers must have had coverage for six consecutive months within the calendar year to be eligible for a credit the following year. The table below illustrates the program.

Year	Percent Reduction	Example
Calendar Year 1	Original Deductible	$5,000
Calendar Year 2	20% Reduction	$4,000
Calendar Year 3	40% Reduction	$3,000
Calendar Year 4	50% Reduction	$2,500

Communicating Benefit Changes

We will include information about the benefit changes as part of the notification existing subscribers receive about this filing. Subscribers will have an opportunity to select any plan by completing an election form. If no election is made, subscribers will be transitioned to the updated plan that is most closely aligned with their current benefits according to the following chart. Additional details regarding the transition process and Blue Cross' communication plans are detailed in the pre-filed testimony of Kimberly Cormier.

Current Plan	Plan Effective April 1, 2012
HealthMate Direct 500	VantageBlue Direct 1000
HealthMate Direct 1000	VantageBlue Direct 1000
HealthMate Direct 2000	HealthMate Direct 2500
HealthMate for HSA 3000	BlueSolutions for HSA Direct 3000
HealthMate for HSA 5000	BlueSolutions for HSA Direct 5000

Rating Structure Changes Effective With This Filing

With this rate filing, Blue Cross is proposing to introduce rate structure changes for the Basic Pool (Pool I). Effective April 1, 2012, the maximum rate differential by age for subscribers under age 65 will be increased to 1.5 to 1 for Basic (Pool I) subscribers. The current rate differential is 1.25 to 1. This change will improve the financial equity between young and old Pool I subscribers and will lessen the rate shock to Direct Pay subscribers in 2014 when the Patient Protection and Affordable Care Act (PPACA) requires the removal of rating by health status.

Also, rate structure changes for subscribers aged 65 and over are being proposed for both Basic (Pool I) and Preferred (Pool II). In last year's Order and Decision, the Commissioner raised concerns regarding the rate structure for Direct Pay subscribers aged 65 and over for both Basic (Pool I) and Preferred (Pool II). This rate filing addresses those concerns. The rate differential between subscribers aged 65 and over and aged 60-64 is being reduced to 24% from the current 49%. This is equivalent to these subscribers receiving no rate change from last year assuming no change in benefits. In addition, a new rate band is being introduced for subscribers aged 65 and over in Preferred (Pool II) to limit the rate shock for those subscribers turning age 65. The rate differential within Pool II between subscribers aged 65 and over and aged 60-64 will be the same as that within Pool I.

Change in Rate Renewal Date

The rates proposed in this rate filing will be in effect for the period April 1, 2012 through September 30, 2013 (18 months). Under proposed Exchange regulations, beginning in 2014, individual market rates need to be in effect for the entire calendar year. This necessitates an eventual change in the renewal date for Direct Pay. Our proposed solution is to extend the rating period for this filing through September 30, 2013. This would allow our members more time to become familiar with the updated plan designs and provide peace of mind that their rate will not increase for 18 months, unless the subscriber moves into a new age band. The subsequent rate filing will be effective with the beginning of the Exchange related open enrollment on October 1, 2013 and extend through the end of calendar year 2014. Thereafter, rate changes will be effective on a calendar year basis.

Reserve Contribution

Blue Cross is not requesting a reserve contribution component from Class DIR subscribers in this rate filing. Historically, Blue Cross and its Directors have taken the position that Direct Pay should not only recover its claims and administrative expenses, but should contribute its fair share towards corporate reserves. Although Blue Cross has not changed its philosophy in this regard, given the current economic conditions in Rhode Island, we are not asking Class DIR subscribers to contribute to corporate reserves at this time. It should be noted that as of September 30, 2011, Blue Cross corporate reserves

were at 19.0% of annual premium, which is below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium.

State Premium Tax and Assessments

In the previous rate decision for Class DIR for rates effective April 1, 2011, the Office of the Health Insurance Commissioner ("OHIC") disallowed charges for the state premium tax and state assessments. The required rates in this filing include the state premium tax and a documented allocable portion of the state assessments.

The basis for the Commissioner's denial of state assessments in rates charged to Class DIR subscribers was that Blue Cross had not developed a more accurate method of allocating the assessments to Direct Pay. In this rate filing, Blue Cross is including only those expenses that can be explicitly shown to have accrued as a result of a Direct Pay member receiving an immunization during the experience period analyzed. This new methodology is detailed on schedules 25 and 26 of Blue Cross Exhibit 2.

The required rates in this filing include 2% for the state premium tax. In last year's rate filing, the Commissioner's denied inclusion of the state premium tax in Direct Pay rates on the basis of affordability concerns. For the reasons outlined in pre-filed testimony, we believe this rate filing addresses these affordability concerns, and thus the rating component for premium taxes should be allowed in Class DIR rates. Moreover, for the reasons our attorneys will articulate in connection with the hearings, we believe the law requires inclusion of the premium taxes in the Class DIR rates.

The state premium tax is assessed on a premium base that includes Class DIR and the determination of the assessments to Blue Cross is based on premium reported on annual financial statements, including premium for the Class DIR line of business. If Blue Cross is continued to be denied a mechanism to collect these taxes and assessments from Class DIR subscribers, Blue Cross subscribers in other market segments would be assessed a disproportionate share of these fees.

The inclusion of these taxes and assessments in Class DIR premiums is fair and makes practical business sense. State premium tax and assessments are borne by all fully insured subscribers in Rhode Island, in accordance with State law. The state premium tax and assessment requirements combined add approximately 3.8% to the cost of insurance coverage in all markets, including Class DIR.

Affordability as Addressed in the Rate Filing

In consideration of previous rate decisions issued by the OHIC, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Among these are the value based benefits inherent in the updated plan designs and the introduction of a new product targeted at the uninsured population. Specifics of these programs will be detailed in the pre-filed testimonies of Dr. Manocchia, Kimberly Cormier, and me. In addition,

along with this rate filing, we are submitting as Exhibit 3 the "Resources for Health System Improvements - Survey". Exhibit 3 outlines Blue Cross' strategies regarding improving the overall affordability of health care in Rhode Island.

Required Rates

Blue Cross last filed rate changes for its Class DIR subscribers on November 19, 2010 for an effective date of April 1, 2011. In its decision rendered on March 7, 2011, The OHIC approved an aggregate increase of 1.9%.

The overall average required rate increase projected in this filing, exclusive of any AccessBlue (premium assistance) amounts, is 4.4%. This projected average increase is based on the same subscriber migration pattern inherent in the premium rate calculations. Actual rate changes will vary based on the actual benefit plan selected. All rates included in this filing will remain in effect for the eighteen-month period commencing April 1, 2012. The Class DIR Basic (Pool I) required monthly rates and the Preferred (Pool II) required monthly rates for the six Direct Pay products are included in the following tables.

Class DIR Basic (Pool I)
Required Rates Effective April 1, 2012

		VantageBlue/HealthMate			Blue Solutions for HSA		BlueValue
		1000	1500	2500	3000	5000	2500
Under 25	Individual	$542.94	$492.06	$428.36	$376.62	$302.23	$267.89
	Family	$1,022.18	$926.39	$806.47	$709.05	$569.00	N/A
25-29	Individual	$554.70	$502.72	$437.64	$384.78	$308.78	$273.69
	Family	$1,043.74	$945.93	$823.48	$724.01	$581.00	N/A
30-34	Individual	$575.28	$521.37	$453.88	$399.05	$320.23	$283.84
	Family	$1,082.94	$981.46	$854.41	$751.20	$602.82	N/A
35-39	Individual	$596.84	$540.91	$470.89	$414.01	$332.23	$294.48
	Family	$1,124.11	$1,018.77	$886.88	$779.75	$625.73	N/A
40-44	Individual	$609.58	$552.46	$480.94	$422.85	$339.33	$300.77
	Family	$1,147.63	$1,040.08	$905.44	$796.07	$638.83	N/A
45-49	Individual	$647.81	$587.10	$511.10	$449.36	$360.60	$319.63
	Family	$1,220.15	$1,105.81	$962.66	$846.38	$679.20	N/A
50-54	Individual	$707.59	$641.28	$558.26	$490.83	$393.88	$349.12
	Family	$1,331.87	$1,207.06	$1,050.81	$923.88	$741.39	N/A
55-59	Individual	$787.95	$714.11	$621.67	$546.58	$438.61	$388.77
	Family	$1,483.78	$1,344.73	$1,170.66	$1,029.25	$825.95	N/A
60-64	Individual	$814.41	$738.09	$642.55	$564.93	$453.34	$401.83
	Family	$1,532.78	$1,389.14	$1,209.32	$1,063.24	$853.22	N/A
65+	Individual	$1,012.38	$917.51	$798.74	$702.25	$563.54	$499.51
	Family	$1,910.10	$1,731.10	$1,507.01	$1,324.97	$1,063.26	N/A

Class DIR Preferred (Pool II)
Required Rates Effective April 1, 2012

		VantageBlue/HealthMate			Blue Solutions for HSA		BlueValue
		1000	1500	2500	3000	5000	2500
Under 25	Male	$206.73	$187.36	$163.10	$143.40	$115.07	$102.00
	Female	$289.06	$261.98	$228.06	$200.51	$160.90	$142.62
	Family	$692.67	$627.78	$546.49	$480.48	$385.56	N/A
25-29	Male	$228.65	$207.23	$180.40	$158.61	$127.27	$112.82
	Female	$327.54	$296.86	$258.42	$227.21	$182.32	$161.61
	Family	$775.90	$703.21	$612.15	$538.22	$431.89	N/A
30-34	Male	$260.42	$236.02	$205.46	$180.65	$144.96	$128.49
	Female	$389.29	$352.82	$307.14	$270.04	$216.69	$192.08
	Family	$822.88	$745.79	$649.22	$570.81	$458.04	N/A
35-39	Male	$298.01	$270.09	$235.12	$206.72	$165.88	$147.04
	Female	$386.16	$349.98	$304.66	$267.87	$214.95	$190.53
	Family	$868.52	$787.15	$685.23	$602.47	$483.44	N/A
40-44	Male	$318.59	$288.74	$251.36	$221.00	$177.34	$157.20
	Female	$422.40	$382.83	$333.26	$293.01	$235.12	$208.42
	Family	$887.76	$804.59	$700.41	$615.81	$494.15	N/A
45-49	Male	$385.26	$349.17	$303.96	$267.25	$214.45	$190.09
	Female	$468.04	$424.19	$369.27	$324.67	$260.53	$230.94
	Family	$935.64	$847.98	$738.19	$649.03	$520.81	N/A
50-54	Male	$488.18	$442.44	$385.16	$338.64	$271.74	$240.87
	Female	$546.80	$495.57	$431.40	$379.30	$304.36	$269.79
	Family	$1,042.13	$944.50	$822.21	$722.90	$580.08	N/A
55-59	Male	$625.55	$566.94	$493.54	$433.93	$348.20	$308.65
	Female	$624.21	$565.73	$492.48	$432.99	$347.45	$307.99
	Family	$1,166.53	$1,057.24	$920.35	$809.19	$649.33	N/A
60-64	Male	$668.95	$606.28	$527.78	$464.03	$372.36	$330.07
	Female	$668.95	$606.28	$527.78	$464.03	$372.36	$330.07
	Family	$1,267.65	$1,148.89	$1,000.13	$879.33	$705.62	N/A
65+	Male	$831.38	$753.49	$655.93	$576.70	$462.77	$410.21
	Female	$831.38	$753.49	$655.93	$576.70	$462.77	$410.21
	Family	$1,579.53	$1,431.56	$1,246.20	$1,095.68	$879.22	N/A

Filing Schedules

Schedules displaying the required rates and detailed actuarial schedules documenting the calculation of the required rates are enclosed as Blue Cross Exhibit 2.

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

Pre-Filed Testimony

With this filing, we are submitting the pre-filed testimony of Kimberly Cormier, who will be Blue Cross' witness regarding benefit changes and communication strategies, and myself, who will be Blue Cross' actuarial and policy witness at the upcoming rate hearing on this matter. We will be submitting, no later than November 28, 2011, the pre-filed testimony of Augustine Manocchia, MD, Senior Vice President & Chief Medical Officer, who will be Blue Cross' witness with regards to affordability and medical management issues. We believe submitting the pre-filed testimony contemporaneously with the rate filing will make the discovery process more efficient and decrease the length of time of all aspects of the hearing process.

Conclusion

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

In accordance with the filing fee requirements contained in section 42-14-18 of the General Laws of Rhode Island, a filing fee of $150 ($25 for each policy) has been included with this submission via electronic funds transfer (EFT). This filing pertains to the following direct pay products: *VantageBlue Direct 1000/2000, VantageBlue Direct 1500/3000, HealthMate Coast-to-Coast Direct 2500/5000, BlueSolutions for HSA Direct 3000/6000, BlueSolutions for HSA Direct 5000/10000, and BlueValue Direct 2500.* The policy form numbers for these products, which (except as noted) have been submitted to the Department under separate cover, are:

- FRONT DIRECT (04-12)
- SUMMARY DIRECT (04-12)
- INTRODUCTION DIRECT (04-12)
- ELIGIBILITY DIRECT (04-12)
- COVERED DIRECT (04-12)
- EXCLUSIONS DIRECT (04-12)
- PAYMENT DIRECT (07-10) (previously approved)
- COB DIRECT (07-10) (previously approved)
- APPEALS DIRECT (04-12)
- GLOSSARY DIRECT (04-12).

When combined, these ten subsections comprise the subscriber agreements for the six Direct Pay policies.

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

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

Sincerely,

Jeffrey McLane, F.S.A., M.A.A.A.
Associate Actuary

JGM/swl

Enclosures

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

Schedule 1

Blue Cross and Blue Shield of Rhode Island
Direct Pay Rate Filing Effective April 1, 2012
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Schedule 2

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Section I:

Basic Required Rates (Pool I)

Schedule 6

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of VantageBlue Direct 1000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$1,027.47	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$980.04**	(C)

	(1)	(2)	(3)	(4)
	Individual		Family	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.554	$542.94	1.043	$1,022.18
25-29	0.566	$554.70	1.065	$1,043.74
30-34	0.587	$575.28	1.105	$1,082.94
35-39	0.609	$596.84	1.147	$1,124.11
40-44	0.622	$609.58	1.171	$1,147.63
45-49	0.661	$647.81	1.245	$1,220.15
50-54	0.722	$707.59	1.359	$1,331.87
55-59	0.804	$787.95	1.514	$1,483.78
60-64	0.831	$814.41	1.564	$1,532.78
65+	1.033	$1,012.38	1.949	$1,910.10

(A) Per Schedule 21, Column 3 for VantageBlue Direct 1000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual/family rating category.
(E) Item (iii) times Column 1.
(F) Item (iii) times Column 3.

Schedule 7

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of VantageBlue Direct 1500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$931.19	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$888.20**	(C)

	(1)	(2)	(3)	(4)
	Individual		Family	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.554	$492.06	1.043	$926.39
25-29	0.566	$502.72	1.065	$945.93
30-34	0.587	$521.37	1.105	$981.46
35-39	0.609	$540.91	1.147	$1,018.77
40-44	0.622	$552.46	1.171	$1,040.08
45-49	0.661	$587.10	1.245	$1,105.81
50-54	0.722	$641.28	1.359	$1,207.06
55-59	0.804	$714.11	1.514	$1,344.73
60-64	0.831	$738.09	1.564	$1,389.14
65+	1.033	$917.51	1.949	$1,731.10

(A) Per Schedule 21, Column 3 for VantageBlue Direct 1500.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual/family rating category.
(E) Item (iii) times Column 1.
(F) Item (iii) times Column 3.

Schedule 8

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of HealthMate Direct 2500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$810.64	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$773.22**	(C)

	(1)	(2)	(3)	(4)
	Individual		Family	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.554	$428.36	1.043	$806.47
25-29	0.566	$437.64	1.065	$823.48
30-34	0.587	$453.88	1.105	$854.41
35-39	0.609	$470.89	1.147	$886.88
40-44	0.622	$480.94	1.171	$905.44
45-49	0.661	$511.10	1.245	$962.66
50-54	0.722	$558.26	1.359	$1,050.81
55-59	0.804	$621.67	1.514	$1,170.66
60-64	0.831	$642.55	1.564	$1,209.32
65+	1.033	$798.74	1.949	$1,507.01

(A) Per Schedule 21, Column 3 for HealthMate Direct 2500.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual/family rating category.
(E) Item (iii) times Column 1.
(F) Item (iii) times Column 3.

Schedule 9

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of BlueSolutions for HSA Direct 3000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$712.72	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$679.82**	(C)

	(1)	(2)	(3)	(4)
	Individual		Family	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.554	$376.62	1.043	$709.05
25-29	0.566	$384.78	1.065	$724.01
30-34	0.587	$399.05	1.105	$751.20
35-39	0.609	$414.01	1.147	$779.75
40-44	0.622	$422.85	1.171	$796.07
45-49	0.661	$449.36	1.245	$846.38
50-54	0.722	$490.83	1.359	$923.88
55-59	0.804	$546.58	1.514	$1,029.25
60-64	0.831	$564.93	1.564	$1,063.24
65+	1.033	$702.25	1.949	$1,324.97

(A) Per Schedule 21, Column 3 for BlueSolutions for HSA Direct 3000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual/family rating category.
(E) Item (iii) times Column 1.
(F) Item (iii) times Column 3.

Schedule 10

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of BlueSolutions for HSA Direct 5000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$571.94	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$545.54**	(C)

	(1)	(2)	(3)	(4)
	Individual		Family	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.554	$302.23	1.043	$569.00
25-29	0.566	$308.78	1.065	$581.00
30-34	0.587	$320.23	1.105	$602.82
35-39	0.609	$332.23	1.147	$625.73
40-44	0.622	$339.33	1.171	$638.83
45-49	0.661	$360.60	1.245	$679.20
50-54	0.722	$393.88	1.359	$741.39
55-59	0.804	$438.61	1.514	$825.95
60-64	0.831	$453.34	1.564	$853.22
65+	1.033	$563.54	1.949	$1,063.26

(A) Per Schedule 21, Column 3 for BlueSolutions for HSA Direct 5000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual/family rating category.
(E) Item (iii) times Column 1.
(F) Item (iii) times Column 3.

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of BlueValue Direct 2500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$506.95	(A)
(ii)	Rate Tier Normalization Factor	1.0484	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$483.55**	(C)

	(1)	(2)
		Individual
Age Category	**Rate Factor**	**Required Monthly Subscription Rate**
	(D)	(E)
Under 25	0.554	$267.89
25-29	0.566	$273.69
30-34	0.587	$283.84
35-39	0.609	$294.48
40-44	0.622	$300.77
45-49	0.661	$319.63
50-54	0.722	$349.12
55-59	0.804	$388.77
60-64	0.831	$401.83
65+	1.033	$499.51

(A) Per Schedule 21, Column 3 for BlueValue Direct 2500.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, contract type and product. Factor is developed in Schedule 19, line 9.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age in the individual rating category.
(E) Item (iii) times Column 1.

Section II:

Preferred Required Rates (Pool II)

Schedule 13

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of VantageBlue Direct 1000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$405.76	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$447.46**	(C)

	(1)	(2)	(3)	(4)	(5)	(6)
	Individual				Family	
	Male		Female		Male/Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)	(D)	(G)
Under 25	0.462	$206.73	0.646	$289.06	1.548	$692.67
25-29	0.511	$228.65	0.732	$327.54	1.734	$775.90
30-34	0.582	$260.42	0.870	$389.29	1.839	$822.88
35-39	0.666	$298.01	0.863	$386.16	1.941	$868.52
40-44	0.712	$318.59	0.944	$422.40	1.984	$887.76
45-49	0.861	$385.26	1.046	$468.04	2.091	$935.64
50-54	1.091	$488.18	1.222	$546.80	2.329	$1,042.13
55-59	1.398	$625.55	1.395	$624.21	2.607	$1,166.53
60-64	1.495	$668.95	1.495	$668.95	2.833	$1,267.65
65+	1.858	$831.38	1.858	$831.38	3.530	$1,579.53

(A) Per Schedule 21, Column 5 for VantageBlue Direct 1000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male/female or family rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.
(E) Item (iii) times Column 1
(F) Item (iii) times Column 3
(G) Item (iii) times Column 5

Schedule 14

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of VantageBlue Direct 1500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$367.74	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$405.54**	(C)

	(1)	(2)	(3)	(4)	(5)	(6)
	Individual				Family	
	Male		Female		Male/Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)	(D)	(G)
Under 25	0.462	$187.36	0.646	$261.98	1.548	$627.78
25-29	0.511	$207.23	0.732	$296.86	1.734	$703.21
30-34	0.582	$236.02	0.870	$352.82	1.839	$745.79
35-39	0.666	$270.09	0.863	$349.98	1.941	$787.15
40-44	0.712	$288.74	0.944	$382.83	1.984	$804.59
45-49	0.861	$349.17	1.046	$424.19	2.091	$847.98
50-54	1.091	$442.44	1.222	$495.57	2.329	$944.50
55-59	1.398	$566.94	1.395	$565.73	2.607	$1,057.24
60-64	1.495	$606.28	1.495	$606.28	2.833	$1,148.89
65+	1.858	$753.49	1.858	$753.49	3.530	$1,431.56

(A) Per Schedule 21, Column 5 for VantageBlue Direct 1500.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male/female or family rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.
(E) Item (iii) times Column 1
(F) Item (iii) times Column 3
(G) Item (iii) times Column 5

Schedule 15

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of HealthMate Direct 2500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$320.13	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$353.03**	(C)

	(1)	(2)	(3)	(4)	(5)	(6)
	Individual				Family	
	Male		Female		Male/Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)	(D)	(G)
Under 25	0.462	$163.10	0.646	$228.06	1.548	$546.49
25-29	0.511	$180.40	0.732	$258.42	1.734	$612.15
30-34	0.582	$205.46	0.870	$307.14	1.839	$649.22
35-39	0.666	$235.12	0.863	$304.66	1.941	$685.23
40-44	0.712	$251.36	0.944	$333.26	1.984	$700.41
45-49	0.861	$303.96	1.046	$369.27	2.091	$738.19
50-54	1.091	$385.16	1.222	$431.40	2.329	$822.21
55-59	1.398	$493.54	1.395	$492.48	2.607	$920.35
60-64	1.495	$527.78	1.495	$527.78	2.833	$1,000.13
65+	1.858	$655.93	1.858	$655.93	3.530	$1,246.20

(A) Per Schedule 21, Column 5 for HealthMate Direct 2500.

(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.

(C) Item (i) divided by Item (ii).

(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male/female or family rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.

(E) Item (iii) times Column 1

(F) Item (iii) times Column 3

(G) Item (iii) times Column 5

Schedule 16

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of BlueSolutions for HSA Direct 3000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$281.46	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$310.39**	(C)

	(1)	(2)	(3)	(4)	(5)	(6)
	Individual				Family	
	Male		Female		Male/Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)	(D)	(G)
Under 25	0.462	$143.40	0.646	$200.51	1.548	$480.48
25-29	0.511	$158.61	0.732	$227.21	1.734	$538.22
30-34	0.582	$180.65	0.870	$270.04	1.839	$570.81
35-39	0.666	$206.72	0.863	$267.87	1.941	$602.47
40-44	0.712	$221.00	0.944	$293.01	1.984	$615.81
45-49	0.861	$267.25	1.046	$324.67	2.091	$649.03
50-54	1.091	$338.64	1.222	$379.30	2.329	$722.90
55-59	1.398	$433.93	1.395	$432.99	2.607	$809.19
60-64	1.495	$464.03	1.495	$464.03	2.833	$879.33
65+	1.858	$576.70	1.858	$576.70	3.530	$1,095.68

(A) Per Schedule 21, Column 5 for BlueSolutions for HSA Direct 3000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male/female or family rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.
(E) Item (iii) times Column 1
(F) Item (iii) times Column 3
(G) Item (iii) times Column 5

Schedule 17

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of BlueSolutions for HSA Direct 5000 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$225.86	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$249.07**	(C)

	(1)	(2)	(3)	(4)	(5)	(6)
	Individual				Family	
	Male		Female		Male/Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)	(D)	(G)
Under 25	0.462	$115.07	0.646	$160.90	1.548	$385.56
25-29	0.511	$127.27	0.732	$182.32	1.734	$431.89
30-34	0.582	$144.96	0.870	$216.69	1.839	$458.04
35-39	0.666	$165.88	0.863	$214.95	1.941	$483.44
40-44	0.712	$177.34	0.944	$235.12	1.984	$494.15
45-49	0.861	$214.45	1.046	$260.53	2.091	$520.81
50-54	1.091	$271.74	1.222	$304.36	2.329	$580.08
55-59	1.398	$348.20	1.395	$347.45	2.607	$649.33
60-64	1.495	$372.36	1.495	$372.36	2.833	$705.62
65+	1.858	$462.77	1.858	$462.77	3.530	$879.22

(A) Per Schedule 21, Column 5 for BlueSolutions for HSA Direct 5000.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male/female or family rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.
(E) Item (iii) times Column 1
(F) Item (iii) times Column 3
(G) Item (iii) times Column 5

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of BlueValue Direct 2500 Required Monthly Subscription Rates
for April 1, 2012 Billing Cycle

(i)	Required Monthly Base Rate	$200.20	(A)
(ii)	Rate Tier Normalization Factor	0.9068	(B)
(iii)	**Normalized Required Monthly Base Rate**	**$220.78**	(C)

	(1)	(2)	(3)	(4)
	Individual			
	Male		Female	
Age Category	Rate Factor	Required Monthly Subscription Rate	Rate Factor	Required Monthly Subscription Rate
	(D)	(E)	(D)	(F)
Under 25	0.462	$102.00	0.646	$142.62
25-29	0.511	$112.82	0.732	$161.61
30-34	0.582	$128.49	0.870	$192.08
35-39	0.666	$147.04	0.863	$190.53
40-44	0.712	$157.20	0.944	$208.42
45-49	0.861	$190.09	1.046	$230.94
50-54	1.091	$240.87	1.222	$269.79
55-59	1.398	$308.65	1.395	$307.99
60-64	1.495	$330.07	1.495	$330.07
65+	1.858	$410.21	1.858	$410.21

(A) Per Schedule 21, Column 5 for BlueValue Direct 2500.
(B) Factor to adjust monthly base rates to reflect enrollment distribution by age, gender, contract type, and product. Factor is developed in Schedule 19, line 10.
(C) Item (i) divided by Item (ii).
(D) Factor to convert normalized required monthly base rate to required monthly subscription rates for each age and individual male or individual female rating category. Factors are unchanged from the previous Direct Pay rate filing, only a factor for 65+ was added.
(E) Item (iii) times Column 1
(F) Item (iii) times Column 3

Schedule 19

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Rate Tier Normalization Factors
for April 1, 2012 Billing Cycle

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
				Rate Period (4/2012-9/2013) Projected Contracts						
		Rate Factors		VantageBlue/HealthMate			Blue Solutions for HSA		BlueValue	Total
	Rate Tier	Existing	Proposed	1000	1500	2500	3000	5000	2500	Contracts
Basic Rates (Pool 1)	Individual: Under 25	0.554	0.554	392	108	126	22	80	32	760
	Individual: 25-29	0.560	0.566	1274	366	738	226	488	168	3,260
	Individual: 30-34	0.570	0.587	827	233	414	142	218	66	1,900
	Individual: 35-39	0.581	0.609	648	192	432	96	186	66	1,620
	Individual: 40-44	0.587	0.622	564	156	540	244	496	160	2,160
	Individual: 45-49	0.606	0.661	1285	355	1062	342	616	200	3,860
	Individual: 50-54	0.636	0.722	2231	629	1566	574	1032	328	6,360
	Individual: 55-59	0.676	0.804	4380	1220	3168	968	2212	772	12,720
	Individual : 60-64	0.689	0.831	9934	2766	7470	2374	4562	1514	28,621
	Individual : 65+	1.024	1.033	669	171	126	102	320	112	1,500
	Family: Under 25	1.043	1.043	0	0	0	0	0	0	0
	Family: 25-29	1.054	1.065	47	13	18	10	24	8	120
	Family: 30-34	1.073	1.105	295	85	144	48	40	8	620
	Family: 35-39	1.094	1.147	467	133	108	52	134	46	940
	Family: 40-44	1.105	1.171	844	236	396	124	268	92	1,960
	Family: 45-49	1.141	1.245	1354	386	630	230	354	106	3,060
	Family: 50-54	1.197	1.359	1799	501	1170	386	698	226	4,780
	Family: 55-59	1.273	1.514	2594	726	1080	416	916	308	6,040
	Family: 60-64	1.297	1.564	2653	747	1800	520	1114	386	7,220
	Family: 65+	1.933	1.949	64	16	0	8	10	2	100
	Total Pool 1			**32,322**	**9,039**	**20,989**	**6,884**	**13,768**	**4,600**	**87,603**
Preferred Rates (Pool 2)	Individual Male: Under 25	0.462	0.462	2238	514	1034	195	701	3798	8,480
	Individual Male: 25-29	0.511	0.511	4108	942	1728	522	1270	4142	12,713
	Individual Male: 30-34	0.582	0.582	2210	515	1062	425	414	3889	8,516
	Individual Male: 35-39	0.666	0.666	1091	259	283	142	404	142	2,320
	Individual Male: 40-44	0.712	0.712	1261	290	538	204	476	241	3,010
	Individual Male: 45-49	0.861	0.861	1374	321	623	257	685	282	3,542
	Individual Male: 50-54	1.091	1.091	1091	260	538	398	1054	306	3,648
	Individual Male: 55-59	1.398	1.398	1034	243	609	283	1215	282	3,666
	Individual Male: 60-64	1.495	1.495	793	174	439	239	1153	230	3,028
	Individual Male: 65+	N/A	1.858	0	0	0	0	0	0	0
	Individual Female: Under 25	0.646	0.646	1827	390	1062	159	485	3487	7,411
	Individual Female: 25-29	0.732	0.732	2040	429	1799	195	807	3700	8,970
	Individual Female: 30-34	0.870	0.87	963	209	567	124	411	3314	5,587
	Individual Female: 35-39	0.863	0.863	737	165	467	71	308	165	1,912
	Individual Female: 40-44	0.944	0.944	807	186	595	151	604	225	2,568
	Individual Female: 45-49	1.046	1.046	977	221	722	336	786	338	3,382
	Individual Female: 50-54	1.222	1.222	935	200	609	319	1112	313	3,488
	Individual Female: 55-59	1.395	1.395	1119	237	1077	381	1185	464	4,462
	Individual Female: 60-64	1.495	1.495	1587	351	1133	629	2201	581	6,481
	Individual Female: 65+	N/A	1.858	0	0	0	0	0	0	0
	Family: Under 25	1.548	1.548	0	0	0	0	0	1403	1,403
	Family: 25-29	1.734	1.734	127	23	113	9	5	1444	1,722
	Family: 30-34	1.839	1.839	567	110	227	53	120	1513	2,589
	Family: 35-39	1.941	1.941	864	182	552	115	388	218	2,320
	Family: 40-44	1.984	1.984	1332	294	737	106	382	266	3,117
	Family: 45-49	2.091	2.091	992	218	496	204	547	236	2,692
	Family: 50-54	2.329	2.329	1020	227	680	336	662	333	3,258
	Family: 55-59	2.607	2.607	538	129	524	168	437	204	2,001
	Family: 60-64	2.833	2.833	269	60	127	133	310	92	992
	Family: 65+	N/A	3.530	0	0	0	0	0	0	0
	Total Pool 2			**31,902**	**7,147**	**18,345**	**6,153**	**18,124**	**31,605**	**113,277**
1.	Rate Relativity Factor			0.8174	0.7408	0.6449	0.5670	0.4550	0.4033	
2.	Pool 1 Relativity Factor			2.5322	2.5322	2.5322	2.5322	2.5322	2.5322	
3.	Pool 2 Relativity Factor			1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
4.	**Rate Tier and Rate Relativity Adjusted Contract Months:**									
5.	Both Pools Combined: Existing Age Relativities			84,243	19,897	41,040	12,325	23,232	15,375	196,112
6.	Pool 1: Existing Age Relativities			56,244	14,251	27,602	8,020	12,925	3,828	122,869
7.	Pool 1: Proposed Age Relativities			64,848	16,432	32,069	9,288	14,976	4,438	142,051
8.	**Rate Relativity Adjusted Contract Months**			92,978	22,251	46,106	13,373	24,110	17,444	216,262
9.	**Rate Tier Normalization Factor: Pool 1**									**1.0484**
10.	**Rate Tier Normalization Factor: Pool 2**									**0.9068**

Section III:

Calculation of Monthly Base Rates for Basic and Preferred (Pool I and Pool II)

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Required Monthly Base Rates for Updated Products
for April 1, 2012 Billing Cycle

(i)	Required Income for Basic Rate Rate (Pool I)	$811.27	(A)
(ii)	Required Income for Preferred Rate (Pool II)	$320.38	(B)
(iii)	Pool Relativity for Basic Rate (Pool I)	2.5322	(C)

	(1)	(2)	(3)	(4)	(5)
		Basic (Pool 1)		**Preferred (Pool 2)**	
	Plan Relativity	Contracts	Required Base Rate	Contracts	Required Base Rate
	(D)	(F)	(G)	(H)	(I)
VantageBlue Direct 1000	0.8174	32,322	$1,027.47	31,902	$405.76
VantageBlue Direct 1500	0.7408	9,039	$931.19	7,147	$367.74
HealthMate Direct 2500	0.6449	20,989	$810.64	18,345	$320.13
BlueSolutions for HSA Direct 3000	0.5670	6,884	$712.72	6,153	$281.46
BlueSolutions for HSA Direct 5000	0.4550	13,768	$571.94	18,124	$225.86
BlueValue Direct 2500	0.4033	4,600	$506.95	31,605	$200.20
Composite	0.6454 (E)	87,603		113,277	

(A) Per Schedule 23, column 13, for Pool I
(B) Per Schedule 23, column 13, for Pool II
(C) Per Schedule 23, column 12, for Pool I
(D) Per Schedule 22, column 12.
(E) Plan Relativitities, weighted by premium adjusted Pool I contracts (column 2 multiplied by item iii) and Pool II contracts (column 4).
(F) Per Schedule 28, column 8.
(G) Item (i) multiplied by column 1, divided by composite of column 1.
(H) Per Schedule 29, column 8.
(I) Item (ii) multiplied by column 1, divided by composite of column 1.

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Rate Relativity for Updated Products
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
	Contracts			**Allowed Claims**			**Paid Claims**			**Benefits Only Rate**	**Modification**	**Proposed Rate**
	Pool 1	Pool 2	Total	Pool 1	Pool 2	Total	Pool 1	Pool 2	Total	**Relativity**	**Factor**	**Relativity**
	(A)	(B)	(C)			(D)			(E)	(F)	(G)	(H)
VantageBlue Direct 1000	32,322	31,902	64,225	$1,295.35	$451.71	$876.29	$1,007.31	$352.83	$682.21	0.7785	1.05	0.8174
VantageBlue Direct 1500	9,039	7,147	16,186	$1,298.95	$456.63	$927.03	$961.28	$339.50	$686.74	0.7408	1.00	0.7408
HealthMate Direct 2500	20,989	18,345	39,334	$860.39	$323.41	$609.94	$583.34	$220.34	$414.04	0.6788	0.95	0.6449
BlueSolutions for HSA Direct 3000	6,884	6,153	13,038	$1,203.92	$365.62	$808.26	$661.93	$202.12	$444.91	0.5505	1.03	0.5670
BlueSolutions for HSA Direct 5000	13,768	18,124	31,892	$875.29	$335.28	$568.41	$427.37	$164.65	$278.07	0.4892	0.93	0.4550
BlueValue Direct 2500	4,600	31,605	36,205	$732.61	$260.67	$320.63	$410.07	$151.94	$184.74	0.5762	0.70	0.4033
Composite	87,603	113,277	200,880	$1,088.75	$354.64	$674.78	$751.33	$236.19	$460.84			

(A) Per Schedule 28, column 8.
(B) Per Schedule 29, column 8.
(C) Sum of columns (1) and (2).
(D) Composite of columns (4) and (5), based on enrollment weights in columns (1) and (2).
(E) Composite of columns (7) and (8), based on enrollment weights in columns (1) and (2).
(F) Column (9) divided by column (6).
(G) Factors used to modify the Benefits Only rate relativity (column 10).
(H) Column (10) multiplied by column (11).

Blue Cross & Blue Shield Of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Composite Required Monthly Base Rates for Updated Products
for April 1, 2012 Billing Cycle

	(1)	(2)		(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	Projected Contract Months (A)	Projected Paid Claims Expense PCPM		Child and Adult Assessments Benefit Impact (E)	Impact of Coverage for Dependents up to Age 26 (F)	Projected Paid Claims Adjusted (G)	Administrative Expense PCPM (H)	Projected Incurred Claims and Administrative Expense PCPM (I)	Investment Income Credit PCPM (J)	New System Expense (K)	Contribution to Reserve/ Tax Liability PCPM (L)	Required Income PCPM (M)	Current Pool Relativity (N)	Adjusted Required Income PCPM (O)
Pool 1	87,603	$751.33	(B)	1.0059	1.0072	$761.20	$57.08	$818.28	($3.19)	$2.84	$16.69	$834.62	2.5322	$811.27
Pool 2	113,277	$236.19	(C)	1.0059	1.0072	$239.29	$57.08	$296.37	($1.16)	$1.03	$6.05	$302.29	1.0000	$320.38
Total	**200,880**	**$460.84**	(D)	**1.0059**	**1.0072**	**$466.90**	**$57.08**	**$523.98**	**($2.04)**	**$1.82**	**$10.69**	**$534.45**		**$534.46**

(A) Rate Period (4/1/2012-9/30/2013) projected contract months. Per Schedule 28, composite of column 8 for Pool I. Per Schedule 29, composite of column 9 for Pool II.
(B) Per Schedule 28, column 14 composite.
(C) Per Schedule 29, column 14 composite.
(D) Weighted by contract months in column 1.
(E) Per Schedule 25, line 8.
(F) Last years factor (0.86%), effective 4/1/2011, multiplied by 10/12 (10 months of the base period (6/10-3/11) does not include this impact), plus 1.0000.
(G) Product of columns 2 through 4.
(H) Per Schedule 51, total of column 4.
(I) Column 5 plus column 6.
(J) Investment Income credit of 0.39% of column 7.
(K) Rating component for new 'core payment system' which is 0.34% of the required income.
(L) A 0.00% reserve loading plus 2.00% for state premium tax assessment: (Sum of Columns 7 through 9)/0.9800 - (sum of Columns 7 through 9).
(M) Sum of Columns 7 through 10.
(N) Current Basic (Pool I) rate relativity relative to Preferred (Pool II).
(O) Column 11 adjusted for current pool relativities shown in column 12. The total in column 13 is equal to the total in column 11.

Section IV:

Calculation of Claims Impact of Child and Adult Immunizations Benefit

Schedule 25

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Claims Impact of Child and Adult Immunizations Benefit
for April 1, 2012 Billing Cycle

1) Base Period Benefits (A)	$293,381
2) Base Period Contract Months (B)	116,089
3) Base Period Per Contract Per Month (C)	$2.53
4) Trend (D)	1.0764
5) Rate Period Per Contract Per Month (E)	$2.72
6) Rate Period Projected Claims Expense (F)	$460.84
7) Claims Impact of Child and Adult Immunizations Benefit (G)	0.59%
8) Direct Pay Claims Factor for Child and Adult Immunizations Benefit (H)	**1.0059**

(A) Per Schedule 26, column 7 total. This is the benefit amount directly received by Direct Pay subscribers.
(B) Base Year (6/1/2010-5/31/2011) Contract Months.
(C) Line 1 divided by line 2.
(D) Per Schedule 53, column 4, composite for surgical/medical.
(E) Line 3 multiplied by line 4.
(F) Per Schedule 23, total of column 2.
(G) Line 5 divided by line 6.
(H) Line 7 plus 1.0000.

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Base Period Benefit Amount of Child and Adult Immunizations
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Encounters		**Average Cost Per Encounter**		**Total Cost**		
Vaccine Type	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Total**
	(A)	**(A)**	**(B)**	**(C)**	**(D)**	**(E)**	**(F)**
Flu	2,045	1,307	$13.37	$17.57	$27,337	$22,963	**$50,301**
Flu_Pandemic	7	527	$29.47	$34.08	$208	$17,969	**$18,177**
Pneum	114	340	$55.71	$126.98	$6,339	$43,127	**$49,467**
TD	396	189	$42.23	$44.33	$16,735	$8,365	**$25,099**
DT	16	351	$39.44	$62.24	$635	$21,820	**$22,455**
HPV	16	262	$156.18	$156.18	$2,513	$40,929	**$43,441**
HIB	6	231	$27.34	$26.14	$166	$6,050	**$6,216**
Cpox	3	225	$100.38	$100.38	$307	$22,624	**$22,931**
MMR	3	162	$59.74	$59.74	$182	$9,687	**$9,868**
Mening	1	162	$123.19	$123.26	$123	$19,972	**$20,095**
Rota	3	125	$122.85	$111.74	$370	$13,933	**$14,303**
Hep_B	25	16	$59.41	$30.21	$1,500	$487	**$1,987**
Hep_A	30	1	$85.13	$75.57	$2,573	$76	**$2,648**
Polio	11	15	$29.50	$29.50	$325	$445	**$770**
Shingles	16	0	$184.72	$184.72	$2,967	$0	**$2,967**
Typhoid	19	1	$54.78	$54.98	$1,045	$55	**$1,100**
Rabies	4	0	$234.00	$234.00	$938	$0	**$938**
Tetanus	4	0	$32.30	$32.30	$130	$0	**$130**
Yellow Fever	5	0	$97.26	$97.26	$487	$0	**$487**
Total	**2,725**	**3,914**	**$23.81**	**$58.37**	**$64,879**	**$228,502**	**$293,381**

(A) Applicable to the Direct Pay population. These are base period (6/10-5/11) encounters, completed.
(B) Total cost in column 5, divided by encounters in column 1.
(C) Total cost in column 6, divided by encounters in column 2.
(D) Total cost for the encounters shown in column 1, based on 2011 fee schedule.
(E) Total cost for the encounters shown in column 2, based on 2011 fee schedule.
(F) Column 5 plus column 6.

Section V:

Calculation of Projected Paid Claims for Basic and Preferred (Pool I and Pool II) Rate Development

Schedule 28

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of Composite Projected Paid Claims Expense per Contract Month for Updated Products
for April 1, 2012 Billing Cycle

		(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Prior to Migration	HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured	Total
1.	June 2011 Contracts (A)	1,301	767	1,166	569	577	-	**4,380**
2.	Adjusted Projected Allowed Claims (B)	$1,276.60	$1,329.28	$860.39	$1,379.91	$519.84	-	**$1,088.75**

Migration Grid (C)

		HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured
3.	VantageBlue Direct 1000	80%	75%	0%	0%	0%	-
4.	VantageBlue Direct 1500	20%	25%	0%	0%	0%	-
5.	HealthMate Direct 2500	0%	0%	90%	0%	0%	-
6.	BlueSolutions for HSA Direct 3000	0%	0%	10%	40%	0%	-
7.	BlueSolutions for HSA Direct 5000	0%	0%	0%	50%	70%	-
8.	BlueValue Direct 2500	0%	0%	0%	10%	30%	-

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
		June 2011 Contracts Migrating From (D)								Adjusted					
	Post Migration	HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured	Total	Projected Contracts	Projected Allowed	Net-to Allowed	Utilization Adjustment	Drug Rebates	Additional Benefits	Projected Paid
								(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)
9.	VantageBlue Direct 1000	1,041	575	0	0	0	-	1,616	32,322	$1,295.35	0.7866	1.0000	0.9886		$1,007.31
10.	VantageBlue Direct 1500	260	192	0	0	0	-	452	9,039	$1,298.95	0.7599	0.9855	0.9882		$961.28
11.	HealthMate Direct 2500	0	0	1,049	0	0	-	1,049	20,989	$860.39	0.7187	0.9553	0.9875		$583.34
12.	BlueSolutions for HSA Direct 3000	0	0	117	228	0	-	344	6,884	$1,203.92	0.6519	0.8552	0.9862		$661.93
13.	BlueSolutions for HSA Direct 5000	0	0	0	285	404	-	688	13,768	$875.29	0.6159	0.8045	0.9854		$427.37
14.	BlueValue Direct 2500	0	0	0	57	173	-	230	4,600	$732.61	0.6274	0.8718	1.0000	$9.36	$410.07
15.	Composite	1,301	767	1,166	569	577	-	**4,380**	**87,603**	**$1,088.75**					**$751.33**

(A) Contract distribution of the current plans at June 2011.
(B) Adjusted projected allowed claims for each current plan. Per schedules 30-34, colum 5 total. These are at the VantageBlue Direct 1000 utilization level.
(C) Proportion of existing subscribers expected to migrate to each of the updated plans.
(D) June 2011 contracts distributed to the updated products according to the migration grid.
(E) Sum of columns 1 through 6.
(F) Pool I rate period (4/1/2012 - 9/30/2013) projected contract months. Plan contracts distributed by the proportions in column 7.
(G) Colums 1-6, adjusted projected allowed claims (line 2), weighted with post migration contracts. These are at the VantageBlue Direct 1000 utilization level.
(H) Per schedule 43, line 6.
(I) Factor to adjust the adjusted projected allowed claims in column 9 from the VantageBlue Direct 1000 utilization level, to each updated plan utilization level.
(J) 3.5% rebate on pharmacy, equating to 0.9% of Pool I projected allowed claims. The factor is calculated as 0.9% divided by column 10, subtracted from 1.0000. The BlueValue Direct 2500 plan is not eligible for pharmacy rebates.
(K) Per Schedule 41, line 7.
(L) Product of columns 9 through 12, plus column 13.

Schedule 29

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of Composite Projected Paid Claims Expense per Contract Month for Updated Products
for April 1, 2012 Billing Cycle

		(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Prior to Migration	HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured	Total
1.	June 2011 Contracts (A)	1,784	468	1,295	695	815	1,340	**6,397**
2.	Adjusted Projected Allowed Claims (B)	$462.84	$409.26	$323.41	$365.62	$327.52	$232.47	**$354.64**

Migration Grid (C)

		HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured
3.	VantageBlue Direct 1000	80%	80%	0%	0%	0%	0%
4.	VantageBlue Direct 1500	20%	10%	0%	0%	0%	0%
5.	HealthMate Direct 2500	0%	0%	80%	0%	0%	0%
6.	BlueSolutions for HSA Direct 3000	0%	0%	0%	50%	0%	0%
7.	BlueSolutions for HSA Direct 5000	0%	0%	0%	30%	100%	0%
8.	BlueValue Direct 2500	0%	10%	20%	20%	0%	100%

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
		June 2011 Contracts Migrating From (D)								Adjusted					
	Post Migration	HM 500	HM 1000	HM 2000	HSA 3000	HSA 5000	Uninsured	Total	Projected Contracts	Projected Allowed	Net-to Allowed	Utilization Adjustment	Drug Rebates	Additional Benefits	Projected Paid
								(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)
9.	VantageBlue Direct 1000	1,427	374	0	0	0	0	1,802	31,902	$451.71	0.7866	1.0000	0.9930		$352.83
10.	VantageBlue Direct 1500	357	47	0	0	0	0	404	7,147	$456.63	0.7599	0.9855	0.9928		$339.50
11.	HealthMate Direct 2500	0	0	1,036	0	0	0	1,036	18,345	$323.41	0.7187	0.9553	0.9923		$220.34
12.	BlueSolutions for HSA Direct 3000	0	0	0	348	0	0	348	6,153	$365.62	0.6519	0.8552	0.9916		$202.12
13.	BlueSolutions for HSA Direct 5000	0	0	0	209	815	0	1,024	18,124	$335.28	0.6159	0.8045	0.9911		$164.65
14.	BlueValue Direct 2500	0	47	259	139	0	1,340	1,785	31,605	$260.67	0.6274	0.8718	1.0000	$9.36	$151.94
15.	Composite	1,784	468	1,295	695	815	1,340	**6,397**	**113,277**	**$354.64**					**$236.19**

(A) Contract distribution of the current plans at June 2011, and the expected average monthly enrollment throughout the rate period (4/1/2012-9/30/2013) for the currently uninsured population.
(B) Adjusted projected allowed claims for each current plan and the currently uninsured. Current plans per schedules 35-39, column 5 total. Uninsured per schedule 40, line 6. These are at the VantageBlue Direct 1000 utilization level.
(C) Proportion of existing subscribers and currently uninsured expected to migrate to each of the updated plans.
(D) June 2011 and currently uninsured contracts distributed to the updated products according to the migration grid.
(E) Sum of columns 1 through 6.
(F) Pool II rate period (4/1/2012 - 9/30/2013) projected contract months. Plan contracts distributed by the proportions in column 7.
(G) Colums 1-6, adjusted projected allowed claims (line 2), weighted with post migration contracts. These are at the VantageBlue Direct 1000 utilization level.
(H) Per schedule 43, line 6.
(I) Factor to adjust the adjusted projected allowed claims in column 9 from the VantageBlue Direct 1000 utilization level, to each updated plan utilization level.
(J) 3.5% rebate on pharmacy, equating to 0.55% of Pool II projected allowed claims. The factor is calculated as 0.55% divided by column 10, subtracted from 1.0000. BlueValue Direct 2500 plan is not eligible for pharmacy rebates.
(K) Per Schedule 41, line 7.
(L) Product of columns 9 through 12, plus column 13.

Schedule 30

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 500
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims	**Incurred Allowed Claims PCPM**	**Projection Factor**	**Utilization Adjustment**	**Adjusted Projected Allowed Claims PCPM**
	(A)	(B)	(C)	(D)	(E)
Inpatient	$4,792,530	$263.25	1.1389	1.0298	$291.14
Outpatient	$4,458,791	$244.92	1.1704	1.0298	$278.36
Surgical/Medical	$6,760,375	$371.35	1.0550	1.0298	$380.44
Pharmacy	$5,367,910	$294.86	1.1432	1.0319	$326.66
Total					**$1,276.60**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Basic Rate (Pool I) HealthMate Direct 500 for Jun-2010 to May-2011 estimated to 100% complete.
(B) Column 1 divided by 18,205 Basic Rate (Pool I) HealthMate Direct 500 contract months for Jun-2010 to May-2011.
(C) Per Schedule 53, Column 4, for Pool I.
(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.
(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 31

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 1000

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$1,766,101	$310.06	1.1389	1.0057	$351.13
Outpatient	$1,307,692	$229.58	1.1704	1.0057	$267.18
Surgical/Medical	$1,900,542	$333.66	1.0550	1.0057	$350.02
Pharmacy	$1,812,304	$318.17	1.1432	1.0077	$360.95
Total					**$1,329.28**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Basic Rate (Pool I) HealthMate Direct 1000 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 5,696 Basic Rate (Pool I) HealthMate Direct 1000 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool I.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 32

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 2000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims	**Incurred Allowed Claims PCPM**	**Projection Factor**	**Utilization Adjustment**	**Adjusted Projected Allowed Claims PCPM**
	(A)	(B)	(C)	(D)	(E)
Inpatient	$2,764,416	$185.98	1.1389	0.9686	$218.68
Outpatient	$2,105,836	$141.67	1.1704	0.9686	$171.19
Surgical/Medical	$3,484,807	$234.45	1.0550	0.9686	$255.36
Pharmacy	$2,715,066	$182.66	1.1432	0.9705	$215.16
Total					**$860.39**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Basic Rate (Pool I) HealthMate Direct 2000 for Jun-2010 to May-2011 estimated to 100% complete.
(B) Column 1 divided by 14,864 Basic Rate (Pool I) HealthMate Direct 2000 contract months for Jun-2010 to May-2011.
(C) Per Schedule 53, Column 4, for Pool I.
(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.
(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 33

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate for HSA 3000

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$1,808,888	$243.85	1.1389	0.8751	$317.36
Outpatient	$1,841,380	$248.23	1.1704	0.8751	$331.99
Surgical/Medical	$2,089,590	$281.69	1.0550	0.8751	$339.60
Pharmacy	$2,224,567	$299.89	1.1432	0.8769	$390.96
Total					**$1,379.91**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Basic Rate (Pool I) HealthMate for HSA 3000 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 7,418 Basic Rate (Pool I) HealthMate for HSA 3000 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool I.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 34

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate for HSA 5000

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$543,412	$83.28	1.1389	0.8036	$118.03
Outpatient	$578,747	$88.70	1.1704	0.8036	$129.19
Surgical/Medical	$948,214	$145.32	1.0550	0.8036	$190.78
Pharmacy	$376,115	$57.64	1.1432	0.8052	$81.84
Total					**$519.84**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Basic Rate (Pool I) HealthMate for HSA 5000 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 6,525 Basic Rate (Pool I) HealthMate for HSA 5000 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool I.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 35

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 500

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$1,792,451	$72.12	1.1389	1.0298	$79.76
Outpatient	$2,486,538	$100.05	1.1704	1.0298	$113.71
Surgical/Medical	$4,311,336	$173.47	1.1141	1.0298	$187.67
Pharmacy	$1,756,611	$70.68	1.1928	1.0319	$81.70
Total					**$462.84**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Preferred Rate (Pool II) HealthMate Direct 500 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 24,853 Preferred Rate (Pool II) HealthMate Direct 500 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool II.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 36

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 1000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims	**Incurred Allowed Claims PCPM**	**Projection Factor**	**Utilization Adjustment**	**Adjusted Projected Allowed Claims PCPM**
	(A)	(B)	(C)	(D)	(E)
Inpatient	$100,347	$32.81	1.1389	1.0057	$37.16
Outpatient	$284,997	$93.20	1.1704	1.0057	$108.46
Surgical/Medical	$516,953	$169.05	1.1141	1.0057	$187.27
Pharmacy	$197,309	$64.52	1.1928	1.0077	$76.37
Total					**$409.26**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Preferred Rate (Pool II) HealthMate Direct 1000 for Jun-2010 to May-2011 estimated to 100% complete.
(B) Column 1 divided by 3,058 Preferred Rate (Pool II) HealthMate Direct 1000 contract months for Jun-2010 to May-2011.
(C) Per Schedule 53, Column 4, for Pool II.
(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.
(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 37

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate Direct 2000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims	**Incurred Allowed Claims PCPM**	**Projection Factor**	**Utilization Adjustment**	**Adjusted Projected Allowed Claims PCPM**
	(A)	(B)	(C)	(D)	(E)
Inpatient	$780,147	$45.91	1.1389	0.9686	$53.98
Outpatient	$1,101,187	$64.80	1.1704	0.9686	$78.30
Surgical/Medical	$2,056,260	$121.00	1.1141	0.9686	$139.18
Pharmacy	$718,414	$42.27	1.1928	0.9705	$51.95
Total					**$323.41**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Preferred Rate (Pool II) HealthMate Direct 2000 for Jun-2010 to May-2011 estimated to 100% complete.
(B) Column 1 divided by 16,994 Preferred Rate (Pool II) HealthMate Direct 2000 contract months for Jun-2010 to May-2011.
(C) Per Schedule 53, Column 4, for Pool II.
(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.
(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 38

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate for HSA 3000

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$596,094	$65.90	1.1389	0.8751	$85.77
Outpatient	$601,417	$66.48	1.1704	0.8751	$88.91
Surgical/Medical	$971,972	$107.45	1.1141	0.8751	$136.80
Pharmacy	$360,021	$39.80	1.1928	0.8769	$54.14
Total					**$365.62**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Preferred Rate (Pool II) HealthMate for HSA 3000 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 9,046 Preferred Rate (Pool II) HealthMate for HSA 3000 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool II.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 39

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for HealthMate for HSA 5000

for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)
	Incurred Allowed Claims (A)	**Incurred Allowed Claims PCPM** (B)	**Projection Factor** (C)	**Utilization Adjustment** (D)	**Adjusted Projected Allowed Claims PCPM** (E)
Inpatient	$774,059	$82.08	1.1389	0.8036	$116.33
Outpatient	$477,727	$50.66	1.1704	0.8036	$73.78
Surgical/Medical	$780,153	$82.73	1.1141	0.8036	$114.70
Pharmacy	$144,566	$15.33	1.1928	0.8052	$22.71
Total					**$327.52**

(A) Incurred allowed claims (prior to subscriber cost sharing) for Preferred Rate (Pool II) HealthMate for HSA 5000 for Jun-2010 to May-2011 estimated to 100% complete.

(B) Column 1 divided by 9,430 Preferred Rate (Pool II) HealthMate for HSA 5000 contract months for Jun-2010 to May-2011.

(C) Per Schedule 53, Column 4, for Pool II.

(D) Factor to adjust claims to VantageBlue Direct 1000 utilization level.

(E) Column 2, multiplied by column 3, divided by column 4.

Schedule 40

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Calculation of Adjusted Projected Allowed Claims Expense Per Contract Month for the Currently Uninsured Population

for April 1, 2012 Billing Cycle

1)	Pool 2 HealthMate for HSA Adjusted Projected Allowed Claims (A)	$6,395,912
2)	Pool 2 HealthMate for HSA Contract Months (B)	18,476
3)	Allowed PCPM (C)	$346.17
4)	Pool 2 HealthMate for HSA Age/Gender Factor (D)	1.1152
5)	Target Population Age/Gender factor (E)	0.7489
6)	**Adjusted Projected Allowed PCPM (F)**	**$232.47**

(A) Per Schedule 38 column 5 total multiplied by 9,046 (base period contracts for Pool 2 HealthMate for HSA 3000 plan), plus Schedule 39 column 5 total multiplied by 9,430 (base period contracts for Pool 2 HealthMate for HSA 5000 plan).
(B) Contract months in base period (6/10-5/11) for Pool 2 HealthMate for HSA 3000 and Pool 2 HealthMate for HSA 5000 plans.
(C) Line 1 divided by line 2.
(D) The average Age/Gender factor at June 2011 for Pool 2 HealthMate for HSA 3000 and Pool 2 HealthMate for HSA 5000 plans.
(E) The average Age/Gender factor based on our target population, which is equally split between age groups 18-24, 25-29, and 30-34.
(F) Line 3 divided by line 4, multiplied by line 5.

Schedule 41

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Fitness and Dental Benefits for BlueValue Direct 2500 Per Contract Month
for April 1, 2012 Billing Cycle

	Fitness Benefit	
1)	Annual Reimbursement (A)	$100
2)	Projected Utilization per Contract (B)	25%
3)	Monthly Benefit Amount (C)	**$2.08**
	Dental Benefit	
4)	Gross Cost (Adult Cleaning and Bitewing Series) (D)	$104
5)	Utilization per Contract (E)	84%
6)	Monthly Benefit Amount (F)	**$7.28**
7)	**Fitness and Dental Benefits Total (G)**	**$9.36**

(A) Fitness benefit amount.
(B) Expected proportion of subscribers using the fitness benefit.
(C) Line 1, multiplied by line 2, divided by 12 months.
(D) Dental benefit amount.
(E) Utilization estimate based on the utilization of cleanings for commercial group.
(F) Line 4, multiplied by line 5, divided by 12 months.
(G) Sum of lines 3 and 6.

Section VI:

Net-to-Allowed Factors

Schedule 43

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Net to Allowed Factors
for April 1, 2012 Billing Cycle

		(1)	(2)	(3)	(4)	(5)	(6)
		VantageBlue/HealthMate			Blue Solutions for HSA		BlueValue
		1000	1500	2500	3000	5000	2500
1.	**Allowed Dollar Weights (A)**						
	Deductible Portion	55.6%	55.0%	53.7%	91.1%	90.6%	61.6%
	Non-Deductible Portion	44.4%	45.0%	46.3%	8.9%	9.4%	38.4%
2.	**Original Net-to-Allowed, Total (B)**	**0.7855**	**0.7584**	**0.7165**	**0.6486**	**0.6088**	**0.6261**
3.	**CY 2012 Contract Months (C)**	**124,745**	**124,745**	**124,745**	**124,745**	**124,745**	**124,745**
	Second Year Net-to-Allowed						
	Deductible Portion (D)	0.7927	0.7454	0.6779	0.6268	0.5891	0.6051
	Non-Deductible Portion (E)	0.7813	0.7806	0.7702	0.9420	0.9408	0.6662
4.	**Total (F)**	**0.7876**	**0.7612**	**0.7206**	**0.6549**	**0.6222**	**0.6286**
5.	**CY 2013 Contract Months (G)**	**138,527**	**138,527**	**138,527**	**138,527**	**138,527**	**138,527**
6.	**Rate Period Net-to-Allowed, Total (H)**	**0.7866**	**0.7599**	**0.7187**	**0.6519**	**0.6159**	**0.6274**

(A) The proportion of Allowed Claims which apply to the deductible versus the non-deductible portion.
(B) The Net to Allowed factor, prior to the deductible credit program, for 4/12-9/13.
(C) Per Schedule 51, column 3 for CY 2012.
(D) Per Schedules 44-49, column 9 totals.
(E) The Net to Allowed factor applicable to the claims which do not apply towards the deductible for 4/12-9/13.
(F) Weighted by the allowed dollar weights shown in line 1.
(G) Per Schedule 51, column 3 for CY 2013.
(H) The overall Net to Allowed factors used in the rate period. This is the composite of lines 2 and 4, weighted by the CY 2012 and CY 2013 Contract months in lines 3 and 5.

Schedule 44

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for VantageBlue Direct 1000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	Unique Members	Allowed PMPY	Persistency Rate	Morbidity Factor	Deductible	Unique Members		Allowed PMPY	Total Allowed Dollars	Deductible Portion NTA
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	14,021	-	77%	0.56	800	10,796	(F)	$1,389	$14,990,678	0.8015
Hit Deductible	4,039	-	77%	2.53	1000	3,110	(F)	$6,267	$19,489,806	0.7889
New Members	0	-	N/A	1.00	1000	6,149	(G)	$2,480	$15,246,691	0.7889
Total	18,060	$2,480	77%	1.00		20,055	(H)	$2,480	$49,727,175	0.7927

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Schedule 45

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for VantageBlue Direct 1500
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	**Unique Members**	**Allowed PMPY**	**Persistency Rate**	**Morbidity Factor**	**Deductible**	**Unique Members**		**Allowed PMPY**	**Total Allowed Dollars**	**Deductible Portion NTA**
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	14,795	-	77%	0.59	1200	11,392	(F)	$1,463	$16,665,699	0.7556
Hit Deductible	3,265	-	77%	2.86	1500	2,514	(F)	$7,086	$17,814,785	0.7403
New Members	0	-	N/A	1.00	1500	6,149	(G)	$2,480	$15,246,691	0.7403
Total	18,060	$2,480	77%	1.00		20,055	(H)	$2,480	$49,727,175	0.7454

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Schedule 46

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for HealthMate Direct 2500
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	Unique Members	Allowed PMPY	Persistency Rate	Morbidity Factor	Deductible	Unique Members		Allowed PMPY	Total Allowed Dollars	Deductible Portion NTA
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	15,690	-	77%	0.65	2000	12,081	(F)	$1,612	$19,470,948	0.6898
Hit Deductible	2,370	-	77%	3.32	2500	1,825	(F)	$8,224	$15,009,536	0.6703
New Members	0	-	N/A	1.00	2500	6,149	(G)	$2,480	$15,246,691	0.6703
Total	18,060	$2,480	77%	1.00		20,055	(H)	$2,480	$49,727,175	0.6779

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Schedule 47

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for BlueSolutions for HSA Direct 3000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	Unique Members	Allowed PMPY	Persistency Rate	Morbidity Factor	Deductible	Unique Members		Allowed PMPY	Total Allowed Dollars	Deductible Portion NTA
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	13,760	-	77%	0.53	2400	10,595	(F)	$2,177	$23,066,586	0.6443
Hit Deductible	4,300	-	77%	2.50	3000	3,311	(F)	$10,286	$34,056,202	0.6200
New Members	0	-	N/A	1.00	3000	6,149	(G)	$4,108	$25,258,739	0.6200
Total	18,060	$4,108	77%	1.00		20,055	(H)	$4,108	$82,381,528	0.6268

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Schedule 48

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for BlueSolutions for HSA Direct 5000
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	Unique Members	Allowed PMPY	Persistency Rate	Morbidity Factor	Deductible	Unique Members		Allowed PMPY	Total Allowed Dollars	Deductible Portion NTA
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	15,292	-	77%	0.61	4000	11,775	(F)	$2,506	$29,505,206	0.6155
Hit Deductible	2,768	-	77%	3.15	5000	2,131	(F)	$12,960	$27,617,583	0.5744
New Members	0	-	N/A	1.00	5000	6,149	(G)	$4,108	$25,258,739	0.5744
Total	18,060	$4,108	77%	1.00		20,055	(H)	$4,108	$82,381,528	0.5891

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Schedule 49

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Second Year Deductible Portion Net-to-Allowed Calculation for BlueValue Direct 2500
for April 1, 2012 Billing Cycle

	(1)	(2)	(3)	(4)	(5)	(6)		(7)	(8)	(9)
	First Year				Second Year					
Members	Unique Members	Allowed PMPY	Persistency Rate	Morbidity Factor	Deductible	Unique Members		Allowed PMPY	Total Allowed Dollars	Deductible Portion NTA
	(A)	(B)	(C)	(D)	(E)			(I)	(J)	(K)
Credit Eligible	15,406	-	77%	0.64	2000	11,863	(F)	$1,725	$20,466,878	0.6117
Hit Deductible	2,654	-	77%	3.09	2500	2,044	(F)	$8,328	$17,022,639	0.6010
New Members	0	-	N/A	1.00	2500	6,148	(G)	$2,696	$16,573,348	0.6010
Total	18,060	$2,696	77%	1.00		20,055	(H)	$2,696	$54,062,865	0.6051

(A) Total members for 6/10-5/11, split out by whether or not they met their deductible.
(B) Average annual cost for all members.
(C) Average proportion of members still enrolled after one year.
(D) Factor to account for expected cost differences between members who hit their deductible in the first year and members who did not.
(E) Deductible is 20% less for members who did not reach their deductible in the first year.
(F) Column 1, multiplied by column 3.
(G) Total of column 6, minus remaining rows in column 6.
(H) Column 1 total, multiplied by expected enrollment growth from CY 2012 to CY 2013 (138,527/124,745), per schedule 51, column 3.
(I) Column 4, multiplied by total of column 2.
(J) Column 6, multiplied by column 7.
(K) Deductible portion Net-to-Allowed Factors for corresponding deductible in column 5. Total is weighted by allowed dollars in column 8.

Section VII:

Administrative Expenses

Schedule 51

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Calculation of Administrative Expense Per Contract Month
for April 1, 2012 Billing Cycle

	(1) Number of Months in Rate Period	(2) Calendar Year Administrative Expense Budget	(3) Calendar Year Projected Contract Months	(4) Administrative Expense Budget PCPM (F)
1. CY 2012	9	$7,282,034 (A)	124,745 (D)	$58.38
2. CY 2013	9	$7,745,390 (B)	138,527 (E)	$55.91
3. Total	18	$15,027,424 (C)	263,272 (C)	$57.08

(A) Derived from the 2012 budget for Direct Pay. Includes fees paid to vendors.
(B) Derived from the 2013 budget for Direct Pay. Includes fees paid to vendors.
(C) Line 1 plus line 2.
(D) CY 2012 Projected Contract Months.
(E) CY 2013 Projected Contract Months.
(F) Column 2 divided by Column 3.
The rate period (4/1/2012 - 9/30/2013) has the same midpoint as the above calculation (1/1/2012 - 12/31/2013).

Section VIII:

Trends and Projection Factors

Schedule 53

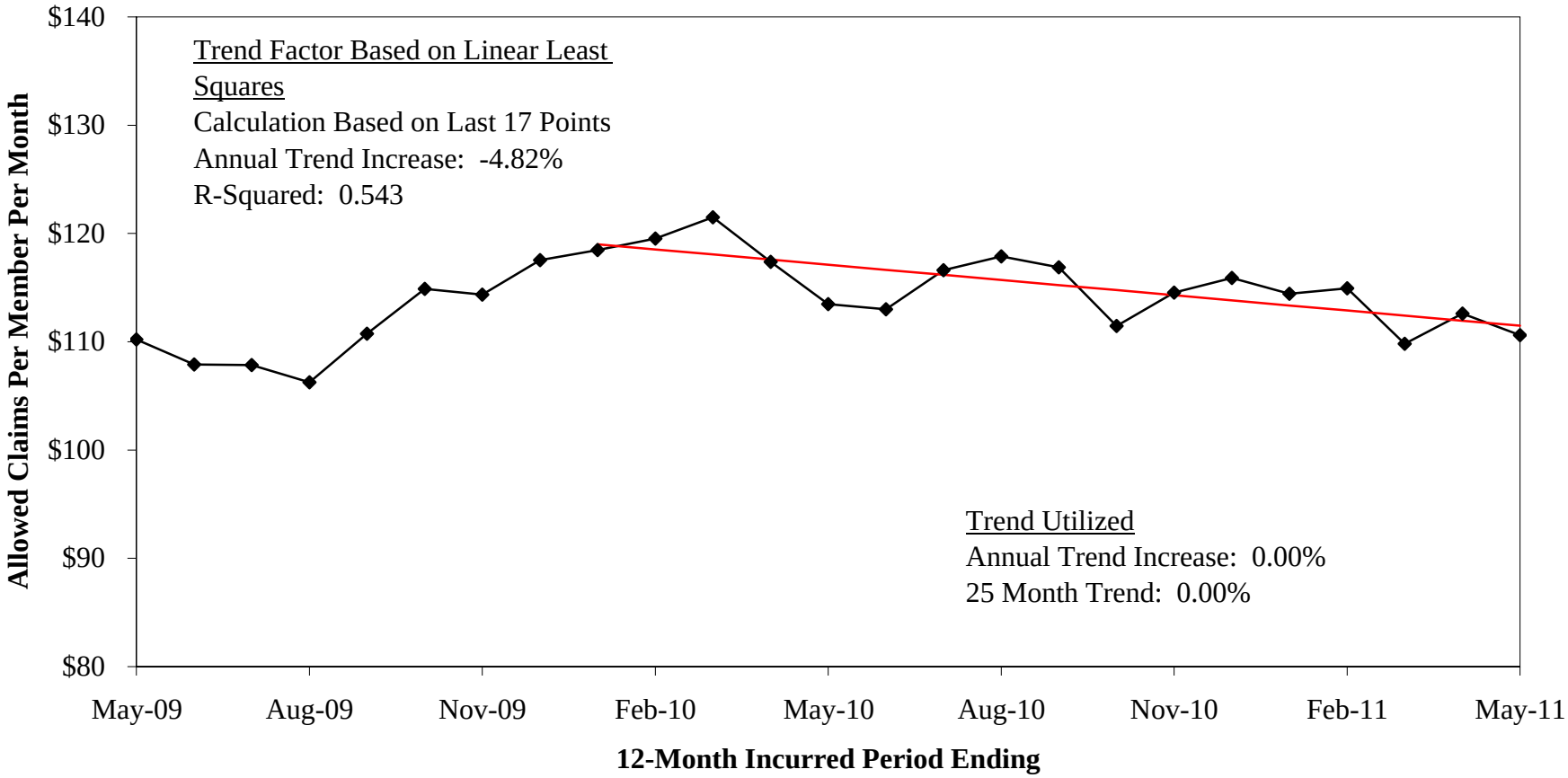
Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I) and Preferred Rate (Pool II)
Projection Factors for Allowed Claims
for April 1, 2012 Billing Cycle

	(1) Price Trend Factor (A)	(2) Utilization/Mix Trend Factor (B)	(3) Claim Adjustment Factor (D)	(4) 25 Month Projection Factor (E)
Pool I				
Hospital Inpatient	1.1389	1.0000	1.0000	1.1389
Hospital Outpatient	1.1279	1.0400	0.9978	1.1704
Surgical/Medical	1.0407	1.0169	0.9969	1.0550
Pharmacy		1.2845 (C)	0.8900	1.1432
Pool II				
Hospital Inpatient	1.1389	1.0000	1.0000	1.1389
Hospital Outpatient	1.1279	1.0400	0.9978	1.1704
Surgical/Medical	1.0407	1.0739	0.9969	1.1141
Pharmacy		1.3402 (C)	0.8900	1.1928
Composite				
Hospital Inpatient				1.1389 (F)
Hospital Outpatient				1.1704 (F)
Surgical/Medical				1.0764 (F)
Pharmacy				1.1533 (F)

(A) Obtained from Blue Cross' Contracting Administration Division for the 25-month projection period.
(B) Based on annual trend assumption, compounded over the 25-month projection period. See graphs in Schedules 54-61.
(C) This factor includes price.
(D) Factor 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.
(E) Product of columns 1-3 for non-pharmacy. Product of columns 2 and 3 for pharmacy.
(F) Pool 1 and Pool 2 projection factors weighted by claims from Schedules 30-39 (column 1).

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

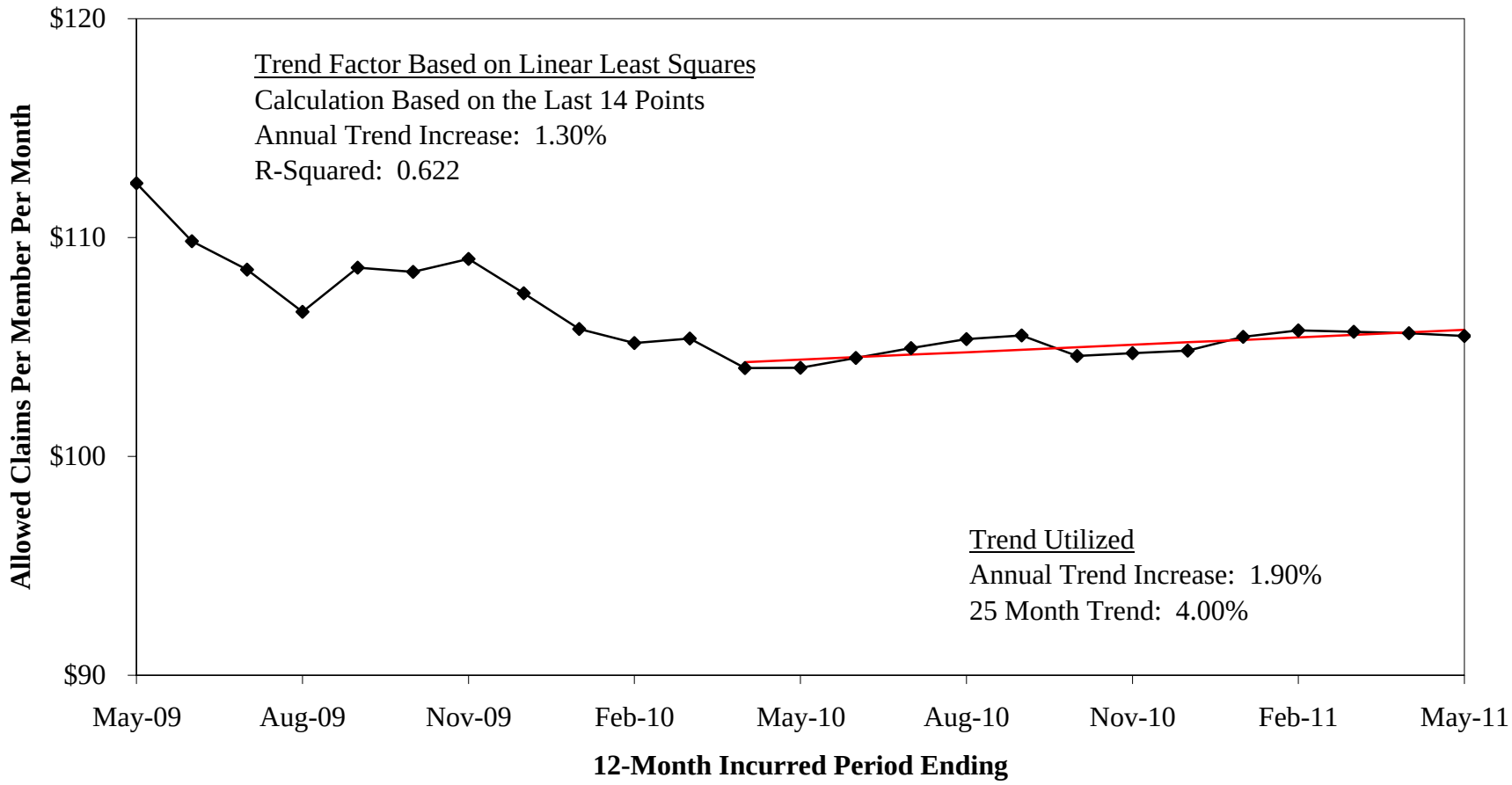
Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends



Schedule 55

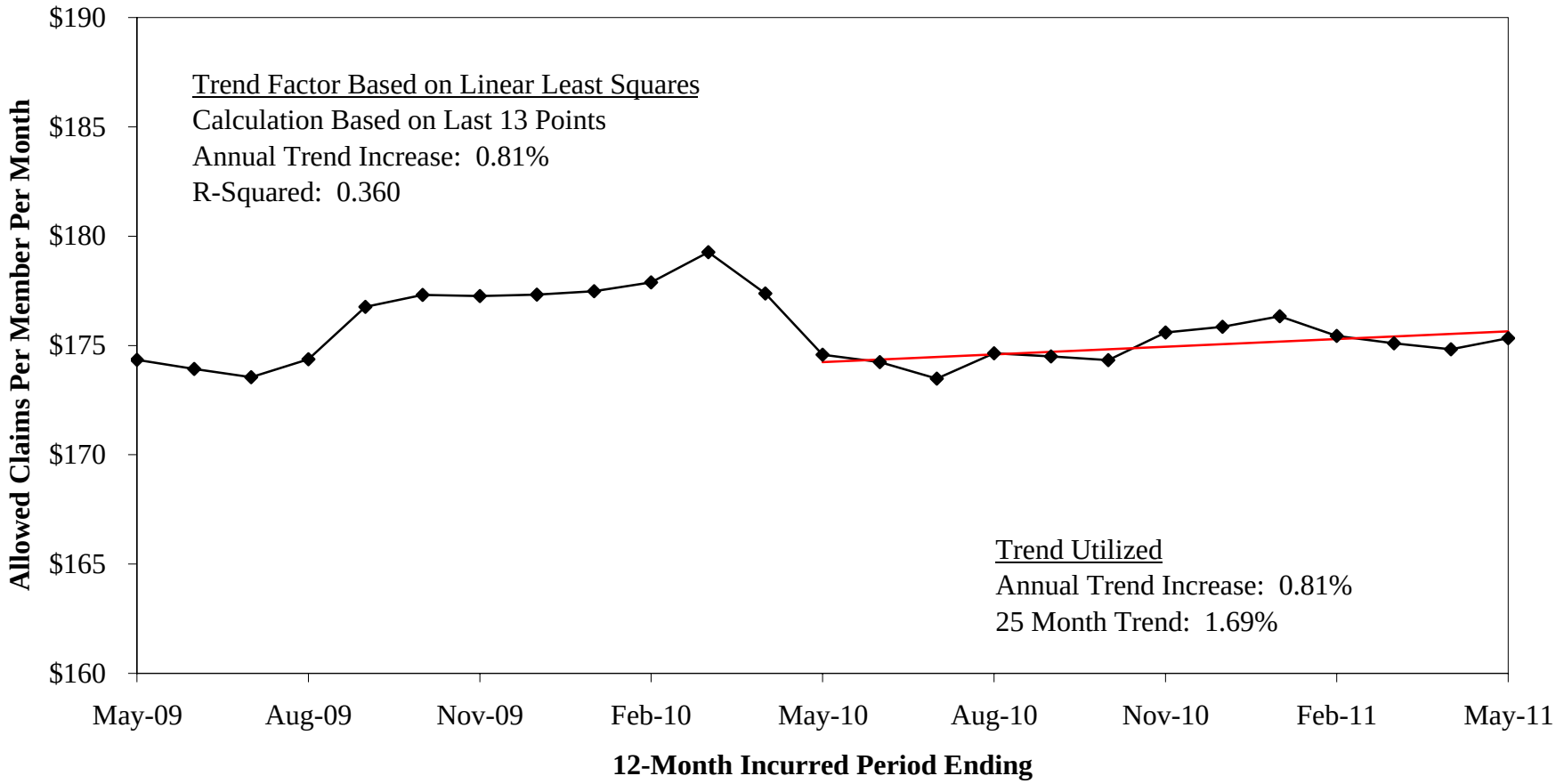
Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Hospital Outpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends



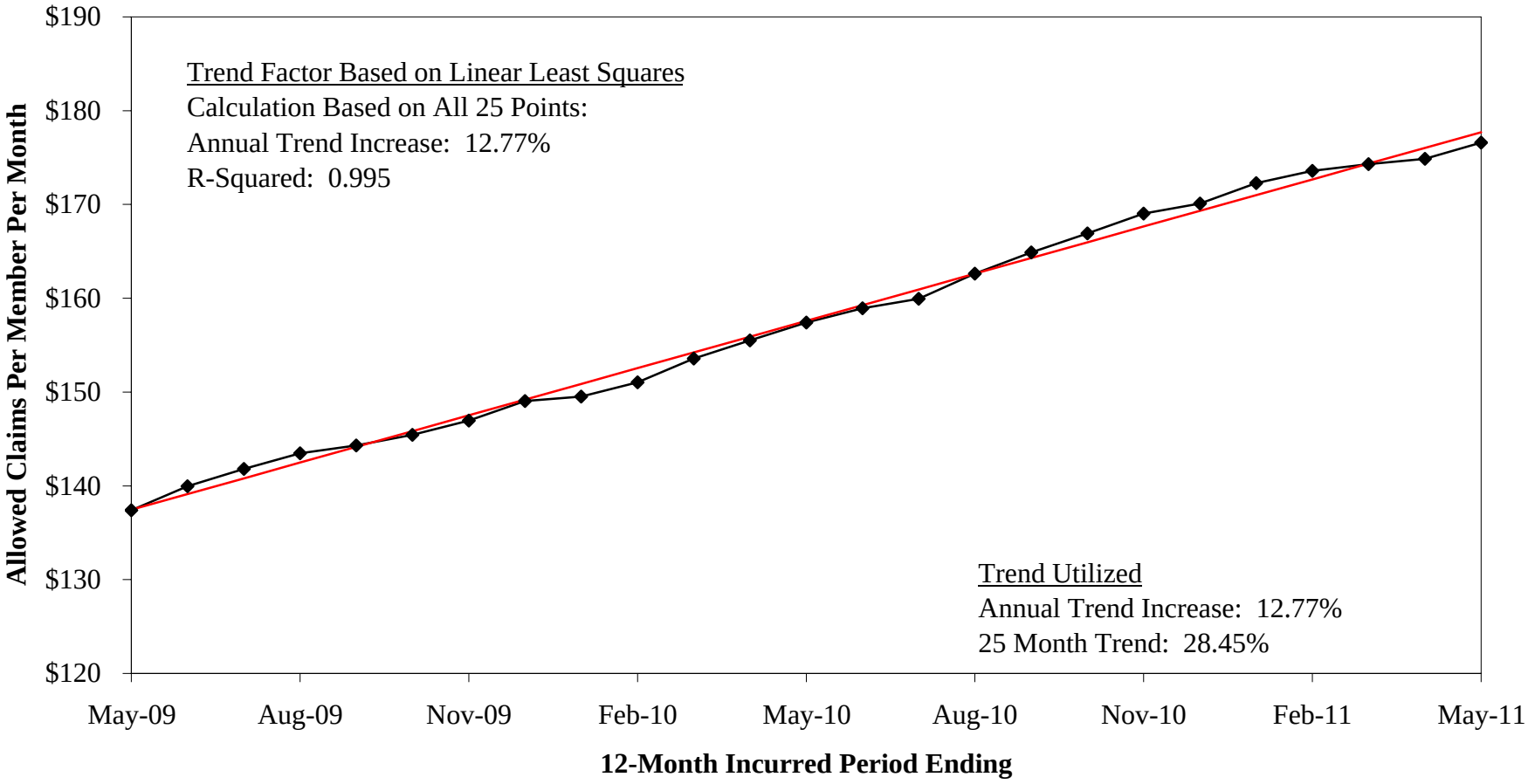
Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Surgical/Medical: Historical Allowed Claims PMPM and Utilization/Mix Trends



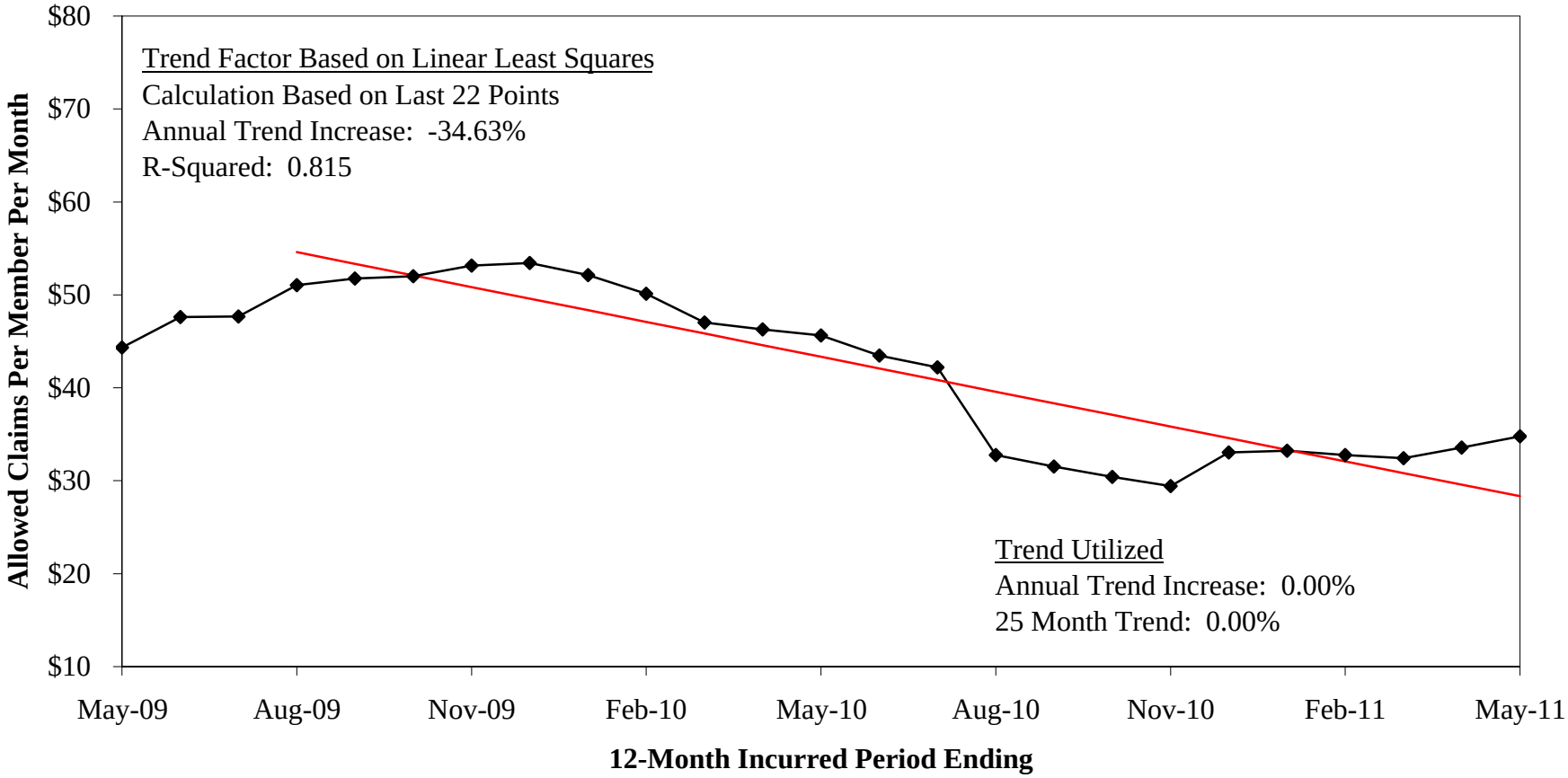
Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)

Pharmacy: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends



Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

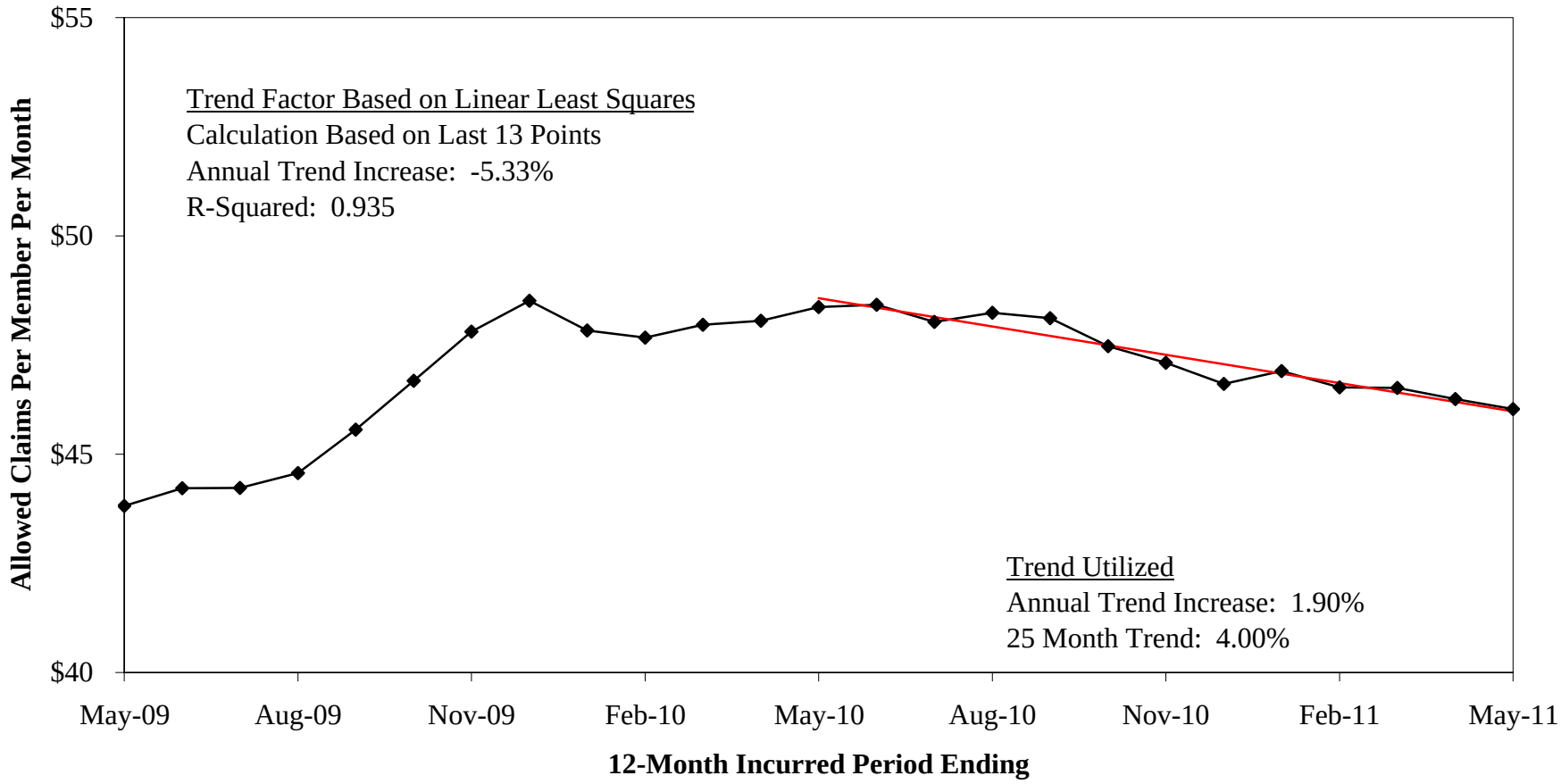
Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends



Schedule 59

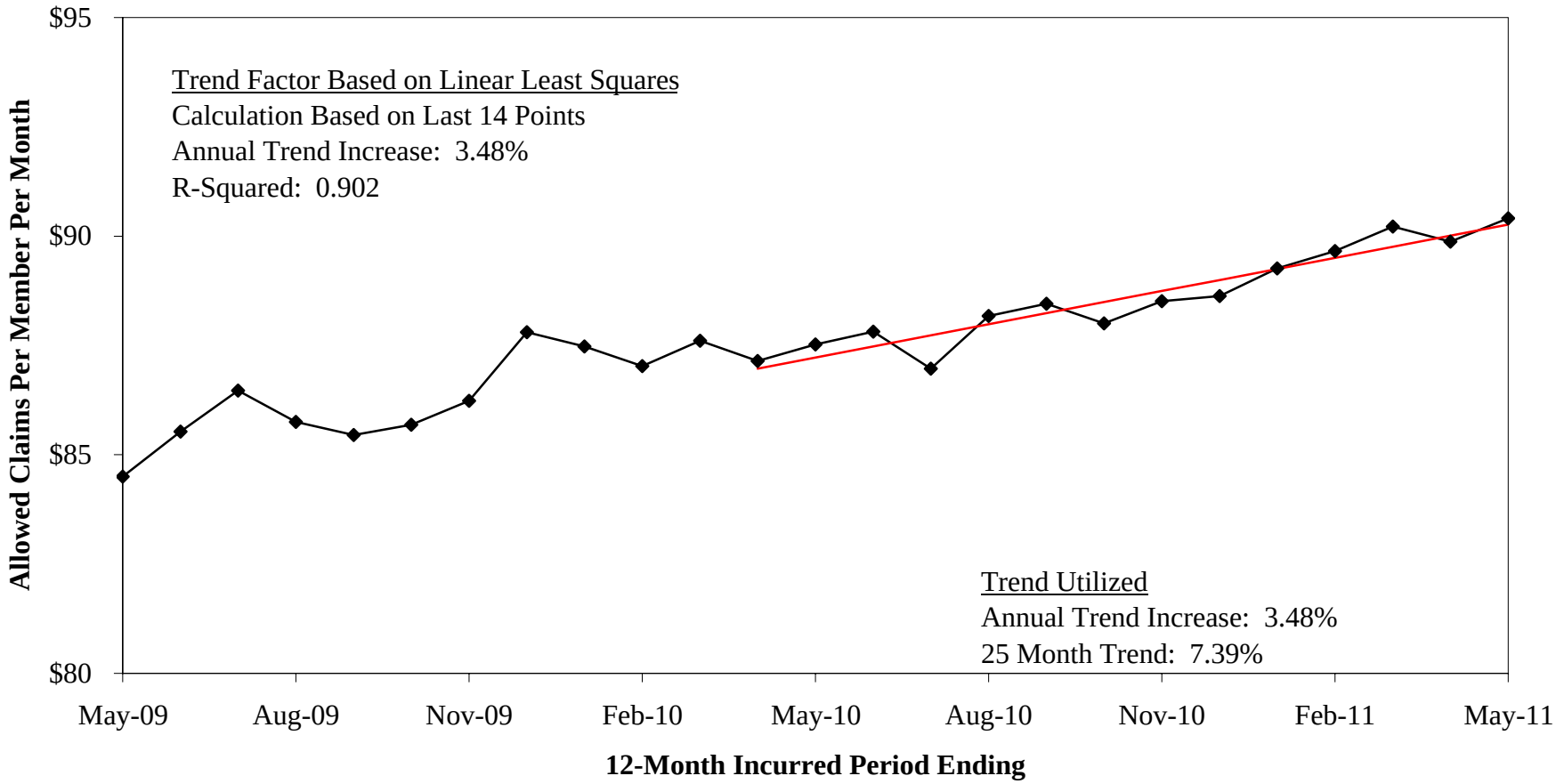
Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Hospital Outpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends



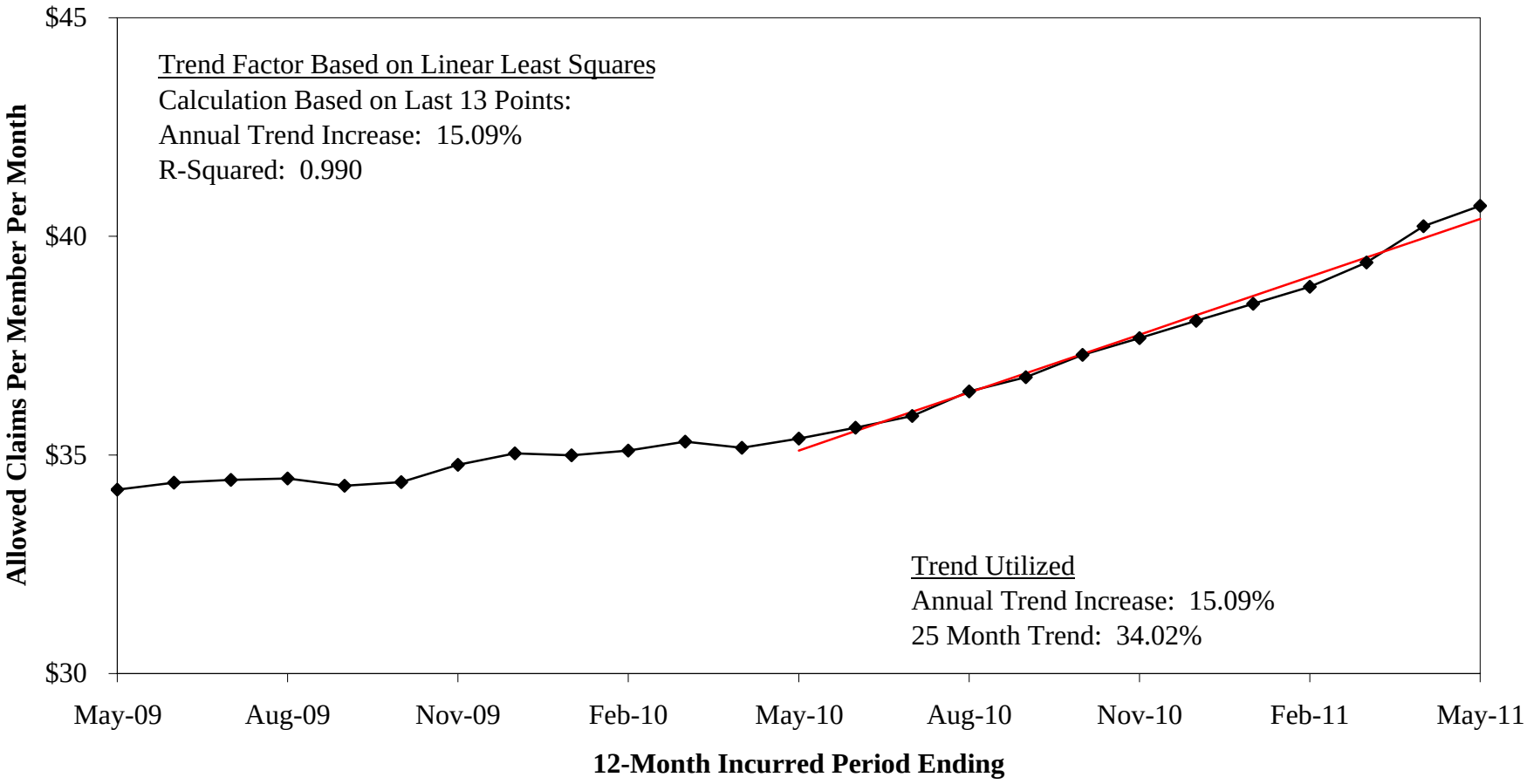
Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Surgical/Medical: Historical Allowed Claims PMPM and Utilization/Mix Trends



Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)

Pharmacy: Historical Allowed Claims
PMPM and Allowed Claims PMPM Trends



Schedule 62

Blue Cross and Blue Shield of Rhode Island
Class DIR Basic Rate (Pool I)
Point Values Utilized in Development of Trends

12-Month Incurred Period Ending	Hospital Inpatient Allowed Claims PMPM (A)	Hospital Outpatient Allowed Claims PMPM (A)	Surgical/ Medical Allowed Claims PMPM (A)	Pharmacy Allowed Claims PMPM
May-09	$110.22	$112.48	$174.34	$137.39
Jun-09	$107.89	$109.83	$173.92	$139.96
Jul-09	$107.85	$108.54	$173.55	$141.81
Aug-09	$106.26	$106.61	$174.37	$143.48
Sep-09	$110.74	$108.62	$176.76	$144.31
Oct-09	$114.87	$108.44	$177.31	$145.44
Nov-09	$114.36	$109.03	$177.26	$146.97
Dec-09	$117.53	$107.45	$177.33	$149.05
Jan-10	$118.47	$105.82	$177.48	$149.51
Feb-10	$119.53	$105.19	$177.89	$151.03
Mar-10	$121.51	$105.39	$179.27	$153.58
Apr-10	$117.39	$104.03	$177.38	$155.51
May-10	$113.48	$104.05	$174.58	$157.41
Jun-10	$113.01	$104.50	$174.24	$158.94
Jul-10	$116.61	$104.95	$173.48	$159.95
Aug-10	$117.88	$105.36	$174.65	$162.62
Sep-10	$116.89	$105.53	$174.49	$164.89
Oct-10	$111.45	$104.59	$174.33	$166.90
Nov-10	$114.54	$104.71	$175.59	$169.02
Dec-10	$115.90	$104.83	$175.85	$170.10
Jan-11	$114.43	$105.46	$176.33	$172.27
Feb-11	$114.93	$105.76	$175.44	$173.59
Mar-11	$109.82	$105.69	$175.09	$174.30
Apr-11	$112.60	$105.63	$174.83	$174.88
May-11	$110.61	$105.50	$175.33	$176.59

(A) All periods adjusted to the June 2008 provider fee level.

Schedule 63

Blue Cross and Blue Shield of Rhode Island
Class DIR Preferred Rate (Pool II)
Point Values Utilized in Development of Trends

12-Month Incurred Period Ending	Hospital Inpatient Allowed Claims PMPM (A)	Hospital Outpatient Allowed Claims PMPM (A)	Surgical/ Medical Allowed Claims PMPM (A)	Pharmacy Allowed Claims PMPM
May-09	$44.32	$43.82	$84.50	$34.21
Jun-09	$47.62	$44.22	$85.53	$34.36
Jul-09	$47.67	$44.23	$86.47	$34.43
Aug-09	$51.04	$44.57	$85.75	$34.46
Sep-09	$51.77	$45.56	$85.45	$34.30
Oct-09	$52.00	$46.68	$85.68	$34.38
Nov-09	$53.14	$47.81	$86.23	$34.77
Dec-09	$53.44	$48.52	$87.81	$35.04
Jan-10	$52.14	$47.84	$87.48	$34.99
Feb-10	$50.13	$47.67	$87.03	$35.10
Mar-10	$47.02	$47.97	$87.61	$35.30
Apr-10	$46.28	$48.06	$87.14	$35.16
May-10	$45.64	$48.37	$87.52	$35.37
Jun-10	$43.46	$48.42	$87.82	$35.62
Jul-10	$42.20	$48.03	$86.97	$35.89
Aug-10	$32.77	$48.24	$88.17	$36.45
Sep-10	$31.52	$48.11	$88.45	$36.78
Oct-10	$30.41	$47.47	$88.01	$37.29
Nov-10	$29.41	$47.09	$88.51	$37.68
Dec-10	$33.05	$46.61	$88.63	$38.07
Jan-11	$33.22	$46.90	$89.26	$38.46
Feb-11	$32.76	$46.53	$89.66	$38.85
Mar-11	$32.43	$46.52	$90.22	$39.40
Apr-11	$33.57	$46.26	$89.87	$40.23
May-11	$34.79	$46.03	$90.41	$40.70

(A) All periods adjusted to the June 2008 provider fee level.

Resources for Health System Improvements - Survey

In April 2011, the Office of Health Insurance Commissioner requested an itemized listing of contributions toward system-wide improvements in the State's healthcare system relating to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote these goals. The OHIC also requested an itemization of activities relating to participation in the development and implementation of public policy issues related to health.

The information included below reflects Blue Cross & Blue Shield of Rhode Island's efforts in these areas through October 31, 2011.

System-wide improvement activity	**Brief description of activity**	**Value of 2011 Plan contributions**
Primary Care Infrastructure Support	BCBSRI provides: • Financial and in-kind support for primary care practices to transform into Patient Centered Medical Homes (PCMH). Support is inclusive of: o Infrastructure support (e.g., Nurse Care Manager (NCM), Physician Champion, Project Management, training, Behavioral health co-location, etc.) o Care management payment – payment for the added time required to appropriately manage the needs of the 'complex' members within the practice o Pay for Performance – Retrospective payment for all BCBSRI patients based on the achievement of nationally recognized clinical process and outcome measures o In kind practice transformation and redesign assistance – PCMH practices are offered added support services through BCBSRI and/or TransforMED (through a contract with BCBSRI) to facilitate practice redesign, leading to more efficient PCMH practices grounded in the principles of PCMH including team based care and pre-visit planning. Assistance is also provided in the proper and consistent use of EHR systems to complement this effort.	~$11M

System-wide improvement activity	Brief description of activity	Value of 2011 Plan contributions
CSI-RI	BCBSRI provides: • Financial support for nurse care manager, project management, and care management PMPM • In-kind support through participation in CSI Steering committee and Co-chair of Training and Support committee	~$1.2M
EHR Grant Program	BCBSRI provides: • Financial support for both new and existing users of EHR technology. • $2,500 per practice funding for an EHR pre-implementation readiness assessment to prepare for successful implementation. • $5,000 per physician support to pay for the purchase of a certified EHR. • Additional specific program created for Community Health Centers adopting EHRs	$231,323
Quality Counts program	BCBSRI provides: • Financial support for EHR adoption and quality metric reporting and results	$129,450
Blue Cross Community Flu Initiative	BCBSRI provides: • A program designed to vaccinate the uninsured in Rhode Island against Influenza • Runs September - November 2011 • Results (through November 18, 2011): □ 864 total vaccines administered □ 614 out of 864 (71.06%) were uninsured Rhode Islanders	$13,000
BCBSRI Wellness Van	BCBSRI provides: • Greater healthcare accessibility to all Rhode Islanders—at no cost for visitors. • Offers health screenings, on-site health and wellness services, health education, and information regarding insurance options. • Staffed by a qualified community health educator. • Year Round programming • Results (to date - programming through year end): □ 84 programs held at local nonprofit organizations □ 1567 people screened and/or educated □ 771 of those were uninsured	In Kind

System-wide improvement activity	Brief description of activity	Value of 2011 Plan contributions
Rhode Island Regional Extension Center (R REC) / currentcare Health Information Exchange	BCBSRI provides: • Financial support • Subject matter expertise on a variety of steering committees. • Provider Relations staff promote RI REC provider enrollment and assist in event planning/promotion. • Jim Purcell, former President & CEO of BCBSRI is the Chair of the Board of Directors and serves on several committees including the RIQI Operations Committee. • Peter Andruszkiewicz, President & CEO of BCBSRI, is a member of the Board of Directors.	$310,000 In Kind In Kind
ICU Collaborative	BCBSRI provides: • Financial and professional support	$242,758
Rhode Island Free Clinic	BCBSRI provides: • Volunteer Support—Dr. Gus Manocchia, BCBSRI's Chief Medical Officer • Board of Directors – Mark Waggoner, VP of Contracting • Financial support for operations • Financial incentives to recruit new volunteers and expand physician volunteer network • BCBSRI Community Wellness Van offers free screenings every monthly "Lottery" night.	$50,000 In Kind
Clinica Esperanza / Hope Clinic	BCBSRI provides: • Financial support for operations • Hosted grand opening celebration in and coordinated media attention for new free clinic • BCBSRI Community Wellness Van offers free screenings at every event	$20,000
WellOne (formerly Northwest Community Health Center)	BCBSRI provides: • Financial support of program to provide co-located behavioral health services in PCP setting	$25,000

System-wide improvement activity	Brief description of activity	Value of 2011 Plan contributions
Rhode Island Kids Count – Covering Kids RI	BCBSRI provides: • BCBSRI is Coalition Member • Participated in the Leadership Roundtables for Children with Special Health Care Needs and the DHS RIte Care Consumer Advisory Committee • Development of an Issue Brief on Preterm Births • Work to close racial and ethnic gaps in health outcomes for children and youth; will issue brief in 2011 • Ongoing support of fundraising events	$22,500, plus In Kind support
RIMS Physician Health Program	BCBSRI provides: • Financial support	$10,000
Beacon Community Project	BCBSRI provides: • Subject Matter expertise at a number of committee meetings aimed at aligning our PCMH program with the Beacon Community. Support is provided by Provider Relations, Medical Director, and Health Analytics staff.	In Kind
Rhode Island Health Literacy Project	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
Healthy RI: National Health Reform Implementation Task Force	BCBSRI provides: ▪ Staff support at 1 meeting per month.	In Kind
DOH Minority Health Advisory Committee	BCBSRI provides: ▪ Staff support at 1 meeting per month. ▪ BCBSRI staff on Advisory Committee. ▪ BCBSRI staff on Data Subcommittee	In Kind
Rhode Island Primary Care Educational Loan Repayment Program	BCBSRI provides: • Participation in development of selection criteria and selection of applicants	In Kind
RI Breastfeeding Coalition	BCBSRI provides: • Staff support at 12 meetings per year. • Sr. level manager on board of directors. • BCBSRI is a breastfeeding friendly workplace. Acknowledged by RIBC as a Silver level employer.	In Kind
Participation on Boards of various non-profit organizations	Executive leaders serve on a number of non-profit boards of organizations aimed at improving the health of Rhode Islanders, such as: the Rhode Island Community Food Bank, Amos House, Family Service Rhode Island, Greater Providence of YMCA, Crossroads RI, Rhode Island Free Clinic, American Red Cross, and Gateway Healthcare.	In Kind

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 18, 2011

PRE-FILED DIRECT TESTIMONY OF
JEFFREY MCLANE

I. INTRODUCTION

Q. Please state your name and professional qualifications.

A. My name is Jeffrey McLane. 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 Associate Actuary and I oversee the rating function within the actuarial department for Blue Cross' individual, Medicare, Medicare supplement, and small group lines of business. A key responsibility of this area 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 for the Company.

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 9, 2007.

Q. Please describe your responsibilities and your experience with respect to actuarial matters.

A. I have been practicing in the actuarial field for the past 17 years during which time I have held various positions of increasing responsibility. I was hired in to the actuarial student program at Sun Life of Canada in 1994, and during my time there had various responsibilities in finance and pricing of life insurance products. I attained my ASA (Associate, Society of Actuaries) in 1998 and became a member of the American Academy of Actuaries in 1999. From 1999 to 2007, I was employed by Phoenix Life Insurance and attained my FSA (Fellowship, Society of Actuaries) in 2003. During this time I had increasing responsibilities including setting policy reserves, calculation of deferred acquisition cost (DAC) assets, cash flow testing, financial forecasting and regulatory compliance. At the time I left Phoenix Life, my title was AVP & Associate Actuary.

I have had primary oversight over the pricing function for Direct Pay products for the last three years and have been involved in the hearing process in various capacities. In addition, I have provided actuarial attestations for Medicare Advantage bids submitted to the Centers for Medicare and Medicaid Services and actuarial equivalency tests pertaining to accounts applying for subsidies under the Federal Retiree Drug Subsidy Program. Furthermore, numerous rate filings have been submitted to, and accepted by, the Office of Health Insurance Commissioner (OHIC) under my signature during the last three 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 18, 2011, 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 guaranteed issue Blue Cross DIR program and has age rating.
- **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. Note that this rating structure will require modifications in order to comply with HealthCare Reform requirements effective January 1, 2014. Our strategy regarding implementing these modifications is discussed later in my testimony.

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 and addresses problems associated with the health characteristics, age, and relatively high claims expenditures for Class DIR. 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 recent enrollment changes in Class DIR?

A. Yes. Since April 2007, the number of members enrolled in Preferred (Pool II) has generally increased. As of April 2007, there were 6,500 Preferred (Pool II) members, representing 47% of the Direct Pay population. In April 2010, this had increased to 7,700, or 55%. Since April 2010, enrollment in Preferred (Pool II) has remained fairly steady.

Enrollment in Basic (Pool I) steadily declined from April 2007 until April 2010, but has increased significantly since then. In April 2010, age rating was introduced in Basic (Pool I). This change in rate structure was designed to improve the financial equity between

younger and older Basic (Pool I) 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 will continue to decline over time, helping to moderate future increases in health care costs. Blue Cross' goal has been to increase enrollment in both Basic (Pool I) and Preferred (Pool II), with enrollment in Preferred (Pool II) increasing at a faster rate. It appears that the introduction of age rating into Basic (Pool I) is having the desired effect of increasing the Pool I enrollment. After a number of years of decline, our Pool I enrollment is starting to show some growth. The table below summarizes the enrollment changes in Direct Pay for Basic (Pool I) and Preferred (Pool II).

	Direct Pay Members			**Percentage**	
Month	Basic	Preferred	Total	Basic	Preferred
April 2007	7,400	6,500	13,900	53%	47%
April 2008	7,000	6,900	13,900	51%	49%
April 2009	6,600	7,300	13,900	47%	53%
April 2010	6,400	7,700	14,100	45%	55%
April 2011	7,000	7,500	14,500	48%	52%
September 2011	7,500	7,600	15,200	50%	50%

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 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. Balancing the desire to maintain attractive Preferred (Pool II) rates in the Direct Pay market, however, is the need to position the market to comply with the requirements of the Patient Protection and Affordable Care Act ("PPACA"). Therefore, in order to minimize the rate shock to Direct Pay subscribers likely to occur with the removal of health status rating in 2014, no changes to the pool subsidy are being proposed with this rate filing.

Q. You mentioned the PPACA requirements for Direct Pay. Please describe those requirements as they relate to this filing.

A. PPACA specifies certain rating rules that must be adhered to by 2014. In particular, beginning in 2014, health status rating will not be allowed, although tobacco use will be allowed as a rating factor up to a maximum differential of 50%. Gender will also be eliminated as a rating factor in 2014. Finally, rating by age will be limited to a maximum ratio of 3:1. As a result of PPACA, absent other guidance, Pool I and Pool II will need to be merged, which will likely result in significant increases in the rates paid by individuals enrolled in Pool II at that time. Additional provisions of PPACA may impact Class DIR over the coming years.

In addition, in July 2011, the U.S. Department of Health & Human Services (HHS) issued proposed regulations on the Establishment of Exchanges and Qualified Health Plans. The proposed regulations clarify that individuals can only enroll in a plan offered through the Exchange during an open enrollment period. The initial open enrollment period for the individual market will begin on October 1, 2013 and run through February 28, 2014. Also under the proposed regulations, beginning January 1, 2014, individual market rates need to be in effect for the entire "benefit year", which is defined as the calendar year. This will require an eventual change to Blue Cross' practice of making rate changes annually on April 1st. Also, under

PPACA, a single risk pool comprised of individuals enrolled in products in the individual market both inside and outside of the exchange will be used to set the rates for products in the individual market.

Finally, there will be certain benefit requirements for all carriers participating on the Exchange beginning January 1, 2014. All benefit plans offered on the Exchange will need to cover, at a minimum, the "essential health benefits", which are yet to be fully defined. Benefit plans will also be classified into four metallic tiers. The four metallic tiers relate to the level of subscriber cost sharing inherent in the plan design, also referred to as "actuarial value." These four tiers are; Platinum (90% actuarial value), Gold (80% actuarial value), Silver (70% actuarial value), and Bronze (60% actuarial value). All benefit plans sold on the Exchange must have a level of benefits at least as rich as the Bronze level. Also, in order to participate in the Exchange, carriers will have to offer at least one product at each of the Silver and Gold metallic tier levels.

Q. What is Blue Cross' strategy regarding making the necessary rating changes to its Direct Pay products in order to comply with these requirements?

A. Blue Cross' strategy regarding making the required rate structure changes is to make modest changes at this time in order to limit rate shock to subscribers and keep rates as attractive as possible in the market. As previously discussed, these changes must be balanced with keeping Preferred (Pool II) rates as attractive as possible, in order to maintain the financial stability of Class DIR.

Regarding the change in rate renewal date required by the proposed exchange regulations, we are proposing a two step approach. The proposed rates in this rate filing will be in effect for eighteen months; from April 1, 2012 through September 30, 2013. This would allow our members more time to become familiar with the updated plan designs and provide

peace of mind that their rate will not increase for 18 months, unless the subscriber moves into a new age band, changes products, or changes from individual to family coverage. The subsequent rate filing will be effective with the beginning of the Exchange related open enrollment on October 1, 2013 and extend through the end of calendar year 2014. Thereafter, rate changes will be effective on a calendar year basis.

Q. Did Blue Cross consider other options regarding the change in rate renewal date?

A. Yes. Blue Cross considered many other options to move the rate renewal date. The other options considered would result in various logistical and customer service related issues. For example, Blue Cross considered a rating period for this filing of April 2012 through March 2013, with subsequent rate filings effective April 2013 and January 2014. However, because of the lead time required to conduct rate hearings and have rates approved for the Exchange related open enrollment effective October 2013, we anticipate that the January 2014 rate filing would need to be submitted sometime around April 2013. Notification for this filing would thus be received by subscribers very close to the effective date of the previous filing. This is likely to lead to significant confusion for our members as they will have essentially received notification pertaining to two separate rate filings nearly simultaneously. Also, conducting three separate Direct Pay rate hearings within an eighteen month period would result in a significant resource drain not only for Blue Cross, but for the Office of the Health Insurance Commissioner and the Attorney General's office. In addition, it is unclear whether the Commissioner would approve a rate increase that would be in effect for only nine months. After consideration of these issues, Blue Cross determined that the proposed eighteen month rate

period, followed by a fifteen month rate period, was the most favorable solution for all parties involved.

Q. Please provide more details regarding the rate structure changes being proposed in this filing.

A. Effective April 1, 2012, the maximum rate differential by age for subscribers under age 65 will be increased to 1.5 to 1 for Basic (Pool I) subscribers. The current rate differential is 1.25 to 1. This change will improve the financial equity between younger and older Pool I subscribers and lessen the rate shock to Direct Pay subscribers in 2014. Also, rate structure changes for subscribers aged 65 and over are being proposed for both Basic (Pool I) and Preferred (Pool II). In last year's Order and Decision, the Commissioner raised concerns regarding the rate structure for Direct Pay subscribers aged 65 and over for both Basic (Pool I) and Preferred (Pool II). This rate filing addresses those concerns. The rate differential between subscribers aged 65 and over and aged 60-64 is being reduced to 24% from the current 49%. This is equivalent to these subscribers receiving no rate change from last year assuming no change in benefits. In addition, a new rate band is being introduced for subscribers aged 65 and over in Preferred (Pool II) to limit the rate shock for those subscribers turning age 65. The rate differential within Pool II between subscribers aged 65 and over and aged 60-64 will be the same as that within Pool I. Current subscribers aged 65 and over who had originally been in Pool II and have not had any gaps in coverage will automatically receive the lower rate as of April 1, 2012.

Q. Would you please describe, in general terms, the proposed benefit changes and new product offering in connection with the subscription rates developed in this filing?

A. Contemporaneous with this rate filing, Blue Cross has filed with the OHIC proposed revisions to the contract forms for each of the five products currently available to Class DIR as well as for a new product offering. These proposed forms provide detailed descriptions of the benefits and other terms of the products. In addition to benefit changes, several of the existing products are being renamed. The following products will be available to Class DIR subscribers effective April 1, 2012:

VantageBlue Direct 1000/2000 Plan (Formerly HealthMate Coast-to-Coast Direct 500/1000)

- $1,000 per individual/$2,000 per family deductible.
- 20% co-insurance in-network for hospitalizations, outpatient hospital services, lab tests, x-rays, and therapy services after deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).
- In-network out-of-pocket maximum of $3,000 per individual/$6,000 per family. The out-of-pocket maximum includes the deductible.
- $20 PCP/$40 specialist co-payments for in-network services (pre-deductible).
- $10/$35/$60/$100 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies. Pharmacy coverage does not apply towards the deductible. The co-payment for certain prescription drugs used to treat diabetes, asthma, and COPD are reduced to $2 for subscribers who are diagnosed with these conditions.

VantageBlue Direct 1500/3000 Plan (Formerly HealthMate Coast-to-Coast Direct 1000/2000)

- $1,500 per individual/$3,000 per family deductible.
- 20% co-insurance in-network for hospitalizations, outpatient hospital services, lab tests, x-rays, and therapy services after deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).
- In-network out-of-pocket maximum of $4,500 per individual/$9,000 per family. The out-of-pocket maximum includes the deductible.
- $20 PCP/$40 specialist co-payments for in-network services (pre-deductible).
- $10/$35/$60/$100 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies. Pharmacy coverage does not apply towards the deductible. The co-payment for certain prescription drugs used to treat diabetes, asthma, and COPD are reduced to $2 for subscribers who are diagnosed with these conditions.

HealthMate Coast-to-Coast Direct 2500/5000 (Formerly HealthMate Coast-to-Coast Direct 2000/4000)

- $2,500 per individual/$5,000 per family deductible.
- 20% co-insurance in-network for hospitalizations, outpatient hospital services, lab tests, x-rays, and therapy services after deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).
- In-network out-of-pocket maximum of $7,500 per individual/$15,000 per family. The out-of-pocket maximum includes the deductible.

- $20 PCP/$40 specialist co-payments for in-network services (pre-deductible).
- $10/$35/$60/$100 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies. Pharmacy coverage does not apply towards the deductible.
- Optional Wellness Reward Program allows subscribers to receive a reward equal to 10% of their annual paid premiums if certain wellness requirements are met.

BlueSolutions for HSA Direct 3000/6000 (Formerly HealthMate for HSA 3000/6000)

- $3,000 per individual/$6,000 per family deductible. The deductible applies to all covered services except certain preventive care services.
- 20% co-insurance in-network after satisfaction of the deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).
- In-network out-of-pocket maximum of $6,000 per individual/$12,000 per family. The out-of-pocket maximum includes the deductible.
- $10/$35/$60/$100 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies after deductible. Pharmacy coverage applies towards the deductible.

BlueSolutions for HSA Direct 5000/10000 (Formerly HealthMate for HSA 5000/10000)

- $5,000 per individual/$10,000 per family deductible. The deductible applies to all covered services except certain preventive care services.
- 0% co-insurance in-network after satisfaction of the deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).

- In-network out-of-pocket maximum of $6,050 per individual/$12,100 per family. The out-of-pocket maximum includes the deductible.
- $10/$35/$60/$100 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies after deductible. Pharmacy coverage applies towards the deductible.

BlueValue Direct 2500 *(New product offering)*

- $2,500 per individual deductible. The deductible applies to most services except certain physician office visits and emergency room visits.
- 50% co-insurance for most in-network services after satisfaction of deductible (30 visit annual limit applies for each of physical therapy, occupational therapy, and speech therapy).
- In-network out-of-pocket maximum of $7,500 per individual. The out-of-pocket maximum includes the deductible.
- $30 co-payment for the first two physician office visits each calendar year in network (pre-deductible). Subsequent office visits are subject to the deductible and co-insurance.
- $200 co-payment for the first emergency room visit each calendar year (pre-deductible). Subsequent emergency room visits are subject to the deductible and co-insurance.
- $4/50%/50%/$200 co-payments for tier 1, tier 2, tier 3, and tier 4 (specialty drugs), respectively, at participating pharmacies. A separate $500 deductible applies to tiers 2, 3, and 4 only.

- Coverage for one annual dental cleaning and one set of bitewing x-rays with no member cost sharing.
- Annual fitness reimbursement of $100 toward a gym membership and certain other fitness activities.

The BlueValue Direct 2500 plan will be available on an individual basis only (no family plans).

The updated products also include an innovative new program that reduces the deductible over time and that will apply to all Direct Pay plans. This program will add value to the proposed benefit plans by reducing the deductible amount in the following calendar year for those members who do not meet their deductible. The deductible continues to be reduced so long as the member does not meet the deductible in any given calendar year until the fourth year, or until the deductible is 50% of the original amount. After the fourth year, the reduced deductible is maintained as long as the deductible is not met. If the deductible is met in any year, the deductible resets to the original amount the following year. After reset, the member can begin to earn the reduced deductible again as long as insurance coverage is maintained. Members must have had coverage for six consecutive months within the calendar year to be eligible for a credit the following year. The table below illustrates the program.

Year	**Percent Reduction**	**Example**
Calendar Year 1	Original Deductible	$5,000
Calendar Year 2	20% Reduction	$4,000
Calendar Year 3	40% Reduction	$3,000
Calendar Year 4	50% Reduction	$2,500

Additional details about the benefit changes described above and our communication strategy for educating current members about these plan changes are described in the pre-filed testimony of Kimberly Cormier.

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 Coast-to-Coast Direct 2000/4000 product was designated as a Wellness Health Benefit Plan. This year, that plan will be renamed the HealthMate Coast-to-Coast Direct 2500/5000 which will carry the Wellness Health Benefit Plan designation. 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. Since the plan's inception and through September 30, 2011, Blue Cross has issued over $82,000 in rewards.

Q. You previously discussed the so-called "metallic levels" in relation to products sold on the Exchange beginning in January 2014. To what degree do the proposed benefit plans meet these requirements?

A. Regulations defining the actuarial value calculations are still outstanding. These regulations will standardize the calculation of the actuarial values across carriers, using a common set of data, so that consumers can make meaningful comparisons between products sold by different insurers. Adding further uncertainty, PPACA requires that actuarial values be calculated based on only the essential benefits, which have yet to be fully defined. Taking into account these uncertainties, Blue Cross has used its own internal data sources and commonly understood definitions of actuarial value to preliminarily estimate the metallic levels of the

proposed benefit plans. Based on our preliminary analysis, the VantageBlue Direct 1000/2000 and VantageBlue Direct 1500/3000 products would fall in the Silver tier; the HealthMate Coast-to-Coast Direct 2500/5000, BlueSolutions for HSA Direct 3000/6000, and BlueSolutions for HSA Direct 5000/10000 would fall in the Bronze tier; and the BlueValue Direct 2500 plan would fall below the level required to be sold on the Exchange. Given the nebulous nature of the regulations at this point in time, there is a high degree of uncertainty involved in these preliminary calculations. It should also be noted that the actuarial value of the benefit plans will tend to increase over time as claims trend erodes the impact of fixed dollar deductibles and copayments.

Q. Please describe AccessBlue.

A. In 2006 Blue Cross launched AccessBlue, previously named the Direct Pay Premium Assistance Program, to help lower income subscribers 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 lower 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 "improve members' health and peace of mind by facilitating their access to 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. During the rating period beginning April 1, 2012, Level 1 will provide a monthly subsidy of $82 for each eligible Direct Pay individual subscriber and $154 for each eligible family subscriber. This equates to assistance ranging from 8% to 80% of the total proposed premium depending on the pool, the selected product, and the age of the subscriber.

Additionally, Direct Pay subscribers who have incomes between 201% and 350% of the FPL are eligible for Level 2. During the rating period beginning April 1, 2012, Level 2 will provide a monthly subsidy of $54 for each eligible individual subscriber and $102 for each eligible family subscriber. This equates to assistance ranging from 5% to 53% of the total proposed premium depending on the pool, the selected product, and the age of the subscriber.

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

A. The 2012 federal poverty levels are expected to be released in late January 2012. Once released, Blue Cross intends to implement the new levels on the income guidelines for April 1, 2012. The 2011 federal poverty levels are as follows:

Family Size	100%	200%	350%
1	$10,890	$21,780	$38,115
2	$14,710	$29,420	$51,485
3	$18,530	$37,060	$64,855
4	$22,350	$44,700	$78,225
Each additional person, add	$3,820	$7,640	$13,370

Approximately 7,600 or 77% of Direct Pay contracts are for individual coverage. With respect to family coverage, the average size family in Direct Pay is 3.4 persons. Approximately 28% of Direct Pay subscribers are currently receiving financial assistance through the AccessBlue program.

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. In 2011, Blue Cross' Board of Directors have authorized an addition $4.5 million to be set aside for AccessBlue. 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 much has Blue Cross provided in assistance to Direct Pay subscribers through the AccessBlue program?

A. From the inception of the AccessBlue program through September 30, 2011, Blue Cross has provided nearly $11 million is assistance to eligible Direct Pay subscribers.

Q. How long will Blue Cross continue AccessBlue?

A. Blue Cross has committed to continue the AccessBlue program through the end of 2013, at which time it will formally retire the program. Effective January 1, 2014, Direct Pay subscribers with an annual household income below 400% of FPL will be eligible for Exchange based subsidies to purchase health insurance as authorized under PPACA.

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

A. Blue Cross and its Board of Directors take pride in the fact that 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. A common way is through Rhode Island Gen. Laws § 27-18.5-3, which provides that coverage is guaranteed for our Pool I 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, 2011 and June 15, 2011 for a July 1, 2011 effective date. Open enrollment was advertised on BCBSRI.com during the entire open enrollment period as well as in the Providence Journal and in the Rhode Island Newspaper Group (RING) newspapers the week of May 11, 2011. BCBSRI also conducted general Direct Pay advertisement via text ads on Google and Yahoo which ran March through December 2011. 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 640 new applications were received.

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

A. The last rate increase was effective April 1, 2011. This was the result of a filing for Class DIR that was submitted to the OHIC on November 19, 2010 and approved on March 7, 2011 with some modifications.

Q. As a result of the March 7, 2011 decision by the OHIC, can you quantify what modifications were made?

A. Yes. Blue Cross filed an aggregate rate increase of 8.1%, which was revised to 7.9% to reflect updated administrative cost information. As a result of the decision by the OHIC, the revised aggregate rate increase was reduced by 6.0% - from 7.9% to 1.9%. This reduction included a modification to the filed claims projection factors, the elimination of the 1%

reserve contribution factor and related taxes, and the exclusion of the 2% state premium tax as well as assessments to fund child immunizations, adult immunizations, and the children's health account (collectively, "State Assessments").

Q. Do Class DIR subscribers benefit from the State Assessment programs?

A. Yes. The child immunization program provides free vaccines to healthcare providers for children from birth through 18 years of age. This program helps ensure that all children in Rhode Island, including Class DIR members, have access to vaccinations according to the recommended Childhood and Adolescent Immunization Schedule and are protected from sixteen serious vaccine-preventable diseases. The child immunization assessment on health insurers provides the funding for insured children under this program.

The adult immunization program provides seasonal influenza and pneumococcal vaccine to adults. Insured persons aged 19 or older who live or work in Rhode Island are eligible to receive vaccinations for free at public flu clinics. These vaccines are funded by the adult immunization assessment on health insurers and health insurers are billed directly by the providers for the administration of the vaccines.

Health insurers in Rhode Island are also charged an assessment on insured premium to fund the Rhode Island Children's Health Account. Administered by the Rhode Island Department of Human Services, this account is intended to be used to provide coverage for children with special health care needs. The following programs are funded through this assessment: CEDARR Services, Home Based Therapeutic Services (HBTS), Personal Assistance Services and Supports (PASS), Kids Connect, Child and Adolescent Intensive Treatment Services (CAITS) program, Private Duty Nursing (PDN), and personal care services. Note that we are not proposing to recover this piece of the State Assessments in this Class DIR filing.

The child immunization, adult immunization, and children's health account are state administered programs that benefit all Rhode Islanders, including Class DIR members. Funding for these programs is through a direct premium assessment on Rhode Island health insurers.

Q. What was the basis for the exclusion of the state premium tax and State Assessments in the Commissioner's decision?

A. The basis for the Commissioner's denial of State Assessments in rates charged to Class DIR subscribers was that the method used by Blue Cross to allocate these costs created a risk that Direct Pay subscribers would be charged more than the costs they actually incurred under the State programs funded through the State Assessments. Since Blue Cross had not developed a method of allocating these costs that met the requirements of the Commissioner, the entire rating component for State Assessments was disallowed.

Regarding the state premium tax, the Commissioner determined that this cost should not be passed along to Direct Pay subscribers because of affordability concerns.

Q. Has Blue Cross addressed these concerns?

A. Yes. Blue Cross has revised the methodology it uses to allocate the costs due to State Assessments to Direct Pay subscribers. In this rate filing, Blue Cross is including only those expenses that can be explicitly shown to have accrued as a result of a Direct Pay member receiving an immunization during the experience period analyzed. This methodology is detailed in Schedules 25 and 26 of Blue Cross Exhibit 2.

Regarding the state premium tax, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Among these are the value based benefits inherent in the VantageBlue plans and the introduction of a new product targeted at the uninsured population.

In addition, as discussed previously, Blue Cross has administered the AccessBlue program since 2006 to provide financial assistance to subscribers meeting certain income thresholds. Finally, by introducing the deductible reduction program, Direct Pay subscribers have the opportunity to reduce their cost-sharing. For these reasons, we believe this rate filing addresses affordability, and thus the rating component for premium taxes should be allowed in Class DIR rates. Moreover, for the reasons our attorneys will articulate in connection with the hearings, we believe the law requires inclusion of the premium taxes in the Class DIR rates.

Q. In your opinion, is it appropriate to include the state premium tax and State Assessments in the rate calculations for the Class DIR line of business?

A. Yes. The premium tax is assessed on a premium base that includes Class DIR and the determination of the assessments to Blue Cross is based on premium reported on annual financial statements, including premium for the Class DIR line of business. The premium tax and the immunization portion of the State Assessments are thus direct costs to the Class DIR line of business and the costs allocated to Class DIR are incurred solely because Blue Cross insures this market segment. The portion of the premium to fund the Rhode Island Children's Health Account is also a direct cost, but since it cannot be directly tied to Direct Pay subscribers we have not included that cost in this filing. If Blue Cross were continued to be denied a mechanism to collect these taxes and assessments from Class DIR subscribers, it would force Blue Cross subscribers in other market segments to be assessed a disproportionate share of these fees. The inclusion of premium tax and State Assessments in Class DIR premiums is fair and makes practical business sense.

Q. What is the reserve contribution component being requested for Class DIR in the proposed filing effective April 2012?

A. Blue Cross is not asking for a reserve contribution in its proposed Direct Pay rates effective April 2012. 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, to keep the Direct Pay portfolio as affordable as possible, Blue Cross is not including a reserve contribution component in this rate filing. Blue Cross is seeking to cover only the cost of paying claims and administering the products in the proposed subscription rates. Blue Cross has made every effort to keep the required rates as low as possible. This includes making benefit changes and not seeking a reserve contribution from Direct Pay subscribers.

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 five existing benefit plans as well as the new proposed plan offering. They apply to Class DIR for the rate period commencing April 1, 2012. Blue Cross Exhibit 2 consists of schedules 1 through 63.

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

A. Blue Cross Exhibit 3 is entitled “Resources for Health System Improvements - Survey.” 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?

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, 2012 billing cycle. 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 solvency 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 changes reflected in this filing?

A. Yes. The Blue Cross Board of Directors met on October 13, 2011, at which time the rate changes reflected in this filing were considered, discussed, and approved for submission. At that time, the Board of Directors also considered, discussed and approved the

benefit changes described herein. The Directors' Finance Committee, which has primary oversight of all rate matters, also reviewed and authorized these rate increases at its meeting, held on October 6, 2011.

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 4 consist.

A. Schedules 1 through 4 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, 2012 billing cycle for the existing products within Class DIR as well as the new proposed product. The actuarial schedules are grouped into sections, labeled as section I through section VIII.

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

A. Section I consists of schedules 5 through 11, which summarize the calculations of the Basic (Pool I) monthly subscription rates for the April 2012 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 12 through 19, which summarize the calculations of the Preferred (Pool II) required monthly subscription rates for the April 2012 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 20 through 23, 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 24 through 26, which summarize the claims impacts from State Assessments related to immunizations. Schedules 25 and 26 detail the calculation of the claims impact of child and adult immunizations explicitly incurred by Direct Pay members during the experience period.

Section V consists of schedules 27 through 41, 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. Schedules 28 and 29 calculate the projected claims expense for the proposed benefit designs while schedules 30 through 39 calculate the projected claims expense for the current plan designs for Basic (Pool I) and Preferred (Pool II). Schedules 40 and 41 detail the calculation of the projected claims costs for the expected new population and new benefits, respectively.

Section VI consists of schedules 42 through 49, which show the development of benefit factors for the revised products, including the new program which provides deductible reductions.

Section VII consists of schedules 50 and 51, providing the administrative expense estimates and calculations.

Section VIII consists of schedules 52 through 63, and contains trends and projection factors.

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 proposed 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, including the currently uninsured population expected to enroll in the new 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, 2010 to May 31, 2011 time period. The base period incurred allowed claims were adjusted by a utilization adjustment factor to convert all products to a common benefit utilization level. The VantageBlue Direct 1000/2000 plan was selected to be the common benefit plan. This adjustment was made so that the claims experience for the updated products could be estimated by combining the experience from the existing products based on the assumed migration from these products. The methodology for deriving the claims expense for the updated products based on the existing products is explained in more detail further on in my testimony.

These adjusted 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. The projected allowed claims for the existing plan designs were then converted to projected allowed claims for the updated plan designs (including the new product offering) by incorporating the assumed subscriber migration patterns. Next, the projected rate period allowed claims for the updated plan designs 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. Since all the experience period claims expense was converted to the utilization level of the VantageBlue Direct 1000/2000 plan in an earlier step, the utilization adjustment factors in this step are all relative to the VantageBlue Direct 1000/2000 plan. 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. Also, the net-to-allowed factors were adjusted this year to account for the expected deductible reductions due to the proposed deductible reduction program. The calculation of the net-to-allowed factors is detailed later in my testimony.

Finally, factors were applied to the adjusted projected allowed claims to reflect anticipated pharmacy rebates for the rate period and additional adjustments were made to account for the costs of additional benefits not reflected in the base period claims experience. This process produced projected paid claims PCPM for each of the updated 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 five updated products as well as the proposed new product within Basic (Pool I) and Preferred (Pool II). This stage begins with the composite projected paid claims PCPM for each pool, which I have just described. The impact of state assessments and covering dependents up to age 26 was then applied to the projected incurred claims cost. The detail behind the claims impact of the child and adult immunization portion of 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.

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 recently enacted health care legislation and the future elimination of rating by health status, balanced by the desire to keep Preferred (Pool II) rates as attractive as possible, we chose to maintain the current pool rate alignment in this rate filing.

The next 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.

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. As mentioned previously, modest modifications are being made to the rate tier factors for Basic (Pool I) and Preferred (Pool II) rates with this year's rate filing. We are proposing to increase the maximum rate differential by age for subscribers under age 65 to 1.5 to 1 for Basic (Pool I) subscribers. The current rate differential is 1.25 to 1. To develop the revised rate tier factors for Basic (Pool I), the age slope was adjusted so that rates for subscribers aged 60-64 were 50% higher than rates for subscribers under age 25. For this step, the rate relationships among the age categories were based on the current Basic Rate (Pool

I) rate structure, with a steeper overall slope. Note that the relationship between family and individual rates within Basic (Pool I) is the same as in previous filings.

In addition to the rate slope changes for Basic (Pool I) subscribers under age 65, modifications are being made to rates for subscribers age 65 and over for both Basic (Pool I) and Preferred (Pool II) to address concern outlined in last year's Order and Decision of the Commissioner. The rate differential between subscribers aged 65 and over and aged 60-64 within Pool I is being reduced to 24% from the current 49%. The 24% rate differential is calculated to be equivalent to these subscribers receiving no rate change from last year assuming no change in benefits. In addition, a new rate band is being introduced for subscribers aged 65 and over in Pool II to limit the rate shock for those subscribers turning age 65. The rate differential within Pool II between subscribers aged 65 and over and aged 60-64 will be the same as that within Pool I.

The calculations of the monthly subscription rates by pool, product, and rate tier 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-payment 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, projected changes in utilization and mix of services, and a claims adjustment factor to adjust for anticipated changes not related to utilization/mix of services or price increases. The price component of the projection factors and the claims adjustment factors are identical for Basic (Pool I) and Preferred (Pool II) since the two populations utilize the same network of hospital and physician providers and are impacted by the same general market forces. 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 the rate filing effective April 2010, we began developing separate utilization factors based on each pool's individual experience. This modestly increased the trend factors developed. However, in determining our overall Class DIR revenue requirements, we also included an explicit assumption relative to pool mix. For this rate filing, we will continue the practice of developing separate utilization/mix factors by pool. In the aggregate, this approach is the equivalent of our prior practice. We are just substituting an explicit pool mix assumption for an implicit one.

Q. You indicated that included in the definition of the projection factors is a claims adjustment factor to adjust for anticipated changes not related to utilization/mix of services or price increases. Please explain how these factors were developed.

A. These factors include the impact of changes to our Radiology Management Program, the impact of contractual changes with our pharmacy benefit manager, the impact of anticipated new brand name drugs being introduced to the market, and the anticipated availability of new generic drugs.

Blue Cross continuously monitors its Radiology Management Program to ensure that it remains effective in controlling unnecessary utilization of high end radiology services. We recently made two changes to the prior authorization process. Effective November 1, 2010, Blue Cross eliminated the Cardiology Gold Card Program. The Cardiology Gold Card Program allowed cardiologists to bypass the utilization review that our radiology management vendor, MedSolutions, conducts on nuclear stress tests. Cardiologists are now subject to the same reviews on their requests as other providers. Also, effective January 1, 2011, facilities are no longer allowed to self authorize high end radiology services. MedSolutions will now only accept

authorizations from the servicing physician. These policy changes are expected to result in reductions in utilization of both outpatient and physician claims.

A claims adjustment factor is also included for the prescription drug line of business to adjust for expected changes in the terms of our contract with CVS Caremark, our pharmacy benefit manager, effective January 1, 2011, July 1, 2011, and January 1, 2012. The pharmacy claims adjustment factor also includes the impacts of the formulary change effective November 1, 2010, anticipated new brand name drugs becoming available in the market and the anticipated availability of new generic equivalents.

Q. In your overview of the basic approach taken, you mentioned that an assumption regarding current subscribers selecting different products was incorporated in developing the required rates. Could you explain in more detail how this was done?

A. Sure. This step begins with the projected allowed claims for each product adjusted to the utilization level of the VantageBlue Direct 1000/2000 product, as mentioned earlier. Due to the significance of the benefit changes, we anticipate that there may be some subscriber movement away from their modified plan as they assess the updated benefit designs as well as their current situation in terms of physical and financial health. This anticipated subscriber movement is incorporated in the migration assumptions. To develop the adjusted projected allowed claims for each updated product, the adjusted projected allowed claims for the current products were weighted together based on the proportion of subscribers expected to migrate to a different products. For example, we have assumed that 80% of the current Pool I HealthMate Direct 500 subscribers and 75% of the current Pool I HealthMate Direct 1000 subscribers will select the updated VantageBlue Direct 1000/2000 product. Therefore, the adjusted projected allowed claims expense for the Pool I VantageBlue Direct 1000/2000 product

is calculated by weighting together the Pool I adjusted projected allowed claims expense from the HealthMate Direct 500 product and the HealthMate Direct 1000 by 80% of the HealthMate Direct 500 subscribers and 75% of the HealthMate Direct 1000 subscribers within Pool I. Similar calculations are carried out for each of the updated products within each pool.

Q. How were the migration assumptions developed?

A. The migration assumptions were developed separately for Basic (Pool I) and Preferred (Pool II). As discussed earlier, given the product changes that are being made, subscribers will be automatically enrolled in the plan that is most similar, in terms of benefits, to their current plan and will be given an opportunity to select a different plan. We assume that the majority of subscribers will remain in the plan that they are enrolled in. However, we did make judgments about what changes subscribers may make. These judgments were largely based on a comparison of the benefits between plans along with the differences between the current and proposed rates. Separate migration assumptions were made for Preferred (Pool II) since the subscribers are generally healthier and thus may make different purchasing decisions. In particular, more Pool II subscribers were assumed to migrate to the BlueValue Direct 2500 plan, since the combination of benefits and premiums for this product are expected to attract healthier members.

Q. Could you generally explain the methodology used to develop the net-to-allowed and utilization adjustment factors?

A. We 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 development of the net-to-allowed factors is explained in more detail later on in my testimony.

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 types of services used. For example, an increase in an emergency room co-payment would likely disincent members from using the emergency room in non-emergency situations. Similarly, an increase in the deductible amount could discourage members from getting an elective outpatient surgery since the member would have to pay more out-of-pocket for the procedure. The utilization adjustment factors used in the Direct Pay filing are based on those used in rating Blue Cross' Commercial Group line of business, which were developed as part of our rating system.

Q. You mentioned that the net-to-allowed factors were adjusted this year to account for the expected deductible reductions due to the proposed deductible reduction program. Could you explain the approach you used to estimate this impact?

A. Yes. As discussed earlier, this new benefit provision will reduce the deductible amount in the following calendar year for members who do not meet their deductible in the current year. This benefit provision will be effective April 1, 2012, however claims expenses incurred between January 2012 and March 2012 will be included in the deductible accumulation amounts for current members.

The deductible reductions will begin effective January 1, 2013 for members who qualify. Therefore, two sets of net-to-allowed factors were developed for each updated benefit

plan; one based on deductibles in effect in 2012, and one based on deductibles in effect in 2013. These two sets of net-to-allowed factors were then weighted together by the expected enrollment in each respective year to arrive at the net-to-allowed factors used to develop the updated product rates. Since no deductible reductions will be in effect in 2012, these net-to-allowed factors were developed using the standard methodology that Blue Cross has employed in previous rate filings. However, since 2013 will involve a mix of members who have a reduced deductible and members who do not have a reduced deductible, an alternate methodology was developed.

Q. Please describe the methodology for developing net-to-allowed factors for the year that deductible reductions will be in effect.

A. As I just mentioned, in 2013, there will really be two sets of benefits for each benefits plan. For example, for members who select the VantageBlue Direct 1000/2000 plan, a subset of them will have the original deductible of $1,000 and a subset of them will have a reduced deductible of $800. Therefore, two sets of net-to-allowed factors were developed for each benefit plan; one based on the original deductible, and one based on the reduced deductible. These calculations were done in the same manner that has been employed in previous filings with one exception. Since we are only concerned at this point with claims that accumulate toward the deductible, only that portion of the claims were used to develop these factors. The portion of claims that does not accumulate toward the deductible is unaffected by the deductible reductions and is incorporated in a later step.

These two sets of net-to-allowed factors then have to be weighted together by the proportion of claims for the underlying populations that are expected to have each deductible variation. Also, since the Direct Pay population tends to exhibit significant turnover, a persistency assumption and an overall enrollment growth assumption are incorporated to account

for members leaving the pool and new members enrolling. New members will not receive a reduced deductible since they will not have been enrolled long enough to qualify.

The next step necessary for the calculation of the net-to-allowed factors including deductible reductions is to estimate the enrollment and claims cost for the three relevant populations; those members who did not meet their deductible in the prior year, those members who did meet their deductible in the prior year, and members who were not enrolled in the prior year (new members). As I just mentioned, the number of new members is estimated by incorporating an assumption for enrollment growth and the historical rate of persistency within Direct Pay. This population is assumed to have a level of claims expense equal to an average Direct Pay member. To determine the number of members who did and did not meet their deductible, a claims analysis was conducted using 12-months of claims expense for each member. For each benefit plan design, the number of members who did and did not meet the deductible value was tabulated. The membership for each group was then reduced by the assumed persistency rate mentioned earlier. To estimate the claims expense in the second year, a parameter was estimated to distribute the aggregate claim expense between members who did and did not meet their deductible in the first year. This parameter was developed based on actual experience using an analysis of claims, by member, over two calendar years, where the claims expense incurred by members in the second year were compared to the claims expense incurred in the first year by the same members. This parameter essentially reflects the fact that there is a random component to the claims expense incurred by members, i.e. some members who incur a low level of claims expense in one year will have a high level of claims expense the following year, and vice versa.

The final step for developing the net-to-allowed factors for the year in which deductible reductions will be in effect is to weight the deductible portion of the net-to-allowed factor with the non-deductible portion, as alluded to earlier. The detailed schedules that lay out the calculations involved in the preceding methodology will be discussed later in my testimony. Note that the impact of the deductible reductions to the rates proposed in this filing is a modest 0.3%.

Q. When describing the development of the projected paid claims PCPM, you also mentioned that adjustments were made to reflect anticipated pharmacy rebates and the cost impact of additional benefits. Could you explain these adjustments?

A. Yes. Due to the provisions of our contract with our pharmacy benefit manager (PBM), depending on the design of our formulary, Blue Cross receives rebates on certain brand drugs. These rebates are passed along to our subscribers in the form of lower subscription rates and are reflected in the prescription drug rebate factors displayed on schedules 28 and 29 of Exhibit 2. Note that the prescription drug benefit design of the BlueValue Direct 2500 plan does not qualify to receive prescription drug rebates, per the provisions of our PBM contract. Therefore, no adjustment is made to the projected claims expense for this plan.

An adjustment was also made for additional benefits for the proposed new product offering. As discussed previously in my testimony, BlueValue Direct 2500 will provide coverage for one annual dental cleaning and set of bitewing x-rays as well as a $100 annual fitness reimbursement toward a gym membership or certain other fitness activities. Schedule 41 details the development of the projected cost of these benefits.

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, so 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 ($110-$50) in the following year. 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 distribution of enrollment by pool has shifted. 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 period using projection factors that were appropriate

for each pool. Next, contract months over the rate period were projected for each pool by looking at recent historical enrollment changes and incorporating expected shifts in the population. 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 period. Finally, required income PCPM was calculated for each pool using the current pool rate alignment. Similarly, the projected contract months over the rate period were used in the calculation of the rate tier normalization factor. The calculation of the required income PCPM for each pool and the calculation of the rate tier normalization factor are displayed in Exhibit 2 on schedules 23 and 19, respectively. By projecting the claims costs separately for the two pools and recalculating the composite based on the projected enrollment over the rate period, the issue of enrollment shifting amongst the pools is dealt with explicitly in the rating methodology.

Q. Is there any impact on the proposed Direct Pay rates as a result of Premium Deficiency Reserves (PDR) for the Direct Pay line of business?

A. No. A premium deficiency reserve (PDR) is a reserve that is established when future premiums are not sufficient to cover future claim payments and expenses over current and future contract periods. The PDR represents the estimated future losses that will be incurred as a result of inadequate premiums and is recognized in current earnings as a separate expense. The PDR impacts the timing of the recognition of financial results but does not change the actual results. Since the rate setting process is concerned with covering the expenses expected to be incurred during the rating period, the establishment of the PDR is irrelevant. Note that Blue Cross does not expect to have a premium deficiency reserve at year end 2011.

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

Q. Please turn to schedule 28 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 28 is entitled "Calculation of Composite Projected Paid Claims Expense per Contract Month for Updated Products for April 1, 2012 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the projected period contract months and the projected paid claims PCPM for each updated product. It uses the projected allowed claims expense for each existing product from schedules 30 through 34, the June 2011 contract distribution, and an expected migration that we previously discussed to predict rate period contracts and claims expenses for each of the updated products. The expected migration predicts that most existing subscribers will stay in their updated plan, but that some subscribers will choose plans with relatively lower benefits in exchange for a relatively lower rate. Calculations are documented in the footnotes.

Q. You mention that schedule 28 applies to Basic (Pool I) only. Is there a corresponding schedule for Preferred (Pool II)?

A. Yes, it is schedule 29.

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

A. The same calculations are carried out, and the same issues are present, however, there are two minor differences.

One difference is that the migration expectations are not the same for Basic (Pool I) and Preferred (Pool II). The expected migrations for Basic (Pool I) and Preferred (Pool II)

both predict that most existing subscribers will stay in their updated plan and that some subscribers will choose plans with relatively lower benefits in exchange for a relatively lower rate, but the exact proportion is different for Basic (Pool I) versus Preferred (Pool II).

The other difference is that in Preferred (Pool II) there is an expectation that some currently uninsured people will buy the BlueValue Direct 2500 plan. Because we do not have base period experience for this population, it was necessary to estimate allowed claims for this population. This calculation is done in schedule 40.

Q. Please turn to schedule 40 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 40 is entitled "Calculation of Adjusted Projected Allowed Claims Expense per Contract Month for the Currently Uninsured Population for April 1, 2012 Billing Cycle." It applies to Preferred (Pool II) only.

Based on demographic information, the uninsured people who we expect to buy the BlueValue Direct 2500 plan are mainly healthy individuals under the age of 35. Therefore, in schedule 40, we use the Preferred (Pool II) experience for the plans which have healthiest members based on claims experience, namely the HealthMate for HSA 3000 and HealthMate for HSA 5000 plans, to predict the experience for this group.

Once we have the projected allowed claims for the Preferred (Pool II) HealthMate for HSA 3000 and HealthMate for HSA 5000 plans, we reduce these claims for the differences in the underlying demographics of our target population. This final amount is carried forward to schedule 29.

Q. Please turn to schedule 30, where the projected allowed claims for HealthMate Direct 500 that are used in schedule 28 are developed. Please describe schedule 30.

A. Schedule 30 is entitled "Calculation of Adjusted Projected Allowed Claims Expense per Contract Month for HealthMate Direct 500 for April 1, 2012 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the projected allowed claims PCPM for HealthMate Direct 500 for Basic (Pool I).

Q. How does schedule 30 compare with schedules 31 through 34?

A. Schedules 31 through 34 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 1000, HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively; whereas schedule 30 applies to HealthMate Direct 500.

Q. On a column-by-column basis, would you explain what is contained in schedules 30 through 34? 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. 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 2010 through May 2011. Incurred allowed claim amounts for this base period reflect actual claim submissions through July 2011, adjusted to a fully complete basis.

Column 3 shows the projection factors used to incorporate trends into the projection of allowed claims PCPM to the rate period. The projection factors are developed in schedule 53. Consistent projection factors are used in all five schedules.

Column 4 displays the utilization adjustment factor used to put each product on a consistent benefit basis, namely the VantageBlue Direct 1000/2000 Plan. As discussed previously in my testimony, it is necessary to have all products on a consistent basis at this step.

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

Q. You state that schedules 30 through 34 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 35 through 39.

Q. Are there any differences between schedules 30 through 34 and schedules 35 through 39, 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 53 and describe that schedule.

A. Schedule 53 is entitled "Projection Factors for Allowed Claims for April 1, 2012 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). 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 2010 through May 2011, while the rate period is April 2012 through September 2013. The midpoint of the base period is Dec 1, 2010 and the midpoint of rate period is Jan 1, 2013. The difference between these two periods is 25 months. The projection factors reflect Blue Cross' expectation for cumulative trends over this 25-month period. These trends have a price component, a utilization and mix of services component, and an additional adjustment component to reflect one time claims impacts not included in utilization/mix or pure price trends.

Q. On a column-by-column basis, would you please explain what is contained in schedule 53?

Column 1 of schedule 53 shows the price trend factor components of the projection factors. These price trend factors apply to the 25-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 utilization/mix trend factor components of the projection factors. These utilization/mix trend factors also apply to the 25-month projection period from the base period to the rate period. For pharmacy, these trends also include price. Schedules 54 through 61 document the trend assumptions for utilization / mix selected by Blue Cross, shown on schedule 53.

Column 3 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/mix or pure price trends. These adjustments include high end imaging changes, savings from vendor discounts and dispensing fees, and changes in the prescription drug market (such as brand drugs becoming generic).

Column 4 contains the projection factor. This is simply the product of columns 1 through 3.

Q. With regard to the utilization / mix trend factors shown in column 2, 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 2008, 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 2009. Twenty-five data points, which equates to three years of experience, were analyzed. 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, generally with a minimum R-squared value of 0.70 to help assure reasonable fit to the data points.

Given that the underlying data is credible, 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 actuarially acceptable. Adjustment or modification to this result, or substitution of an alternative assumption, may occur if the original result is not credible, 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. The method of linear least squares quantifies the 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 r-squared value 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, but not always, considered statistically acceptable to us.

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. Is it ever appropriate to select a trend line that has an r-squared value less than 0.70?

A. Yes. When a trend line has a slope close to zero, the r-squared value will be low. Therefore, in some cases, if the underlying data is credible and the trend seems reasonable, it may be appropriate to select a trend value with a lower than 0.70 r-squared value.

Q. Is it ever appropriate to not select a trend that has an r-squared value greater than 0.70?

A. Yes. A non-credible experience base, an erratic or biased pattern of data points, or otherwise unreasonable result, may provide reasons to utilize actuarial judgment in trend determination rather than selecting a trend corresponding to a valid r-squared value.

Q. You mention that it is not appropriate to base trend selections on a non-credible experience base. What would you consider a non-credible experience base?

A. In order to be considered credible, the data must be stable. The data are split into four lines of business (hospital inpatient, hospital outpatient, surgical/medical, and pharmacy), and within each line of business it is further split into Basic (Pool I) and Preferred (Pool II). Below is a chart showing the average claim amount and number of claims for each line of business and pool for the base period (6/1/2010-5/31/2011).

	Basic (Pool I)		**Preferred (Pool II)**	
	Mean	Actual # of Claims	Mean	Actual # of Claims
Inpatient	$15,211	738	$15,420	254
Outpatient	$555	18,202	$473	10,262
Professional	$153	95,271	$145	57,202
Pharmacy	$78	159,171	$56	56,473

The chart shows that the fewest claims occur in the inpatient line of business, with fewer than 1,000 claims in each pool. It is my opinion that our recent inpatient trend experience is not credible for projecting future trends in Basic (Pool I) or for Preferred (Pool II). Overall, the inpatient line of business is the least credible, the professional and pharmacy lines of business are the most credible, and the outpatient line of business falls somewhere in between.

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 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 describe what is contained in schedules 54 through 63.

A. Each of the eight schedules, 54 through 61, contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points, for one line of business, for Basic (Pool I) and also for Preferred (Pool II). The data points begin with the 12-month period ending May 2009 and continue through the 12-month period ending May 2011. In order to reflect only changes in utilization and mix of services, the allowed claim amounts for hospital inpatient, hospital outpatient, and surgical / medical have been adjusted, or depriced, to June 2008, so that intervening price increases have been removed from the allowed claim PMPM values used. The pharmacy allowed claim amounts have not been depriced, and therefore include price.

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). This line is shown on schedules 54 through 61, as well as the highest r-squared value, corresponding trend, and corresponding number of points used. In addition, our trend selection is shown on an annual basis and also on a 25 month basis. This selection may be the same as the underlying trend which corresponds to the highest r-squared value or it may be different for reasons previously discussed.

Schedules 62 and 63 display the allowed claims PMPM values for Basic (Pool I) and Preferred (Pool II), respectively, which are utilized to calculate trends in schedules 54 through 61. 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 54 through 61 for each of the applicable lines of business.

Q. Please describe each of your trend selections and the rationale for each selection, beginning with hospital inpatient.

A. For hospital inpatient, as shown in schedules 54 and 58, the Basic (Pool I) line with the best fit has an r-squared value of 0.543 corresponding to an annual trend of -4.82%, and the Preferred (Pool II) line with the best fit has an r-squared value of 0.815 corresponding to an annual trend of -34.63.

As previously stated, we do not consider the experience in the hospital inpatient line of business to be fully credible on its own for predicting future utilization trends. Another example, which shows that the Class DIR inpatient data is not stable, is the erratic nature of current and past trends based on the highest r-squared value. As demonstrated by the chart below, these trends do not increase our confidence in the predictive ability of the inpatient data for either pool.

	2009 Filing		2010 Filing		2011 Filing	
	R-Squared	Trend	R-Squared	Trend	R-Squared	Trend
Pool I	*0.92*	-11.7%	*0.61*	7.4%	*0.54*	-4.8%
Pool II	*0.93*	42.5%	*0.64*	-16.4%	*0.82*	-34.6%

The lack of credibility and erratic nature of the experience make it difficult to predict changes in inpatient utilization, therefore we have chosen a 0.00% utilization trend for Basic (Pool I) and Preferred (Pool II). This is consistent with the 0.00% inpatient utilization trend for Commercial Group that was approved by the OHIC in the most recent commercial rate filing. Additionally, since we are projecting from a base period that consists of the twelve months ending May 2011, I point out that our rate development has fully recognized the decreases in inpatient utilization that have occurred to date.

Q. Please continue with the hospital outpatient trend selection process.

A. For hospital outpatient, as shown in schedules 55 and 59, the Basic (Pool I) line with the best fit has an r-squared value of 0.622 corresponding to an annual trend of 1.30%, and the Preferred (Pool II) line with the best fit has an r-squared value of 0.935 corresponding to an annual trend of -5.33%.

The Basic (Pool I) r-squared value does not meet the minimum criteria of 0.70. However, as discussed previously, an r-squared value less than 0.70 may produce an appropriate result if the indicated trend is close to zero. In contrast, the Preferred (Pool II) r-squared value does meet the minimum criteria, however the data is less credible than Basic (Pool I). Also, we do not believe that a -5.33% trend can reasonably be expected to continue. In addition, the past outpatient data has been volatile as shown in the chart below.

	2009 Filing		2010 Filing		2011 Filing	
	R-Squared	Trend	R-Squared	Trend	R-Squared	Trend
Pool I	*0.67*	7.4%	*0.93*	-7.6%	*0.62*	1.3%
Pool II	*0.92*	12.7%	*0.96*	11.8%	*0.93*	-5.3%

So looking at outpatient as a whole, it seems reasonable to not directly use the indicated Class DIR data. The Commercial Group outpatient trend, approved by the OHIC, implies an annual trend of 3.80% for utilization and mix. We believe mitigating Group's outpatient trend to give some weight to the trend we are seeing in Class DIR is a reasonable proxy for future Class DIR outpatient trend. Therefore, we have selected half of Group's approved trend factor as our Basic (Pool I) and Preferred (Pool II) outpatient trend. This is an annual trend of 1.90%, which equates to a 25-month trend assumption of 4.00%. This is also relatively close to the calculated Direct Pay Basic (Pool I) trend, which we believe produces a reasonable result.

Q. Please now describe the surgical / medical trend selection.

A. As shown in schedules 56 and 60, the Basic (Pool I) line with the best fit has an r-squared value of 0.360 corresponding to an annual trend of 0.81%, and the Preferred (Pool II) line with the best fit has an r-squared value of 0.902 corresponding to an annual trend of 3.48%.

The Basic (Pool I) r-squared value does not meet the minimum criteria of 0.70. However, as discussed previously, an r-squared value less than 0.70 may produce an appropriate result if the indicated trend is close to zero. We believe that the 0.81% trend produced is a reasonable indication of future costs. The Preferred (Pool II) r-squared value does meet the minimum criteria and seems reasonable. The underlying data for each pool is credible, and past experience is not erratic. Therefore we have selected to use the trends produced by the liner least squares method for both Basic (Pool I) and Preferred (Pool II). The Basic (Pool I) annual trend of 0.81% equates to a 25-month trend assumption of 1.69%. The Preferred (Pool II) annual trend of 3.48% equates to a 25-month trend assumption of 7.39%.

Q. Please now describe the Pharmacy trend selection.

A. As shown in schedules 57 and 61, the Basic (Pool I) line with the best fit has an r-squared value of 0.995 and represents a calculated annual trend of 12.77%, and the Preferred (Pool II) line exhibiting the best fit has an r-squared value of 0.990 producing an annual trend of 15.09%.

Since both r-squared values meet our minimum criteria of 0.70, and the results seem reasonable, we selected to utilize the calculated annual trends. The Basic (Pool I) annual trend of 12.77% equates to a 25-month trend assumption of 28.45%. The Preferred (Pool II) annual trend of 15.09% corresponds to a 25-month trend of 34.02%.

Q. In your selection of inpatient and outpatient trend, you mention a consistency with the Commercial Group trends, which were approved by the OHIC. Is it appropriate to consider Commercial Group trends in the selection process of Class DIR trends?

A. Yes. When Class DIR data is not credible, or does not seem to have a reasonable trend result, it is appropriate to consider other sources. Commercial Group trends are a good proxy for Class DIR trends because both groups of members participate in the same healthcare market. The same hospitals, doctors, and medical services which are available to Commercial Group members are also available to Class DIR members. Also, members of Commercial Group and Class DIR, are utilizing these services in the same geographic area. Therefore, it is reasonable that changes over time, which are measured by trend, will be similar for these two groups. Finally, for a line of business as small as our DIR segment it is useful to consider the reasonableness of the aggregation of the different trend assumptions made in the various service categories discussed above. The annual utilization trend assumptions across all medical categories (i.e. excluding pharmacy) underlying this filing average to 0.9% for Pool 1 and to 2.2% on Pool 2, equating to a single composite annual utilization trend assumption of only 1.3% across all of DIR. We note that a 2008 Congressional Budget Office study concluded that "roughly half of the increase in health care spending during the last several decades was associated with the expanded capabilities of medicine brought about by technological advances." I submit that it is not at all unreasonable to assume that the effects on the ongoing technological changes in healthcare delivery will push composite DIR utilization levels up by at least this 1.3% per annum rate.

Q. Turning back to schedule 43, where the net-to-allowed factors used in schedules 28 and 29 are developed, could you please describe generally the method used to develop these net-to-allowed factors?

A. Sure. Generally, to determine net-to-allowed factors, the allowed claims for each Class DIR member are re-adjudicated to simulate members having each of the updated plan designs for the rate period, April 2012 to September 2013.

First, the base period claims, June 2010 to May 2011, were adjusted to a consistent utilization level, namely the VantageBlue Direct 1000/2000 Plan. Then these allowed claims were projected to the rate period. For each of the plans, the projected allowed claims were then re-adjudicated to the corresponding net payment level. The original net-to-allowed factors, shown on schedule 43, are then the ratio of the projected rate period net claims expense to the projected rate period allowed claims for each plan.

To adjust for the deductible reduction program, all projected allowed claims were split into two groups: the projected allowed claims which apply towards the deductible (Deductible Portion) and the projected allowed claims which do not apply towards the deductible (Non-Deductible Portion). The net-to-allowed factors corresponding to the Deductible Portion and the Non-Deductible Portion of the claims expense were then developed in the manner I just described. The Non-Deductible Portion net-to-allowed factors are shown on schedule 43. The Deductible Portion of the net-to-allowed factors was then modified to account for the deductible reduction program. The modification calculation is shown, for each plan, in schedules 44 through 49. The resulting Deductible Portion net-to-allowed factors for the second year are summarized in schedule 43.

Now that we have all the components of our net-to-allowed factors for each of the six updated plans, we must simply weight them together. For each of the plans, we first calculate a total deductible reduction program (Second Year) net-to-allowed factor using the allowed dollar weights for the Deductible Portion and the Non-Deductible Portion of each plan, shown on schedule 43. Then the total Original net-to-allowed factor is weighted with the Second Year net-to-allowed factor, by the projected contract months shown in schedule 51, to produce the Rate Period Total net-to-allowed factors for each of the plans.

Q. You mention that the Deductible Portion for the Second Year net-to-allowed factors comes from schedules 44 through 49. Please turn to schedule 44 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 44 is entitled "Second Year Deductible Portion Net-to-Allowed Calculation for VantageBlue Direct 1000 for April 1, 2012 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of this schedule is to display the calculation of the deductible portion of the net-to-allowed factors for VantageBlue Direct 1000/2000 in the year that the deductible reductions will be effective.

Q. How does schedule 44 compare with schedules 45 through 49?

A. Schedules 45 through 49 are comparable in nature. They also apply to both Basic (Pool I) and Preferred (Pool II). The difference is that they apply to VantageBlue Direct 1500/3000, HealthMate Coast-to-Coast Direct 2500/5000, BlueSolutions for HSA Direct 3000/6000, BlueSolutions for HSA Direct 5000/10000, and BlueValue Direct 2500, respectively; whereas schedule 44 applies to VantageBlue Direct 1000/2000.

Q. On a column-by-column basis, would you explain what is contained in schedules 44 through 49? Please note any relevant differences among them.

A. The first column of each of these schedules shows the number of unique members in the base period, June 1, 2010 through May 31, 2011, broken out by whether or not members are expected to reach their deductible in CY 2012.

The second column of schedules 44 through 49 indicates the annual allowed cost for the first year per member for each type of member indicated in each line description.

The third column shows that the persistency rate is 77%. This is the proportion of members from column 1 who are expected to still be members the following year.

Column 4 shows a morbidity factor, which accounts for differences in the expected average cost for members who hit their deductible versus members who do not hit their deductible in the first year.

Column 5 shows the second year deductible for the corresponding type of member. This essentially indicates whether or not a particular type of member is eligible for the reduced deductible. The deductible is reduced by 20% for the contracts which are not new and did not reach their deductible in the prior year.

Column 6 shows the number of unique members expected in the second year. For members who either hit or did not hit their deductible the first year this number is 77% of the first years' unique members. Additionally, there are new members who were not enrolled in the first year, which represent the 23% turnover plus an overall expected growth in contracts of 11% from CY 2012 to CY 2013.

Column 7 indicates the expected annual allowed cost in the second year per member for each type of member indicated in each line description.

Column 8 shows the total annual allowed cost for each type of member indicated in each line description. This is simply column 6 multiplied by column 7.

The final column of these schedules, column 9, is the deductible portion of the net-to-allowed factor that corresponds to the deductible shown in column 5. The total in this column is the average, weighted by the annual allowed cost from column 8.

Q. Turn to schedule 41, where the additional benefits used in column 13 of schedules 28 and 29 are developed. Could you please describe schedule 41?

A. Schedule 41 is entitled "Calculation of Fitness and Dental Benefits for BlueValue Direct 2500 per Contract Month for April 1, 2012 Billing Cycle". It applies to both Basic (Pool I) and Preferred (Pool II).

The fitness benefit has an annual reimbursement amount of $100 per contract. We have modestly estimated 25% of the BlueValue Direct 2500 plan to receive this reimbursement, thus the cost per contract per month is $2.08.

The dental benefit has a cost of $104 for a cleaning and x-rays. The utilization per contract is estimated to be 84%. This utilization is based on actual commercial group utilization data. Thus the cost per contract per month for the dental benefit is $7.28.

Q. Turning back to schedules 28 and 29, prescription drug rebate factors are shown in column 12. Could you please describe generally the method used to develop these factors?

A. To calculate the prescription drug rebate factors, projected prescription counts for the Class DIR population were multiplied by the contracted minimum rebate per script premier formulary guarantees from our Pharmacy Benefits Manager. Actual rebates have been below and are projected to remain below the contracted minimums. The projected rebates were divided by projected claims expense to calculate the prescription drug rebate factors.

Q. Column 11 of schedules 28 and 29 shows utilization adjustment factors. Could you please describe generally these utilization adjustment factors?

A. The projected allowed claims are on a consistent utilization basis, namely the VantageBlue Direct 1000/2000 Plan. These utilization adjustment factors are applied to adjust for expected changes in utilization due to differences in member cost sharing amounts for each of the updated products. These utilization factors are based on those used in rating Blue Cross' Commercial Group line of business.

The net-to-allowed factors and utilization adjustment factors adjust for the impact of benefit changes between the existing products in the base period and the updated products in the rating period.

Q. You have now described and explained schedules 28 and 29, along with the various schedules supporting them. You have stated that schedules 28 and 29 develop the projected paid claims PCPM for each of the updated 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 21 and describe that schedule.

A. Schedule 21 is entitled "Calculation of Required Monthly Base Rates for Updated Products for April 1, 2012 Billing Cycle." The purpose of this schedule is to display the calculation of the required monthly base rates for each of the products under Basic (Pool I) and Preferred (Pool II).

Q. Please describe the important points of schedule 21.

A. Item (i) and item (ii) show the composite required monthly base rate for Basic (Pool I) and Preferred (Pool II), respectively. These base rates are developed in schedule 23.

Column 1 displays the proposed plan relativity factor for each plan. These factors are developed in schedule 22 and are used to distribute the rate need for each pool across plans.

Columns 3 and 5 calculate the proposed monthly base rates for each plan for Basic (Pool I) and Preferred (Pool II), respectively. These are the base rates, by product, that correspond to the proposed plan relativities which are shown in column 1.

Q. In schedule 21 you refer to the development of the plan relativity factors, shown in column 1, in schedule 22. Please turn to schedule 22 and describe that schedule.

A. Schedule 22 is entitled "Calculation of Rate Relativity for Updated Products for April 1, 2012 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 plan relativities. Calculations are documented in the footnotes.

Column 10 of schedule 22 shows the product relativities based on the benefits only, without regard for the projected experience of subscribers expected to choose each product (i.e. excluding selection). These relativities are calculated using the projected data shown on the same schedule, which is developed elsewhere in the filing schedules, as documented in the footnotes. We then apply modification factors which will either increase or decrease these product relativities. The modification factors were selected to balance potential cross subsidies due to expected selection and the rate increase for current members, while maintaining reasonable rate relativities between products.

Q. With regard to the composite required monthly base rate in items (i) and (ii) of schedule 21, you refer to their development in schedule 23. Could you please turn to schedule 23 and describe that schedule?

A. Schedule 23 is entitled “Calculation of Composite Required Monthly Base Rates for Updated Products for April 1, 2012 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 income on a current pool rate alignment basis for each of the two pools.

Q. On a column-by-column basis, would you explain what is contained in schedule 23?

A. Column 1 of schedule 23 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 schedules 28 and 29.

Column 3 shows the child and adult immunization portion of the State Assessments benefit impact. As indicated in the footnote, this factor comes from schedule 25.

Column 4 shows the anticipated claims impact of covering dependents up to age 26, as required by PPACA. As indicated in the footnote, this factor is from last years filing. It is modified to account for two months of this coverage in our base period.

Column 5 shows the projected incurred claims expense PCPM including the impact of State Assessments for immunizations and coverage of dependents up to age 26 for each of the two pools. This is the product of columns 2 through 4. The sources of these values are documented in the footnotes.

Column 6 contains the administrative expense PCPM for the rate period. As indicated in the footnotes, the value contained in column 6 is developed in schedule 51.

Column 7 is simply the sum of columns 5 and 6.

Column 8 shows the investment income credit. 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 taking into account the two sources of investable funds that are directly attributable to Direct Pay; namely, prepaid subscription income and claim reserves. This represents a change in methodology from previous years when the negative contingency reserves allocated to this market segment were also included as investable funds. With this change in methodology, subscribers are no longer unfavorably impacted by the accumulation of previous years' losses that negatively affect the contingency reserves allocated to Direct Pay, which would result in less of a rate credit. This means that current and future subscribers will not be penalized for inadequate rates charged to previous generations of subscribers.

The investment income credit included in the proposed rates is 0.39%, expressed as a percent of projected incurred claims and administrative expense for the rate year. This credit was calculated by applying the expected rate of return on our investment portfolio to the estimated amount of prepaid subscription income and claim reserves that will be available to generate earnings throughout the rate year.

Column 9 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.

Column 10 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 state premium tax assessment on health insurance premiums.

The factor used to calculate column 10 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. Thus, since we have not included a contribution to reserve, the combined contribution to reserve and tax PCPM is then calculated using a factor of 0.9800.

Column 11 contains the required income 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 claims expense and retention components based fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

Column 12 is the current pool rate alignment. This is the existing ratio between Basic (Pool I) and Preferred (Pool II) rates. We have chosen to keep the same ratio in our proposed rates.

Column 13 shows the adjusted required income PCPM. These are the proposed base rates for each pool and they are calculated by distributing the composite required income using the ratio in column 12 so that the overall required rate is maintained.

Q. You mention child and adult immunization benefit impact factor in column 3 of schedule 23 related to that portion of the State Assessments. Could you please explain the calculation of this factor?

A. Section IV shows the development of this factor. Section IV consists of schedules 25 and 26. Schedule 25 is titled "Calculation of Claims Impact of Child and Adult Immunizations Benefit for April 1, 2012 Billing Cycle" and illustrates the benefits that Class DIR has received due to the State's immunization programs that are funded by these assessments. Schedule 26 is titled "Base Period Benefit Amount of Child and Adult Immunizations for April 1, 2012 Billing Cycle" and shows details of the data used to calculate the benefit amount in schedule 25.

Q. With regard to the administrative expense PCPM shown in column 6 of schedule 23, you refer to its development in schedule 51. Could you please turn to schedule 51 and describe that schedule?

A. Schedule 51 is entitled "Calculation of Administrative Expense per Contract Month for April 1, 2012 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 2012 and 2013, in aggregate and PCPM. Then the PCPM amounts for 2012 and 2013 are weighted together to produce an appropriate amount for the April 1, 2012 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 CY2011, CY2012, and CY2013 developed internally by Blue Cross for Class DIR.

Q. How are the 2011, 2012, and 2013 Class DIR operating expense budget amounts determined?

A. In preparation for this Class DIR filing, we developed a projected actual for 2011 and estimated budgets for Class DIR calendar years 2012 and 2013. Attached hereto as Blue Cross Exhibit 5 is a document entitled "Blue Cross & Blue Shield of Rhode Island Class DIR – Comparison of CY12 Budget to CY11 Projected Actual by Natural Account." Blue Cross Exhibit 5 compares by natural account (1) 2011 Projected Operating Expenses to (2) the 2012 Operating Expense Budget. The CY11 Projection is based on actual reported expenditures through August of 2011, with an estimate for the remainder of the year. The CY12 amounts reflect the budget for the calendar year. The third column of Blue Cross Exhibit 5 shows the dollar increase or decrease between CY11 Projected and CY12 Budget. The fourth column shows the percentage increase or decrease. The methodology used to create the 2012 budget was to use the 2011 allocations by department as of September and then multiply those against the 2012 Corporate Budget (as of October).

For purposes of this filing, the calendar year 2012 budget results in a total budgeted amount for Class DIR of $7,282,034, as reflected in column 2 of schedule 51 of Blue Cross Exhibit 2. This in turn was divided by total projected Class DIR contract months for 2012 of 124,745 for a projected total Class DIR operating expense per contract month figure of $58.38 for calendar year 2012. See column 4 of schedule 51 of Blue Cross Exhibit 2.

For 2013 attached hereto as Blue Cross Exhibit 6 is a document entitled "Blue Cross & Blue Shield of Rhode Island Class DIR – Comparison of CY13 Budget to CY12 Budget

by Natural Account." Exhibit 6 employs the same format as Exhibit 5, except that it compares CY13 to CY12. The CY13 budget amount of $7,745,390 as reflected in column 2 of schedule 51 of Blue Cross Exhibit 2 is divided by the total projected Class DIR contract months for 2013 of 138,527, for a projected total Class DIR operating expense per contract month figure of $55.91. Attached hereto as Blue Cross Exhibit 7 is a detailed narrative breaking down the administrative expenses for the Class DIR budget.

Q. Please turn back to schedule 23. In your testimony regarding column 10 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 .9800 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 Class DIR population should contribute their fair share to reserves, given the current economic conditions in Rhode Island and other considerations we have elected to not request any contribution to reserves at this time. In the future, we do intend to request a contribution to reserves from this population that is in line with their fair share. As of September 30, 2011, Blue Cross' surplus levels as a percent of annual premium are at 19.0% of annual premium, which is below the 23% minimum of the Blue Cross surplus range recommended by the Lewin report.

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

A. Blue Cross' reserve position at September 30, 2011 was $300,221,812, or 2.37 months in reserve, on a SAP basis.

Q. Please turn now to schedule 6 and describe that schedule.

A. Schedule 6 is entitled "Calculation of VantageBlue Direct 1000 Required Monthly Subscription Rates for April 1, 2012 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. Monthly subscription rates in schedule 6 are shown separately on a required rate basis. The Basic (Pool I) age categories are identical to the Preferred (Pool II) age categories. The only difference is that proposed rates for Basic (Pool I) do not vary by gender.

Q. How does schedule 6 compare with schedules 7 through 11?

A. Schedules 7 through 11 are comparable in nature. They also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to VantageBlue Direct 1500/3000, HealthMate Coast-to-Coast Direct 2500/5000, BlueSolutions for HSA Direct 3000/6000, BlueSolutions for HSA Direct 5000/10000, and BlueValue Direct 2500, respectively; whereas schedule 6 applies to VantageBlue Direct 1000/2000. Also, schedule 11, showing the BlueValue Direct 2500 rates, has rates for individuals only, as this product will not be offered with a family rate.

Q. On a column-by-column basis, would you explain what is contained in schedules 6 through 11?

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 21.

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 6

through 11, determined across the entire pool. The rate tier normalization factor is developed in schedule 19.

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 discussed previously in my testimony, the Basic (Pool I) rate factors are being revised with this year's filing. The Preferred (Pool II) rate factors are the same factors that were used in last year's rate filing, with the addition of an age 65+ rate factor.

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 6 through 11 you refer to its development in schedule 19. Could you please turn to schedule 19 and describe that schedule?

A. Schedule 19 is entitled "Calculation of Rate Tier Normalization Factors". Column 1 is the "Rate Factors" that are used in our existing rates which convert monthly normalized base rates to monthly subscription rates for individuals and families, by age category for Basic (Pool I) and for male, female, and families, by age category for Preferred (Pool II). Column 2 shows our proposed "Rate Factors" that we intend to use in our rates effective April 1, 2012. Note that these are different for Basic (Pool I), but are not different (with the exception of adding a 65+ factor) for Preferred (Pool II).

As in previous filings, the purpose of the rate tier normalization factors, developed in schedule 19, is to develop factors for Basic (Pool I) and Preferred (Pool II) which, when applied to the required monthly base rates, will normalize those rates. In other words, the aggregate revenue produced by the subscription rates after normalization will be equal to the required income demonstrated on schedule 23, column 13.

In this filing, we have chosen to first maintain the existing pool relativity of 2.5322. This produces a rate tier normalization factor of 0.9068 as shown in line 10. However, since we are modifying the Basic (Pool I) age relativities, this factor is applicable only to Preferred (Pool II). The Basic (Pool I) factor needs to be further modified to account for the changing age relativities. The Basic (Pool I) rate tier normalization factor becomes 1.0484, which will produce the same Basic (Pool I) aggregate rate using the proposed age factors as the 0.9068 factor would have produced using the existing age factors.

Q. Please turn back now to schedule 6. You described the calculations involved in columns 2 and 4 of schedule 6. The result is what is shown in these two columns as the Basic (Pool I) monthly subscription rates for VantageBlue Direct 1000/2000. 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 6 applies to the VantageBlue Direct 1000/2000 product under Basic (Pool I). You testified that schedules 7 through 11 are comparable, for the other five updated product rates for Basic (Pool I). Is that also correct?

A. Yes.

Q. You state that schedules 6 through 11 apply to Basic (Pool I), for each of the current six updated products being offered. Are there comparable schedules for Preferred (Pool II)?

A. Yes. Schedules 13 through 18 correspond to schedules 6 through 11, for Preferred (Pool II) versus Basic (Pool I).

Q. Please turn to schedule 13. Are the same calculations carried out for the VantageBlue Direct 1000/2000 product in schedule 13 for Preferred (Pool II) as in schedule 6 for Basic (Pool I)?

A. The same types of calculations are carried out in schedule 13 for Preferred (Pool II) as in schedule 6 for Basic (Pool I). I would note that the format and structure of schedule 13 differs slightly from schedule 6; labeling and rate development is consistent, however. The structural difference occurs since Preferred (Pool II) has separate individual rates for male vs. female subscribers.

Q. You state that schedules 13 through 18 for each of the Preferred (Pool II) products correspond to schedules 6 through 11 for Basic (Pool I). You have just described schedule 13. Are there any differences between schedules 14 through 18 and schedule 13, 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.

V. CONCLUSION

Q. Are the rates developed in Exhibit 2 and displayed in schedules 6 through 11, and 13 through 18 consistent with rates presented in your letter dated November 18, 2011 and included as Blue Cross Exhibit 1?

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

Q. Was Blue Cross Exhibit 2, schedules 1 through 63 prepared by you or under your direction and supervision?

A. Yes. These schedules were prepared by my staff in the actuarial department of Blue Cross.

Q. Was Blue Cross Exhibit 2, schedules 1 through 63 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 63 reflects fair, accurate and reasonable computations of required rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

A. Yes.

Blue Cross & Blue Shield of Rhode Island
Class DIR - Comparison of CY12 Budget to CY11 Projected Actual by Natural Account

Natural Account	CY2011 PROJECTED	CY2012 BUDGET	Increase (Decrease)	%
Salaries And Wages	$2,463,447	$2,589,880	$126,433	5.1
Temporary Empl Serv	16,484	19,322	2,838	17.2
Fringe Benefits	911,941	1,001,311	89,370	9.8
Outside Services	449,527	448,590	(937)	(0.2)
Legal	102,108	100,640	(1,468)	(1.4)
Facilities & Occupancy	325,182	326,888	1,706	0.5
Equipment	155,295	154,685	(610)	(0.4)
Software	305,376	283,442	(21,934)	(7.2)
Insurance	22,899	30,377	7,478	32.7
Travel	25,829	27,447	1,618	6.3
Printing/Office Supplies	78,080	87,448	9,368	12.0
Postage	220,893	234,778	13,885	6.3
Telephone	55,213	59,418	4,205	7.6
Advertising And Public Relations	145,793	169,222	23,429	16.1
Corporate & Civic Dues	43,619	44,428	809	1.9
Vendor Fees	1,480,736	1,391,099	(89,637)	(6.1)
Other	183,102	184,582	1,480	0.8
Sub Total:	**$6,985,524**	**$7,153,555**	**$168,031**	**2.4**
Beacon Mhsa	38,345	40,004	1,658	4.3
Radiology Vendor Fee	44,347	49,528	5,181	11.7
Pharmacy Benefit Management	12,251	13,908	1,656	13.5
Billed Services	(9,671)	(9,961)	(290)	3.0
Sub Total (Lob):	**$7,070,797**	**$7,247,034**	**$176,237**	**2.5**
Change In Claim Handling	(66,200)	35,000	101,200	(152.9)
Total:	**$7,004,597**	**$7,282,034**	**$277,437**	**4.0**
PCPM	$59.58	$58.38	($1.20)	**(2.0)**
Contracts	**117,566**	**124,745**	**7,179**	**6.1**

Blue Cross & Blue Shield of Rhode Island
Class DIR - Comparison of CY13 Budget to CY12 Budget by Natural Account

Natural Account	CY2012 BUDGET	CY2013 BUDGET	Increase (Decrease)	%
Salaries And Wages	$2,589,880	$2,694,677	$104,797	4.0
Temporary Empl Serv	19,322	23,466	4,144	21.4
Fringe Benefits	1,001,311	1,072,547	71,236	7.1
Outside Services	448,590	463,197	14,607	3.3
Legal	100,640	102,509	1,869	1.9
Facilities & Occupancy	326,888	336,695	9,807	3.0
Equipment	154,685	159,325	4,640	3.0
Software	283,442	291,945	8,503	3.0
Insurance	30,377	31,288	911	3.0
Travel	27,447	28,271	824	3.0
Printing/Office Supplies	87,448	99,072	11,624	13.3
Postage	234,778	265,821	31,043	13.2
Telephone	59,418	61,200	1,782	3.0
Advertising And Public Relations	169,222	174,299	5,077	3.0
Corporate & Civic Dues	44,428	45,761	1,333	3.0
Vendor Fees	1,391,099	1,568,188	177,089	12.7
Other	184,582	188,642	4,061	2.2
Sub Total:	**$7,153,555**	**$7,606,904**	**$453,348**	**6.3**
Beacon Mhsa	40,004	44,423	4,419	11.0
Radiology Vendor Fee	49,528	54,999	5,471	11.0
Pharmacy Benefit Management	13,908	14,325	417	3.0
Billed Services	(9,961)	(10,260)	(299)	3.0
Sub Total	**$7,247,034**	**$7,710,390**	**$463,356**	**6.4**
Change In Claim Handling	35,000	35,000	0	0.0
Total:	**$7,282,034**	**$7,745,390**	**$463,356**	**6.4**
PCPM	$58.38	$55.91	($2.46)	**(4.2)**
Contracts	**124,745**	**138,527**	**13,782**	**11.0**

The following provides a breakdown of calendar year 2012 administrative expenses by natural expense account for Direct Pay products. The Direct Pay Budget is consistent with the 2012 Corporate Budget approved by the Board of Directors

Salaries & Wages/Temporary Services

Salaries, bonuses, overtime pay and outside temporary services are included in this natural expense account. The following departments are included in the 2012 Direct Pay budget with the allocation based on the nature of the work performed:

Customer and Provider Services (12.8 FTEs, salaries ($487,956) staff responds to questions from members and providers regarding benefit coverage, payment status, eligibility and various other issues.

Individual Sales (0.7 FTEs, salaries $105,780) sells the Direct Pay product to the non-group market. Staff members are responsible for answering all inbound calls as they relate to the Direct Pay product. The process includes a thorough explanation of covered services, plan limitations, enrollment guidelines and benefits associated with the Direct Pay product.

Marketing (0.8 FTEs, salaries $114,184) includes support staff, which performs the following activities:

- Intake and processing in Individual Sales which require coding for correct processing. Outgoing calls and emails to verify that the provided information is accurate.
- Production of Sales Opportunities through "disenrolls" from groups.
- Support of Spanish telephone line.

Strategic Marketing & Product Innovation (3.1 FTEs, salaries $253,921) department is responsible for the development, implementation and ongoing management of the Direct Pay products including the following activities:

- Development and implementation of features and/or services that will make the product more enticing to prospective enrollees.
- Development and maintenance of all Direct Pay sales and member materials.
- Regular briefings of internal operating areas on Direct Pay benefits and administration.
- Investigating and resolving any service and/or operational issues related to benefit design.

Underwriting/Staff (5.0 FTEs, salaries $393,116) reviews health questionnaires for applicants requesting the Preferred rate (Pool II) in one of the Direct Pay products.

The Medical Underwriters in the Small Group Underwriting Department review the health questionnaires and any recent Blue Cross/Blue Shield claims history to determine the health risk of an applicant. The department uses a health insurance medical manual as guidelines for making the risk assessment. If the underwriter does not have sufficient information to make the health risk assessment, the applicant may be required to submit additional medical information from their health care provider. The Medical Underwriter

notifies the applicant regarding their eligibility for the preferred rate through a letter. If the applicant is denied the preferred rate they are informed of the medical condition(s) that did not meet the underwriting guidelines for acceptable risk. The Medical Underwriter also notifies the Membership Department of applications approved for the preferred rate.

The Underwriting Unit is also responsible for administering Access Blue which involves reviewing the premium assistance application and the applicant's prior year's income tax return. A letter of determination for the premium assistance program along with the letter concerning medical review is sent to the applicant. The application is coded according to the appropriate decision and forwarded to the Membership department.

Small Group Individual & Senior Products (1.0 FTEs, salaries $38,775) is responsible for activities associated with regulatory (rate) filing, forecasting, and development of claims reserves. Rate filing expenses account for $6,951 of the total expense, while the remaining $31,824 is related to claims reserve and forecast activities.

Statistical (0.1 FTEs, salaries $6,330) is responsible for the pricing of product benefits, providing detailed enrollment analysis as well as trend analysis and other studies.

Cash Receipts (0.4 FTEs, salaries $21,642) processes the individual premium payments made by subscribers. The process includes opening the mail, scanning the remittance, depositing the checks and posting the payments to the subscriber's account.

The remaining departments in **Finance** (1.8 FTEs, salaries of $176,146) are responsible for rate filing activities and day to day financial activities necessary to run the business. The rate filing activities include the development of operating expense budgets and responding to Attorney General data requests. Direct Pay is also allocated a share of day to day financial activities such as: Accounts Payable, Payroll, Corporate Accounting, etc.

Information Technology/Governance (3.3 FTE's, salaries $297,694) encompasses the following functions:

- Project management oversees the assignments that allocate to Direct Pay and limits cost overruns for projects benefiting Direct Pay (e.g. ICD-10, BCBSA system mandates, iHealth Care Reform implementation).
- Governance of the Dell outsourcing agreement relating to membership and claims processing functions for Direct Pay, ensuring that members are enrolled accurately and timely and that claims are processed according to standards.
- Web site development and maintenance enhances the BCBSRI web site allowing Direct Pay members access to obtain information relating to specific health and wellness topics.

Replacement Claims System Staff time devoted to the development and upgrade of a new claims system from LRSP will allocate $88,461 (1.0 FTEs) to Direct Pay. This important system upgrade will benefit all products by providing a state of the art claims processing system. The Corporation has consistently allocated these costs to all product lines rather than focus on each migration.

Communications Services (0.6 FTEs, salaries $50,101) provides Client Service, Design, Production, Traffic, and Copy support to produce member/sales collateral and open enrollment advertising for the Direct Pay Product.

Quality Assurance & External Audits (0.1 FTEs, salaries $10,414) performs claims audits, reports on numerous performance measures required by the Blue Cross Blue Shield Association, and coordinates activities for external audits. These audits ensure that Direct Pay members are enrolled on a timely basis and their claims are paid properly and timely.

The **Legal** department (0.8 FTEs, salaries $80,871) provides guidance on contracts, reviews subscriber agreements and works with outside counsel on Direct Pay rate filings and general litigation.

Human Resources (0.6 FTEs, salaries $52,309) performs all employee recruitment and is responsible for administering compensation, benefits, and training for all employees. The work in this department impacts all employees who work on Direct Pay activities.

Grievance & Appeals (0.6 FTEs, salaries $29,613) responded to 646 grievances and appeals from Direct Pay members in a twelve month period (June 2009 – May 2010).

Office Services (0.4 FTEs, salaries $24,096) is responsible for management of facilities and mail delivery, benefiting those employees who work on Direct Pay.

Internal Audit (0.2 FTEs, salaries $14,029) is responsible for the review of BCBSRI internal controls, payment processes and systems audits.

Corporate Compliance (0.2 FTEs, salaries $16,969) develops and enforces the corporate compliance program.

Audit Recovery Services (0.3 FTEs, salaries $22,735) is responsible for auditing how providers bill BCBSRI relative to American Medical Association (AMA) and plan contractual requirements. The AMA provides current procedural terminology (CPT) codes.

Contracting (0.7 FTEs, salaries $67,328) is responsible for the negotiation of contracts for all hospitals, physicians, ancillary providers, pharmacies, etc. In addition, this department is responsible for the maintenance of these contracts which includes administration, contract analysis, pricing updates, credentialing providers and maintaining provider databases.

Health Management Integration (2.2 FTEs, salaries $153,531) is staffed by clinical and non-clinical staff whose primary responsibilities are detailed below.

- Utilization review functions ensure claims are paid only for services rendered, billed in compliance with acceptable subscriber agreements, and medically necessary.

- Medical Policy department is responsible for reviewing requests for coverage of new technology, changes in benefits, new mandates, and requests for revision to current policy.
- Provider profiling compares individual physicians or groups of physicians to others in their same specialty with regards to total annual claims cost and outpatient service utilization.
- Chronic Illness/Disease Management department develops programs based on claims utilization and cost drivers for inpatient and outpatient services and the likelihood that interventions can reduce costs in the future.
- Catastrophic/Complex Case Management is a collaborative process of working with members who have complex or catastrophic events with the goal of optimizing health, enhancing quality of life and promoting cost effective care.

For additional detail, please see the pre-filed direct testimony of Augustine Manocchia, MD.

Expenses for **Corporate Executives, Government Relations, General Corporate Expenses, and Program Management** are corporate in nature and are allocated to all product lines and market segments resulting in a charge to Direct Pay of $103,202 (0.4 FTEs).

The succeeding chart provides a comparison for the Full Time Equivalents allocated to Direct Pay with the total staff in each department.

	Full Time Equivalents	
	Direct Pay	Total
Customer & Provider Services	12.8	216.1
Individual Sales	0.7	20.0
Marketing	0.8	45.0
Strategic Marketing & Product Innovation	3.1	27.0
Underwriting/Staff	5.0	20.6
Small Group, Individual & Sr Products	1.0	7.7
Statistical	0.1	8.0
Cash Receipts	0.4	11.2
Finance	1.8	66.4
Information Technology/Governance	3.3	125.8
Replacement Claims System	1.0	35.0
Communications Services	0.6	19.5
Quality Assurance & External Audits	0.1	14.0
Legal	0.8	33.0
Human Resources	0.6	21.6
Grievance & Appeals	0.6	15.1
Office Services	0.4	12.6
Internal Audit	0.2	8.0
Corporate Compliance	0.2	9.0
Audit Recovery Services	0.3	14.0
Contracting	0.7	49.0
Health Management Integration	2.2	146.0
All Other	0.4	91.4
TOTAL	**37.1**	**1,015.9**

Fringe Benefits

Fringe benefits are generally charged to cost centers based on the costs incurred at the employee level. These costs are then allocated to product lines in the same manner as the employees' salaries and wages. The specific components of fringe benefits are outlined below.

Payroll Taxes

FICA, Federal & State Unemployment, Medicare taxes paid on salaries and wages referenced above. For the purposes of this computation, we assumed that the tax rates will remain constant and maximums will move in relation to the salary increases.

Health Insurance

The Health Insurance expense includes the company's contribution for:

- Comprehensive group health coverage for individual and families
- Group Dental coverage with an annual $1,500 maximum
- Basic Life Insurance & Accidental Death & Dismemberment
- Post Retirement Medical Benefits for employees that were hired prior to January 1, 1992 and retire after age 55 after attaining minimum service requirements.

Pension

Expenses within this category include:

- Regular Pension - The Retirement Plan is a Defined Benefit Plan which provides a monthly retirement benefit to eligible participants at normal retirement, age 65 (full benefit) or at early retirement, age 55 to 64 (actuarially reduced benefit.) Vesting occurs in the Retirement Plan upon the completion of five plan years of service. Expenses are calculated in accordance with Financial Accounting Standard (FAS) #87.

- Supplemental Executive Retirement Plan (SERP) provides benefits to employees (vice presidents and above) who have been designated as eligible by the Board of Directors vote. Vesting requirements of at least 5 years at age 55 or 15 years of services at any age prior to 55 are necessary prior to payment of any benefits. Expenses are determined in accordance with FAS #87.

Fringe -Other

This category of expense includes:

- Money Match Employee Savings Plan. The expenses associated with this 401k program reflect the employer match costs (50% on employee pre tax contributions up to 6%) and the costs associated with Massachusetts Mutual's administration of the program. Employees hired after January 1, 2011 receive 100% match up to 6% but do not participate in the pension plan.
- Employee Long Term Disability Insurance provides the employee with partial disability insurance in the event of total disability.
- Workers Compensation Insurance.

Outside Services

Outside Services are external personnel (excluding lawyers) engaged to provide expertise or services that are not available from the existing staff, or to handle project work. The projected 2012 allocation to Direct Pay is $448,590. Major expense inclusions are noted below:

Enterprise Project Management Office/Information Technology – Outside professional services are utilized to assist on various projects including implementation of International Classification of Diseases, 10th Edition (ICD-10) which is mandated for diagnosis code set in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after 1 October, 2013, along with technical assistance on website development and maintenance. The projected 2012 impact on Direct Pay is $138,151. The primary methods of allocation for Information Technology are machine utilization, paid claims, contract months, and interplan teleprocessing services**.**

- **Strategic Marketing & Product Innovation** - $113,392 - Consulting of on-line panel and health content material are available to our members on our website. The on-line panel is used to test products and services to gain necessary feedback

from members. The health content material is a library of health related topics to help members understand and take action on their health conditions.

- **Corporate Expense –** This cost reflects the anticipated expenses incurred by Rhode Island Attorney General for the rate hearing ($5,331).
- **Communications Services** – The cost reflects the services provided by Rivers Doyle & Walsh ($10,998) for Public Relations and Advertising.
- **Human Resources** – Outside professional services are used for a variety of activities including compensation benchmarking, pension valuation, employee training and support of Human Resource systems. The allocation is estimated to be $25,374. The primary method of allocation for Human Resources is Full-Time Equivalents (FTEs).
- **Compliance and Audit** functions add $15,752 to the Outside Services line item. Compliance activities include conforming to Sarbanes-Oxley principles and the BCBSRI compliance program. Audit activities include technical support for internal audits and the annual corporate audit. These activities are corporate in nature and are allocated to all lines of business.
- **Legal –** Actuarial dollars of $47,540 will be utilized to support the Direct Pay rate filing.
- **Post Production Support** - $67,925 is being utilized for upgrading of Facets for various corporate initiatives (ICD-10, HIPAA 5010, Behavioral Health Initiatives and EDR).
- **Other** ($24,127) is spread across numerous operating departments and is used to support the operations in those areas.

Legal

Projected costs for outside legal services are $100,640 including $93,430 for costs associated with the hearing officer fees, rate filing and related work. The budget also includes $7,210 for Direct Pay's share of corporate litigation and other legal services. The rate filing expenses are charged directly to Direct Pay and the remainder of the expenses is corporate in nature, and is charged based on total cost ratio.

Facilities & Occupancy

This expense category includes all costs related to the operation of the facilities occupied by BCBSRI employees. The $326,888 allocation reflects 2.9% of the anticipated facilities costs for the corporation and is related to the departments whose activities allocate to Direct Pay as mentioned in the Salaries and Wages portion of this exhibit as well as the computer operations area.

Equipment

The allocation of equipment expenses are expected to be $154,685 for Direct Pay in 2012.

Depreciation, property taxes, rental and maintenance associated with computer hardware and employee workstations accounts for $151,113 of the budget. The budget also includes $3,572 for the purchase of equipment costing less than $1,500 per item, by the departments listed in the salaries and wages section.

Software

Software charges are anticipated to be $283,442 for Direct Pay. The largest single expense inclusion ($94,846) is license maintenance and hosting fees associated with BlueTransIT. The balance of this expense is associated with amortization and maintenance agreements for Information Technology (IT) systems ($51,773), Customer Relationship Management System amortization ($32,265) and other ($104,558) (WebMd, Healthshare, Data Leakage Protection (DLP), Skillsoft Education and Mckesson - documenting clinical events).

The IT systems include the corporate website BCBSRI.com, HIPAA and license agreements used by the Data Center. The BCBSRI website is accessible by Direct Pay subscribers to review benefits, claims activity and wellness tips.

Insurance

The Insurance account includes the following coverages as a prudent risk strategy:

- Directors & Officers
- e- Business Liability
- Employment Practices Liability
- Errors & Omission
- Managed Care Liability

The Direct Pay allocation of these corporate expenses is anticipated to be $30,377.

Travel

Travel expenses ($27,447) are allocated to product lines based on the reasons and benefits derived from the travel. Employee travel that is beneficial to the overall performance of the employee is allocated to product lines based on the allocation of salaries and wages for the employees department. Most travel falls into this category and includes educational conferences, training seminars on new systems and/or processes, and Blue Cross Blue Shield Association events.

If the travel benefits a specific product line or market segment other than Direct Pay then the travel will be charged to that product/segment directly and there will be no charge to Direct Pay.

Printing, Stationery and Office Supplies

The printing budget for Direct Pay includes $80,800 for materials such as welcome letters, applications, benefit summaries, and Access Blue literature.

Also included is the allocation of Office Supplies to Direct Pay ($6,648) which is directly related to the activities of the departments mentioned in the salaries and wages narrative. This category of expense includes toner cartridges for laser printers, paper, pens, folders, etc.

Postage

The $234,778 expense reflects the allocation of postage paid to mail the following items to Direct Pay subscribers:

- rate filing notification and rate decision,
- enrollment kits,
- provider directories,
- premium billings,
- claims correspondence, and
- premium assistance program.

Telephone

Telephone expenses are expected to be $59,418 in 2012 and include the following:

- line charges for Customer/Provider Service,
- data lines and web hosting fees for BCBSRI.com, and
- line charges necessary for all other employees to conduct business.

Advertising and Public Relations

Advertising is used to build brand awareness and understanding, sell products and services and provide important information to the community. BCBSRI uses a number of diverse media to communicate consistent messages regarding our competitive differentials, superior services and product offerings, and our brand position.

Direct Pay is charged directly for messages that pertain only to this product and is allocated a pro rata share of the costs of general advertising resulting in a total expense of $169,222. No cost is allocated to Direct Pay for advertisements that relate specifically to any other products (e.g. Healthmate, Blue Cross Dental).

Corporate & Civic Dues

Corporate and Civic Dues add $44,428 to the 2012 expense budget and are divided between two sub-categories: Dues and Contributions.

Direct Pay will be charged $31,774 for Dues expense in 2012 with $21,151 of this amount for corporate dues assessed by the Blue Cross Blue Shield Association. The Association calculates the dues each plan must pay based on the number of contracts and revenue that plan has. Direct Pay is allocated its share of these expenses based on a percentage of revenue. The remaining $10,623 is for professional dues which are allocated based on the departmental activities as mentioned in the salaries and wages section of this exhibit.

Charitable contributions represent $12,654 related to the ICU Collaborative to improve the culture of safety and specific clinical outcomes in the state. The specific evidence-based activities implemented in Phase I and II have included: reducing catheter-related blood stream infections (BSI) and ventilator-associated pneumonia

(VAP), improving care of sepsis patients, and administering a Safety Attitudes Questionnaire.

Vendor Fees

Vendor Fees contribute $1,391,099 to the 2012 expense budget and are divided among three major sub-categories: Dell (Perot Systems) Corporation ($1,174,181), Post Production support ($119,488) and other ($97,430).

Blue Cross has outsourced the following functions to Dell Corporation with a cost of $1,174,181 to Direct Pay:

- $429,855 - Data Center Operations.
- $462,880 - Claims Processing including Claims Disbursements.
- $149,752 - Application Development and Maintenance.
- $103,270- Network & Telecommunication Services.
- $ 28,424 - Desk Side Services.

Data Center Operations ($429,855) – Services necessary for the operation, administration, management and support of all, mainframe, printing and mailing applications area provided in this area. This process includes, but is not limited to:

- performing master console functions, including automation, centralization and consolidation of console functions and use of automation tools,
- managing, maintaining, monitoring, and controlling scheduled and unscheduled on-line batch processing,
- completing BCBSRI-defined processing and backups in correct sequence and within the time periods designated by BCBSRI,
- performing load balancing and where applicable perform as much scheduled batch work with automated tools,
- monitoring, verifying, and making appropriate adjustments to support proper executions of applications,
- identifying job and schedule dependencies, creating and maintaining job information dependencies on the master scheduling database, and prioritizing/scheduling batch jobs,
- supporting, maintaining and coordinating all on-line print/imaging/insertion activities,
- preparing reports for distribution and distributing them,
- developing, maintaining, ordering and storing print/image/insertion output forms libraries, inventories, and supplies,
- coordinating with external print/image/insertion third party vendors, and coordinating ad hoc mailing requests in the same manner as mail insertion services.
- assuring that midrange servers are kept in working order and that procedures are developed with reasonably adequate controls and audit trails.
- scheduling, coordinating, and overseeing all activities requiring the physical presence of third party vendors.
- coordinating rollouts and upgrades of equipment and applications, including

responsibility for coordinating any testing, scheduling and installation of such equipment or application.

- managing Direct Access Storage Devices (DASD) by monitoring and controlling storage performance, assigning and initializing DASD volumes, determining data set and volume placement, and setting and maintaining DASD resource efficiency/standards.
- providing performance monitoring, system performance tuning, and making recommendations based on system performance review.
- monitoring system utilization and capacity and advising BCBSRI of the need for additional capacity.
- providing daily monitoring and support for all servers, including, but not limited to: loading operating system software, installing back-up software and maintaining backups, performing restoration of data upon request, providing systems level support to the Application Development and Maintenance (ADM) team, providing data storage management, implementing and adhering to change control procedures, and administering clustered servers on different hardware platforms.

The primary method of allocation for Data Center Operations is machine utilization.

Claims Processing ($462,880) – Dell is responsible for all aspects of Direct Pay Claims Administration including Claims Receipt and Imaging, Claims Entry, Suspense Relief, and Correspondence and Adjustment processing. The primary method of allocation is based on paid claims.

Applications Development & Maintenance ($149,752) – Provide programming support for all systems applications used by Blue Cross & Blue Shield of Rhode Island. Direct Pay is charged directly for programming efforts that are specifically related to Direct Pay and the program is charged a pro rata share for generic applications (e.g. LRSP maintenance, Financial Systems, etc.).

Network & Telecommunication Services ($103,270)

- Manage the Wide Area Network (WAN) and Local Area Network (LAN) at BCBSRI sites.
- Perform the design, installation, termination, maintenance, and documentation of all intra-building copper and fiber optic cabling for Ethernet, FDDI, SONET, ATM and WAN environments.
- Install and maintain WAN connections and upgrades.
- Monitor WAN and leveraged LAN bandwidth, report on Internet access and usage, and maintain adequate Internet access bandwidth in accordance with business needs.
- Support all BCBSRI internal and external audits for regulatory or business function purposes.
- Perform all functions required in order to support telecommunication services of the BCBSRI user community (order, install, remove, upgrade, replace, manage, and maintain equipment and software).

The primary method of allocation for Network & Telecommunication Services is Full-Time Equivalents (FTEs).

Desk Side Services ($28,424)

- Perform maintenance on desk side equipment and software as necessary.
- Order, build and deploy desk side equipment as requested by BCBSRI users.
- Provide break-fix field service to all BCBSRI equipment.
- Improve the efficiency and reliability of desk side equipment. This process shall include correction of all desk side equipment problems that require software and/or desk side maintenance, switching devices, and encryption/security devices.
- Recommend solutions and implement mutually agreed upon processes and procedures to optimize the overall infrastructure.
- Provide Help Desk services including: providing a single point of contact for reported problems, questions or requests. Provide first call problem resolution and route problems to the proper technical area.

The primary method of allocation for Desk Side Services is Full-Time Equivalents (FTEs).

Post Production ($119,488)

Hosting Fees for the Facets application are supported in this area. Also, support of corporate initiatives such as ICD-10, Behavioral Health Initiatives and EDR has created this placeholder.

Other Processing Fees ($97,430)

Other fees are included in the General Expense, Finance and Human Resources divisions related to the employee wellness and health, Payroll System and the hosting of the fraud and abuse application in the Special Investigative Unit.

Miscellaneous

Payments for out of area fees relating to Direct Pay claims account for $73,442 of the budget. These fees are paid to other Blue Cross and Blue Shield plans when BCBSRI members obtain covered services outside the State of Rhode Island. The fees enable BCBSRI to utilize the discounts negotiated by other plans.

Insurance license, employee education and fees and other miscellaneous items account for the remaining $111,140. These expenses are allocated to Direct Pay based on the department activities as noted in the salaries and wages narrative.

Change in Claims Handling

The estimated liability to process outstanding Direct Pay claims is expected to increase by $35,000 in 2012.

Radiology Vendor Fee

BCBSRI has contracted with a vendor (MedSolutions) to perform specific radiology

management services, which includes privileging (determining whether each radiology provider (both high-end and low-end) uses appropriate equipment and has the appropriate credentials to perform radiology services. In addition, MedSolutions obtains preauthorization for certain high-end radiology services (such as CT, MRI, Pet Scans and Nuclear Cardiology). The administrative expense for this service is $49,528.

Pharmacy Benefit Management Fee

Direct administrative cost ($13,908) pertaining to the outsourcing of drug claims processing by CVS.

Beacon MHSA

Blue Cross & Blue Shield of Rhode Island out sources the management of mental health and substance abuse through Beacon Health Strategies.

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 18, 2011

PRE-FILED DIRECT TESTIMONY OF
KIMBERLY CORMIER

Q. Please state your name for the record.

A. My name is Kimberly Cormier.

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 Manager of the Commercial Market; I am responsible for management of all commercial market segments, which includes the Direct Pay market segment. My responsibilities include: identifying market opportunities, evaluating concepts, and, ultimately, leading key projects and initiatives from concept through design, launch, and implementation. I work closely with market research, sales, clinical management, actuarial, underwriting, customer advisory groups, and external advisors and consultants to monitor external trends and become intimate with and anticipate customer segment needs, desires, and value perceptions.

Q. What was your role in this rate filing?

A. As I indicated, my responsibilities include management of the Direct Pay market segment. In this capacity, I am responsible for reviewing enrollment in our Direct Pay products, understanding opportunities in the marketplace, and recommending products that will meet the

needs of our current or prospective members. As a result, I oversaw the development of the new product included in this filing, the BlueValue Direct 2500 plan, as well as the benefit changes in our other direct pay products. I also directed the other program changes that are reflected in this filing, including the deductible reduction program. Communication materials relating to this filing, the benefit changes to our existing products and our new product will be prepared under my direction.

Q. Will Blue Cross be making changes to the current Direct Pay portfolio?

A. Yes, we have proposed benefit changes to all of the existing Direct Pay products and added one new product to the portfolio. In addition to benefit updates, several of the existing products are being renamed. These benefit changes, new product names, and the new BlueValue Direct 2500 product, are reflected in the contract forms that were filed with the Office of Health Insurance Commissioner contemporaneously with this filing. In addition, we are introducing a new program that will reduce the subscriber's deductible if the deductible is not satisfied within a given year.

Q. Lets start with the benefit changes being made to the existing Direct Pay products described in the pre-filed testimony of Jeffrey McLane. Why are these changes being made?

A. We have not made significant changes to our Direct Pay products since 2006. Changes to benefits are necessary in order to keep pace with industry standards and to address affordability.

When considering industry standards, we recognized that our products did not have consistent procedures. The changes we have proposed will ensure that similar products work in the same way. We believe these changes will make it is easier for members to understand how

their plans work when they transition from one Direct Pay product to another, or convert from a group plan to a Direct Pay plan. These changes include:

1. The deductible will be calculated in the same way for the VantageBlue and HealthMate Coast-to-Coast products. The changes include: no one family member is required to satisfy the individual deductible and no one family member will exceed the individual deductible. All family members work toward the family deductible. The deductible will now apply to the out-of-pocket maximum, and for all products the out-of-pocket maximum is three times the in-network deductible amount. Certain services, including surgery performed in a physician's office and laboratory testing as part of an annual examination, are not subject to deductible. The deductible will apply to all diagnostic radiology services (i.e. major diagnostic and nuclear medicine).

2. Changes are also being made to the BlueSolutions for HSA plans. On the BlueSolutions for HSA 3000/6000 plan, a coinsurance is being added which will apply once the in-network deductible is met, up to the in-network out-of-pocket maximum. The in-network out-of-pocket maximums are also being increased to be either two times the in-network deductible amount or the maximum out-of-pocket limit established by the Internal Revenue Service. The out-of-network deductible is being increased to two times the in-network deductible, and the out-of-network out-of-pocket maximum is being increased to three times the out-of-network deductible.

Q. How do the benefit changes help with affordability?

A. Increased cost-sharing (e.g. deductibles) is a way that we can mitigate premium increases. At the same time, we do recognize that increased deductibles are difficult for our subscribers to bear. That is why we are also introducing the deductible reduction program. It is

important to note that, during the deductible accumulation period, members benefit from our negotiated rates with providers. As a result, members are paying less than they would if they were to go without insurance.

In addition, we are including value based benefit programs in VantageBlue 1000/2000 and 1500/3000 plans. As you may recall, these programs incent members to comply with their medication regimen by reducing prescription copayments associated with asthma, diabetes and Chronic Obstructive Pulmonary Disease (COPD). The office visit copayment for annual foot and eye exams are also waived for members diagnosed with diabetes. Members also receive a financial reward for completing a Personal Health Assessment, and participating in a care coordination program.

In compliance with the Rhode Island General Law 27-18.5, Blue Cross also offers the HealthMate Coast-to-Coast Direct 2500/5000 plan. This plan is designated as a Wellness Health Benefit Plan and incents members to comply with specific voluntary wellness requirements such as selecting a primary care physician, signing a wellness pledge, and participation in a care coordination program if identified as someone who could benefit from the program. In return, subscribers are eligible to receive a wellness reward equal to 10% of their annual paid premium.

Q. You mentioned the new product, BlueValue Direct 2500, why is Blue Cross introducing this product?

A. This is an innovative plan design that is intended to provide an affordable health insurance option to uninsured individuals. While it is likely to be particularly attractive to young and healthy individuals because of the plan design, this affordable option is available to all Class DIR subscribers. The plan provides 100% coverage for preventive medical and dental services (beyond those required by the Patient Protection and Affordable Care Act or PPACA). This

plan features a $2500 deductible and $7500 out of pocket maximum (not including prescription drugs). It also provides limited office visits at a flat dollar copayment, subsequent office visits and hospitalization at 50%, and a $4 copayment for generic drugs. Subscribers are also eligible for a fitness center reimbursement program to promote member engagement, and incent individuals to live an active lifestyle. This plan is available on an individual basis only.

The Preferred (Pool II) premium for the BlueValue Direct 2500 plan for a male aged 25 to 29 years old is $113 per month, which is 51% less than our VantageBlue 1000/2000 plan and 11% less than our BlueSolutions for HSA 5000/10000 plan

Q. Earlier, you mentioned a deductible reduction program. What is this program and to which plans does it apply?

A. The deductible reduction program is similar to "vanishing deductibles" you may have heard about in auto insurance commercials. All Direct Pay subscribers will be eligible for this program, regardless of which product they are enrolled in, as long as they have been continuously enrolled for six months. This feature encourages members to remain insured and rewards them for maintaining health insurance. Eighty percent of our Class DIR members do not satisfy their deductible; therefore, the vast majority of Class DIR enrollees will qualify for the deductible reduction program.

If the individual or family does not meet the calendar year deductible under the plan in the first year, the deductible in the subsequent year is reduced. The deductible continues to be reduced each year so long as the individual or family does not meet the reduced deductible in any given calendar year until the deductible reaches 50% of the original amount. After the individual or family reaches 50%, that level of deductible is maintained as long as the reduced deductible *is not* met. If the reduced deductible is met in any calendar year, the deductible resets

to the original amount the following year. After reset, the individual or family can earn the deductible reduction again as long as coverage is maintained.

The subscriber also has the advantage of paying the lower premium associated with the plan design with the higher deductible even though his/her deductible has been reduced. Below is an example of how the deductible reduction program works:

Year	Percent Reduction	Example
Calendar Year 1	Original Deductible	$5,000
Calendar Year 2	20% Reduction	$4,000
Calendar Year 3	40% Reduction	$3,000
Calendar Year 4	50% Reduction	$2,500

Q. What is Blue Cross doing to ensure that the plan changes are communicated in plain language that is easy for Direct Pay subscribers to understand?

A. Blue Cross strives to create simple communications that are easily understood. We continually try to refine our communications to ensure that we are providing valuable information that is easy to understand. We do this by revising materials based on consumer feedback received through Sales and Customer Service. As part of our brand standards, our writing level is geared toward an eighth grade reading level. In addition to our marketing collateral being at an eighth grade level, and in compliance with Regulation 5 "The Standard for Readability of Health Insurance Forms," our subscriber agreements are written at an eighth grade reading level. Lastly, Blue Cross will be implementing the summary of benefits and coverage and the uniform glossary as required by PPACA. These documents are designed to help individuals better understand their health plan benefits.

Q. How will Blue Cross communicate the proposed changes to existing Direct Pay subscribers?

A. We will be engaging in a proactive communications strategy. As required by law, we will mail a letter including a notification of the rate increase along with a copy of the legal notice of hearing to all subscribers once the Office of the Health Insurance Commissioner has established a hearing date, time and place. Along with this letter, we will include ea description of the benefit changes that are effective as of April 2012, and will also tell the member what his/her plan will be if they do not take any action to select a different plan.

Timely approval of rates is critical to a smooth transition to the 2012 products. Once the Health Insurance Commissioner has approved our rate filing and subscriber agreements, we will mail a rate decision and information packet to all subscribers. This packet will include a brochure that outlines the coverage under each plan, a rate sheet with the final rates for each plan, a plan election form. The purpose of this mailing is to notify our members what plans and rates have been approved and provide them with instructions on how they can change their plan.

We will invite members to attend one of our four member education sessions, which will be held throughout the State. The goal of these sessions is to provide members with an overview of the changes Blue Cross is making and to give members an opportunity to ask questions about their plan options.

Customer service representatives will be specifically trained to answer telephone questions during this transition period. In addition, our healthcare information website (bcbsri.com/together) will be used to post 2012 enrollment related information. Details of the communications plan continue to be developed, and the plan will be monitored and modified, if necessary, as we move forward.

Q. Can you provide more detail about Blue Cross's communication and education regarding the benefit changes?

A. A series of communication efforts will occur such as:

- At least ten days prior to the hearing – notice of the rate hearing and opportunity to comment will be mailed. The mailing will include a copy of the legal notice regarding the hearing. The mailing will also include a description of the 2012 benefit changes;
- March, 2012 – rate decision letter with a description of the 2012 product options, new plan features, plan specific benefit changes, the changes being made to their plan, the product the subscriber will be transitioned to (unless he/she makes a change), and an election forms for the subscriber to use if he/she wants to purchase a different product.
- March, 2012 - Community educational meetings will be held.
- Website updates including, posting information to bcbsri.com/together and the direct pay pages of bcbsri.com.

Q. You mentioned community meetings that will be held for current subscribers to learn about their options and to ask questions. What information will be provided during those meetings?

A. Blue Cross will hold four community meetings throughout the State beginning March 2012. The meetings will include an overview of the following:

- 2012 Direct Pay products;
- Plan specific benefit changes;
- New deductible reduction program; and

- Review of how a member can change their plan, and the time line associated with making changes.

Q. How did Blue Cross decide which plan subscribers would be transitioned to?

A. As discussed above, all products have been renamed and benefit changes have been made to each plan design. Blue Cross is transitioning subscribers to the updated product that is most closely aligned to their current benefits as shown in the table below. Subscribers will have an opportunity to select a different plan.

Current Plan	Plan Effective April 1, 2012
HealthMate Direct 500	VantageBlue Direct 1000
HealthMate Direct 1000	VantageBlue Direct 1000
HealthMate Direct 2000	HealthMate Direct 2500
HealthMate for HSA 3000	BlueSolutions for HSA Direct 3000
HealthMate for HSA 5000	BlueSolutions for HSA Direct 5000

Q. How long will subscribers have to change their plan?

A. Subscribers will have 30 days from the point of notification to change their plan. If a subscriber chooses to elect a different plan, the newly elected plan would go into effect retroactive April 1, 2012.

Subscribers will also have the option to change plans during open enrollment (May 15th-June 15th for a July 1 effective date), upon their anniversary date, or by passing the Medical Underwriting process. Additionally, subscribers can downgrade (e.g. select a plan that has lesser benefits) their plan at any time by contacting Blue Cross.

Q. Can a subscriber change plans over the phone?

A. Subscribers may contact Customer Service for more information about the benefit changes and for assistance in selecting a plan that is best for them; however, subscribers will be required to submit a plan election form to change their plan.

Q. As you increase deductibles, what tools are available to members to understand the cost of services?

A. Blue Cross provides Direct Pay members with a member health statement, Blue View: Your Healthcare At-A-Glance™ ("BlueView"). BlueView gives members a consolidated view of their healthcare utilization, as well as healthcare tips and calls to action intended to inspire members to take actions that will improve their health. Key areas of the BlueView statement include: a value summary that shows members' savings by utilizing Blue Cross's network and negotiated rates, charts that visually indicate progress towards medical and out-of-pocket deductible maximums, detailed claims listings for medical, dental and pharmacy utilization (as applicable for that specific member), definitions of terms used in the BlueView statement, and both textual and graphical health tips that inform or direct the members on seasonal and current issues that impact that member's health.

In addition members can obtain claims information from the Claims Center on bcbsri.com and estimate pharmacy cost through the CVS Caremark Pharmacy Cost Estimator also accessible through bcbsri.com.

Q. Will Blue Cross apply deductible and/or out-of-pocket expenses incurred prior to March 31, 2012 to the deductible and/or out-of-pocket expense that will take effective April 1, 2012?

A. Yes. For all direct pay products, deductible and out-of-pocket maximums are calculated on a calendar year basis. Therefore, if a subscriber and/or dependent incurred claims

under their plan prior to March 31, 2012, claims that were applied toward the deductible and/or out-of-pocket maximum will carry forward toward the deductible and/or out-of-pocket maximum that will be effective April 1, 2012.

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 18, 2011

PRE-FILED DIRECT TESTIMONY OF AUGUSTINE MANOCCHIA, M.D.

Q. Please state your name, title and areas of responsibility.

A. My name is Augustine Manocchia, MD. I am Senior Vice President and Chief Medical Officer at Blue Cross & Blue Shield of Rhode Island (Blue Cross). I have oversight of the Provider Relations, Network Management, and Clinical Quality areas. In addition to direct oversight in these areas, I also have direct involvement in global corporate decisions through my involvement on the Executive Leadership Team. I report directly to the Chief Executive Officer.

Q. Please describe the Affordability Standards that have been adopted by the Office of the Health Insurance Commissioner (OHIC).

A. The OHIC established a set of affordability principles in 2009 with the input of the Health Insurance Advisory Council. These include:

- Expanding and improving the primary care infrastructure in the state – with limitations on ability to pass cost on in premiums;
- Spreading the adoption of the Chronic Care Model-Style Medical Home;
- Standardizing electronic medical record (EHR) incentives; and
- Working toward comprehensive payment reform across the delivery system.

Blue Cross actively supports each of the OHIC primary care spending principles. For its entire membership, and its Direct Pay population in particular, Blue Cross has established or adopted affordability initiatives that address each of these affordability standards.

Q. Please describe Blue Cross' efforts to expand and improve the primary care infrastructure in the state**.**

A. Certainly. The primary standard for meeting this priority is the agreement to increase the portion of Blue Cross's medical budget spent on primary care from 5.9% to 10.9% between 2010 and 2014. On a regular basis, my team meets with OHIC to review the steps Blue Cross is taking to achieve this goal. Additionally, as referenced in the Health Systems Improvement report, Blue Cross makes many charitable contributions to entities aimed at improving primary care in the state. These are detailed in Exhibit 3 to the rate filing.

Blue Cross recognizes the value of the primary care practice and is providing significant support to ensure financial stability and practice improvement. In fact, Blue Cross demonstrated its commitment to primary care long before OHIC required it in 2009. In 2011, Blue Cross expects to spend approximately $44.4 million on primary care for Rhode Island fully-insured commercial business. We expect that primary care spending will increase an additional $9.7M to $54.1 million in 2012. Approximately 7% of this primary care spend is attributable to Direct Pay.

This spending was, and will continue to be, allocated across various areas, with the overall goal being to see greater "value" in the care provided to our members. Examples of these initiatives include:

- **Patient Centered Medical Homes (PCMH):** Blue Cross remains committed to the PCMH concept, through both its involvement in the Chronic Care Sustainability Initiative (CSI-RI) program as well as the expansion of our own program beginning

in November 2009. In 2011, Blue Cross supported approximately 270 primary care providers in this model of care. Support will continue into 2012 with the addition of more than 50 physicians to the Blue Cross program.

- **Health Information Technology (HIT):** Blue Cross supports the adoption and proliferation of HIT within Rhode Island in a number of ways. Blue Cross supports overall improvement of HIT infrastructure in the state through support of public policy changes surrounding EHR, and through funding of existing EHR programs, namely the Rhode Island Quality Institute, the vendor overseeing three main HIT grants within the state: The Regional Extension Center, the Beacon Community program, and the Health Information Exchange.

Q. Please describe Blue Cross's efforts to spread adoption of the "chronic care model" medical home.

A. The standard for compliance with this affordability priority, as established by the OHIC, is for payers to jointly expand theCSI-RI program by an additional 20 physicians by June 2010 and to pay their proportionate share of the fees. Blue Cross has exceeded the requirements of this affordability priority by expanding its own PCMH program, which complements and strengthens the work performed by CSI-RI. In addition to its own program and CSI-RI, Blue Cross has taken an active role in the Beacon Community program, which also serves to strengthen PCMH adoption in the state.

Blue Cross continues to support the expansion of medical homes in Rhode Island through its involvement in the multi-payor CSI-RI, as well as the expansion of its own PCMH program throughout 2011. As discussed above, Blue Cross currently supports more than 270 providers

involved in both of these programs, with a commitment to expand the PCMH program and further support existing practices over the next few years.

Support of participating physician practices through the CSI-RI program involves funding for a nurse care manager and the care management activities associated with improved care coordination. The Blue Cross PCMH program offers those same supports, as well as additional infrastructure support. Specifically, Blue Cross offers added reimbursement for a "physician champion," focused on leading transformation within the practice, which ultimately results in better care coordination and more efficient care for our members. Blue Cross also offers reimbursement for project management, to address the significant process and workflow changes and improvements required in transformation. To ensure providers and their staff receive the necessary training required to achieve transformation, Blue Cross offers a stipend to each provider in the PCMH to cover lost productivity for time spent training. Another component of the Blue Cross PCMH program includes a pay-for-performance (P4P) program, which focuses on the achievement of clinical outcomes for Blue Cross members that are patients of the PCMH based on nationally-recognized standards. In an effort to streamline efforts across PCMH programs and mitigate the concerns of providers participating in programs (i.e. CSI-RI and Blue Cross's PCMH) Blue Cross's 2012 P4P measures will be harmonized with those in the CSI-RI and Beacon Community programs. This harmonization will limit the confusion and work effort required by PCMH practices participating in more than one program. It will also allow for better comparisons across programs.

As part of a long-term commitment to the PCMH model of care, Blue Cross recognizes that the most difficult challenge for practices is the transformation efforts involved in becoming a PCMH. As a result, Blue Cross partnered with TransforMED, a nationally recognized company

specializing in practice transformation, well known for their involvement in the National Medicare Demonstration Project on PCMH to assist with practice transformation in our PCMHs. TransforMED's role is twofold: first, to lead transformation efforts in our PCMH practices, and second, to train Blue Cross Provider Relations employees as practice coaches to sustain this function as Blue Cross continues to invest in and promote the adoption of PCMHs. This model for transformation has been recognized by PCMH thought leaders engaged in the CSI-RI and Beacon Community program as the most successful approach, As such, the Beacon Community program recently enlisted the support of TransforMED to engage in a similar approach whereby they will conduct facilitation of CSI-RI and other Beacon Community practices towards transformation. The transfer of knowledge to the Blue Cross PCMH Training and Support team was successful, with the team currently facilitating transformation in more than fifteen Blue Cross PCMH practices independent of TransforMED's direct oversight. Blue Cross has earned the credibility and trust of PCMH practices across the state. To further the benefit of its lessons learned, Blue Cross has shared its knowledge across programs. In particular, training programs hosted by Blue Cross have been opened to all PCMH program participants. These have included PCMH collaborative sessions focused on motivational interviewing and Nurse Care Manager (NCM) monthly collaborative conference calls, covering a number of topics.

Further demonstrating our support of the PCMH concept, Blue Cross plays an active role in CSI-RI and Rhode Island Quality Institute committees. Specifically, Blue Cross acts as a co-chair to the CSI-RI Training and Support Committee. Additionally, Blue Cross actively supports the CSI-RI Executive, Data and Evaluation, and Steering Committees through attendance and participation.

Finally, in an effort to differentiate PCMH providers, Blue Cross began offering a higher fee schedule for providers that are part of either the CSI-RI or Blue Cross PCMH programs effective December 1, 2010.

As discussed above, our PCMH program includes a P4P component focused on both process and outcome measures. These measures, for both the adult and pediatric population, are largely based on Healthcare Effectiveness Data and Information Set (HEDIS) metrics and other nationally accepted measures. Practices must self report their performance against these measures and targets through extracts from their EHR systems. 2011 adult program measures focus on diabetes, hypertension, tobacco assessment, fall risk assessment and BMI assessment. Measures focused on pediatrics include Body Mass Index (BMI), Chlamydia screening, and appropriate use of antibiotics. Although results against 2011 measures will not be compiled until March of 2012, the same measures in 2010 were achieved by nearly all PCMH practices reporting.

Q. What is Blue Cross doing to support adoption of EHRs and to standardize incentives for such adoption?

C. The standard for compliance with this affordability priority, as established by the OHIC, is to put in place at least one incentive that pays for a portion of the start-up and ongoing costs of certified EHR on or before January 1, 2010. Blue Cross has met or exceeded this standard through its continued support of the purchase, implementation, and optimal use of EHR in physician practices in Rhode Island. Many national studies over the last several years support the concept that widespread use of EHRs lead to improvements in quality of care and patient safety while at the same time reducing the overall cost of care.

The use of certified EHR solutions is critical to Blue Cross' PCMH and health management model, as the technology allows for data aggregation, process measurement, and outcomes-based quality reporting. As a result, to promote and facilitate transition to and implementation of EHRs, Blue Cross has provided the following supports for the adoption of EHRs that are certified by the Certification Commission for Healthcare Information Technology and/or Office of the National Coordinator (ONC) certification:

EHR Grant Program: In 2011, Blue Cross continued the EHR Grant program, providing funding for both new and existing users of certified EHRs. Providers can also use the funding for a pre-implementation EHR readiness assessment. Blue Cross recently launched a new version of the program targeted to the specific needs of Rhode Island community health centers. Since its inception, Blue Cross has approved funding for 47 providers. In 2011, $206, 323 in funding was disbursed to physician practices as part of this program, with an additional $103,000 to be paid pending successful adoption by providers engaged in the EHR Grant Program. In total, Blue Cross has approved funding for $572,959 Rhode Island based primary care and specialist physician practices since the program's inception in 2009.

2. Quality Counts: Our Quality Counts program was designed to incentivize Primary Care Physicians (PCPs) to purchase, implement, and optimize the use of EHRs in their practices. The 80 physicians who participated or are participating in the program have all completed the EHR implementation phase. Program activity in 2011 consisted of standardization of data entry, quality improvement processes to improve workflows, and reporting of clinical quality measures. Blue Cross has received baseline and remeasurement data on the process and outcome measures from the majority of physician practices enrolled in the program. The clinical

quality pay for performance component of the program led to the formation of quality improvement processes in the practices that can be continued into the future.

Through its EHR Grants and Quality Counts programs, Blue Cross has supported, in total, over 378 PCPs with their purchase and implementation of an EHR.

3. Rhode Island Quality Institute (RIQI): The RIQI is the designated Regional Health Information Organization (RHIO) for Rhode Island. As such, the RIQI is leading the development of current*care*, Rhode Island's Health Information Exchange (HIE). In February 2010, RIQI received federal funding to establish a Regional Extension Center (REC) for Health Information Technology and implement a Beacon Community to advance health care quality through health information technology in Rhode Island.

Blue Cross supports the work of the RIQI through strong executive level representation on several RIQI Committees. Our Chief Executive Officer, Peter Andruszkiewicz, is a member of the Board of Directors. Our Chief Operating Officer, William Wray, is a member of the Technical Solutions Group. I am a member of the HIT Physician Advisory Committee. Finally, in 2011, Blue Cross Provider Relations staff continued collaboration with the RIQI to encourage providers to enroll their patients in "current*care*."

We also support this group's activities financially, providing the largest annual contribution of any stakeholder. In 2011, we provided RIQI with $310,000. Through our financial support, RIQI was able to provide a $3 per member reimbursement directly to physicians. Blue Cross has also assisted RIQI in the enrollment of primary care providers into the REC. Recognizing the importance of enrollment into current*care* , Blue Cross's PCMH contract with providers includes a provision about the development of a plan to encourage enrollment of PCMH patients into the HIE.

4. Increased Fee Schedule for Primary Care Physicians (PCPs) using EHRs:

Blue Cross continues to provide an increased fee schedule for PCPs that have and utilize a qualified EHR in their office at a differential of approximately 12-13% overall. PCPs are required to complete an application regarding their EHR and frequency of use of various EHR functionalities to qualify for the higher fee schedule. There are currently over 416 PCPs that are receiving the higher EHR fee schedule. In accordance with CMS Meaningful Use standards, Blue Cross will be aligning its EHR fee schedule requirements with Stage 1 Meaningful Use effective July 1, 2012. Blue Cross will work with practices to assist them in this endeavor, through direct involvement – specifically in PCMH practices, as well as through coordinating efforts between practices and community resources, such as the REC.

Q. Please describe Blue Cross's efforts to implement payment reform across the delivery system.

A. The standard set by OHIC for compliance with this affordability priority is participation in conversations, when convened, on payment reform. Blue Cross is always willing to engage in dialogue on issues of public health policy in Rhode Island, and is committed to participate in the state-facilitated process to explain, assess, recommend, and adjust reforms regarding payment for health care services in Rhode Island. This commitment does not, of course, necessarily mean that Blue Cross will accept or implement every suggestion or recommendation, but does mean that Blue Cross will actively engage as a member of the stakeholder body to be convened and to promote a collaborative environment in which the deliberations will be held.

Moreover, as described throughout my testimony, Blue Cross has several programs in place to provide payment practices that promote cost-effective, appropriate, and quality care to

its members, while promoting the affordability priorities enunciated by the OHIC. These payment reforms include:

- Increased reimbursement fee schedule for PCPs;
- Increased reimbursement fee schedule for PCPs using EHR;
- CSI-RI pilot program supplemental payments;
- Expanding the PCP collaboration incentives; and
- Hospital quality programs.

Finally, Blue Cross actively collaborates with organizations across the state in an effort to promote quality care. Our Quality Management staff maintains liaisons with the Healthcentric Advisors (formerly Quality Partners of Rhode Island) for Collaboratives such as the Intensive Care Unit (ICU) Collaborative, and the Hospital Acquired Infections collaborative as well as with the Department of Health's (DOH) Hospital-Acquired Infections (HAI) and Prevention Advisory Subcommittee. This subcommittee includes Infection Preventionist and infection control staff members, and other health professionals. The goals are to discuss HAI work and make policy recommendations for pending and upcoming reports. We regularly review data on Central Line-Associated Bloodstream Infection (CLABSI), Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. difficile), and employee influenza vaccination rates, among others.

The ICU Collaborative has initiated the CLABSI program. This program, which was partially funded by Blue Cross, has gained wide-spread national recognition, and has improved the quality of care provided in Rhode Island hospitals. Results show significant reduction in 83% in bloodstream infections alone. This collaborative is also addressing Ventilator Associated

Pneumonia and Palliative Care in the ICU setting. Reducing infection rates plays a significant role in controlling the rising cost of health care.

Q. What steps is Blue Cross taking to improve the transparency of data relating to efficiency and quality performance of participating providers?

A. In order for physicians to be able to make well informed decisions around referral to the most efficient specialists and hospitals, it is necessary that they have the appropriate data on the referral network. Physicians, particularly those in our PCMH practices, have been asking for data on both their performance and that of the physicians and specialists to whom they refer. To date, the accuracy and utility of the limited data available has been suspect. Blue Cross is concentrated on capturing this information correctly and offering more transparency in the marketplace. Over the next few months, Blue Cross will be working with specialty providers on establishing metrics to measure success, relying heavily on nationally accepted standards whenever possible. Once this information is compiled, Blue Cross will share this information, first with PCMH practices, to aid in the referral patterns of these practices. Eventually, the ideal state will include sharing of this information with Blue Cross members to foster an environment of informed decision making in choosing a provider.

Q. When do you expect this information to be available to providers and members?

A. It is critical first to ensure that physicians support the program. We are just beginning this process and not yet ready to specify a date by which this information will be available.

Q. What steps has Blue Cross taken to improve the quality of care in Rhode Island hospitals?

A. Blue Cross continues to stress quality and efficiency improvement through our hospital contracts. Blue Cross's standard hospital quality / performance improvement program is

built around national / industry accepted standards and increasing provider accountability. These efforts have resulted in a higher proportion of funding committed to hospital quality and performance improvement initiatives. The hospital contracts will formalize the quality program's objectives, structure and process in order to advance performance in such areas as effective / efficient care management and transition / coordination of care back to the primary care. Additionally, the hospital contracts have established a framework to engage hospitals in a rigorous dialogue to identify opportunities that promote administrative and operational efficiencies. Our hospital contracts will continue to reflect Blue Cross's commitment to address performance improvement through this continually evolving and dynamic process with emphasis on incorporating best practices and raising the bar.

The Blue Cross Hospital Quality Program helps to improve the delivery of care and services to our members and, with better outcomes and care transitions, costs should stabilize. The program was established to accomplish the following objectives:

- Engage in meaningful evidenced-based performance improvement initiatives, the outcomes of which positively impact the patient's health status and/or the patient experience. Examples of these initiatives include Get with the Guidelines Recognition for Stroke, and the National Surgical Quality Improvement Program (NSQIP).
- Improve safety and reduce reasonably preventable events or near events such as medication error reporting, falls, pressure ulcers, and hospital acquired infection rates.
- Improve care coordination across settings of care and eliminate preventable readmissions, specifically, safe transitions measures.

- Compare favorably in performance to national benchmark data. Examples are the Core Measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Press-Ganey member satisfaction, and the HBIP (Inpatient Psychiatric Core measures).
- Endorse professional accountability by integrating referring professional and attending staff into the quality program, and identifying and pursuing opportunities for improvement. Examples are the pre-qualifying conditions such as requirements for public report performance on all applicable quality indicators for publication on the CMS Hospital Compare website, and submitting details on their overall Quality Management Program and structure.
- Participate in regional/national collaboratives such as the ICU Collaborative. The results of the ICU collaborative were:
    - The Statewide aggregate mean for percent of change in BSI (Blood Stream Infections) from 2006 to 2010 is a 53% reduction in infections/100 line days. (Median aggregate was 83.82% reduction).
    - For VAP (Ventilator Associated Pneumonia), the Statewide Aggregate Mean improved by 21%.
    - The VAP bundle composite Statewide Aggregate Mean improved by 41%.
    - The Communication Bundle (Palliative Care), Day 1 composite score percent change from baseline (Q2 of 2010, to Q4) showed 209% improvement; and Day 3 composite, a 362% improvement.

- Mitigate rising healthcare costs by improving processes of care and addressing organizational inefficiencies. Examples include the Computerized Physician Order Entry (CPOE) measures, and cesarean section rates.

Q. Has Blue Cross included the Safe Transitions of Care program in its hospital quality program?

A. Yes, most of our hospital contracts have included the Safe Transitions of Care program. This program focuses on discharge care processes from the hospital to other care settings, promotes community collaboration and cross-setting communication, and aims to improve patients' transition experiences, self-management skills and outcomes. Hospitals are reporting their progress on each element of the program, and we monitor their progress towards established goals. Currently, we are providing incentives for the tracking and trending of the measures, and have assisted in the development of pilot programs for certain measures (in particular the measure pertaining to scheduling post-hospitalization PCP appointments). Also included in the Safe Transitions of Care program is the medication reconciliation measure to verify that a patient is prescribed appropriate medications upon discharge.

Q. Has Blue Cross adopted any other hospital quality programs?

A. Yes. In October of 2010, Blue Cross launched a Transitions of Care (TOC) initiative. The goal of the TOC initiative is to decrease the readmission rate for our members with certain targeted diagnoses which are known to have high readmission rates. Blue Cross nurses visit members face to face in Rhode Island Hospital and Miriam Hospital to engage them and enroll them into our Care Coordination program. Miriam Hospital supports TOC by making follow-up physician appointments for members transitioning home from the hospital.

Face to face visits with members in the hospital have resulted in a higher than average enrollment of members in our Care Coordination program. With the members' consent to participate in the program we follow them closely for a 30 day period to ensure that they have a follow up visit with their provider, that they fill, understand and take their medications appropriately and that any necessary services are in place. One of our nurses may also visit the member's home if appropriate. Frequent telephone contacts are made to ensure that members understand their condition and early signs and symptoms of trouble that should be reported to their provider**.**

Q. In 2010 and again in 2011, the OHIC imposed certain hospital contracting requirements on Blue Cross and other insurers. Is Blue Cross in compliance with those requirements?

A. Yes. The OHIC has required that each carrier in the group health insurance market in Rhode Island adopt certain standards for hospital contracts that have expired since July 2010. The standards require that carriers move away from fee-for-service reimbursement toward a payment methodology that provides incentives for efficiency such as global payments, diagnosis related groupings, and/or ambulatory payment classifications. In addition, these standards include a limitation on the annual base increase tied to the Medicare price index, mandatory quality based incentives of at least 2%, and action by the parties to identify administrative efficiencies. Finally, the standards require contract terms that promote and measure improved clinical communication between hospitals and PCPs, specialists, and long term care facilities. Based on the contract cycles Blue Cross has with various hospitals in Rhode Island, two hospital contracts and hospital contracts with the hospitals comprising one of the systems in Rhode Island are currently in compliance with these standards.

Q. You stated that this is a requirement for carriers in the group market. Does Class DIR benefit from these requirements?

A. Yes. We enter into a single contract with each hospital for all of our commercial business. As a result, Direct Pay members will benefit from our implementation of these hospital contracting standards.

Q. What steps is Blue Cross taking to address the increasing trend in overall medical expenditures?

A. Blue Cross formulated the Medical Expense Trend (MET) team in November of 2009 with the goal of improving quality and affordability for our customers and members. The team has worked diligently over the course of two years to identify areas of opportunity to impact quality and affordability and has implemented a variety of measures that have proven successful in bending the medical expense trend.

The MET meets bimonthly and is comprised of cross-functional leaders within the organization, including representatives from Care Management, Corporate Communications, Government Programs, Sales/Product Marketing, Continuous Improvement, Finance and Provider Network Management. All initiatives undertaken by the MET follow the corporately established Project Development Life Cycle (PDLC) process, ensuring that all efforts include robust internal and external stakeholder analyses, Return on Investment (ROI) and Cost Benefit Analysis (CBA) documentation, project plans and ongoing reporting mechanisms to track results to expected benefits. This commitment to the PDLC process has resulted in improved execution, which has enabled the MET to exceed its goals for both 2010 and 2011 and positioned the committee for continued success in 2012.

In total, the MET has identified savings of approximately $100 million since its inception.

Blue Cross also continues to monitor health care costs through various utilization review activities. Examples include our Radiology Management and Specialty Pharmacy programs, as well as the Premier formulary, which was implemented and reported on in my testimony in 2010.

Q. What is the "Premier" formulary?

A. In November 2010, Blue Cross implemented a new formulary which applies to all of our fully insured members. The premier formulary helps our members get the most value from their health plan, while still providing the highest quality coverage. Blue Cross developed the Premier formulary to encourage the use of medically accepted, cost-effective drugs. Some drugs are excluded from the formulary because alternatives are available. Alternatives may be generic equivalents, alternative prescription drugs, or over-the-counter drugs that offer the same effectiveness and safety as the excluded drug.

The major changes as a result of the Premier formulary were:

- Tier Changes – Blue Cross continues to use a tiered formulary. However, the second tier now includes select high cost generics, previously considered Tier 1 drugs. These Tier 2 generics are generally new to market, have little competition in the market, and as a result are priced comparably to their brand equivalents.

- Value Driven Drug Alternatives - Under the Premier formulary, we have excluded drugs that have viable generic equivalents and/or over-the-counter alternatives from our formulary. These drugs are just as effective as brand name drugs, without the cost. Examples of such drugs include all brand name non-sedating

antihistamines, brand name antihyperlipidemics, brand name dermatological acne and certain Rosacea products, and most sedative hypnotics.

- Ensuring Appropriate Drug Utilization - Prior authorization is the process used to promote the most clinically appropriate, and cost effective therapy. The goal of prior authorization is to make physicians more aware of lower cost alternatives. Authorization also helps counter the consumer response to prescription drug advertisements. These ads may convince members they need a specific medication, even if it is not appropriate or necessary for their condition. It also helps ensure members receive the right drugs for the right conditions.

Effective April 1, 2011, a medical exception process was institituted for the rare cases when a member is taking an excluded drug for which no generic is available and his or her doctor determines that other drugs are not effective. This medical exception process ensures that members have access to the medications that meet their unique needs, while still helping to make healthcare coverage more affordable for all our members.

It is estimated that the implementation of the Premier formulary will result in savings of $14.7Min 2011.

Q. How does Blue Cross actively work to improve health outcomes of those members not being cared for in a PCMH?

A. Blue Cross recognizes that care interventions are most successful when rendered directly in a patient's PCMH practice. However, given the fact that many of our members are not seeing a PCP in a PCMH, Blue Cross has a team of care coordinators focused on working

collaboratively with these members to improve health outcomes, while also eliminating unnecessary costs through improved coordination of care. This team of care coordinators involves the member's physician, whenever possible, to ensure consistency of messaging by both Blue Cross and the provider office. Similar to the PCMH model, Blue Cross Care Coordinators focus their outreach efforts to those individuals with the most complex health care needs. For example, Blue Cross strives to decrease medical costs by identifying members with complex conditions, such as cancer and diabetes with multiple co-morbidities for our case management team to reach out and assist members to coordinate care with multiple physicians and providers and make lifestyle changes that improve health.

Blue Cross stratifies its population into different severity categories, placing particular emphasis on members with chronic conditions such as diabetes and coronary artery disease. These members are further stratified with those members with the highest likelihood to affect change rising to the top for targeted outreach. Care coordinators outreach to these members, via telephone, in an effort to engage them in the care coordination effort. Members work with the care coordinator to develop an action plan with member focused goals. Examples of such goals may include enrollment in a smoking cessation program for a member identified as a smoker. To date, approximately 6,200 members have enrolled in the program with 2,964 engaged. Engaged means these members are actively taking steps to improve their health and have completed a defined set of healthcare goals. Working with members to improve their health and coordinate care has yielded significant results. Members who have engaged in the program are 90% - 98% successful at completing an action item that leads to lifestyle changes. In addition, we have observed that members who are engaged have reduced gaps in care as follows:

- 50% of Blue Cross engaged Diabetics are seeing an improvement in the HbA1c level

- 60% of Blue Cross engaged Diabetics are seeing an improvement in the LDL-C level
- 54% of engaged members had a reduction in emergency room use
- 50% of engaged members had a reduction in inpatient utilization

To date, 98 direct pay members are engaged in care coordination.

There are other activities inherent in care coordination that are leading to improved outcomes. Often transitions in care settings constitute a potential hazard for members, particularly in regard to transfer of the correct medication regimen and the follow-up after hospitalization. Blue Cross care managers focus on two important aspects during these transitional periods and are vigilant about ensuring members are taking the correct medications. These two activities have been proven to decrease medical costs by decreasing readmissions to the hospital, of which medication adverse events and errors in taking medications as well as inadequate follow-up are significant contributors for admission and readmission to the hospital. To that end, care coordinators conduct medication reconciliation at each telephonic health assessment 95% of the time and reconcile the medication list with providers 54% of the time. Moreover, we have introduced a pharmacist to the care team to support these activities and identify poly pharmacy issues (i.e., issues resulting from patients taking multiple medications, that may be contraindicated).

In another attempt to improve our members' health and moderate medical expenses, Blue Cross has committed resources to reduce obesity. As a result of our intervention strategies aimed at improving physician data collection of BMI, we have seen a 12% improvement for adults and a 15% improvement for children in the past year. Our interventions have included several physician targeted education strategies and strong support of the use of EHRs for data collection of BMI. This serves to engage physicians and members in a discussion of weight reduction

strategies as evidenced by approximately 10.5% and 12% improvements in physician counseling for children's nutrition and physical activity, respectively.

Q. How does Blue Cross support the use of evidence based medicine, both internally and in provider practices?

A. Blue Cross supports the use of evidence based medicine through:

- HEDIS Metrics to measure our health management Quality Counts Program,
- Monitoring of provider performance using evidenced based medicine condition management rules
- Disease Management Programming
- Development and measurement of our PCMH P4P program
- Collaborating with other programs to promote evidence based medicine

Quality Improvement Activities (QIA) aimed at improving HEDIS results, directly support evidence based care. HEDIS clinical measures are derived from evidence based practice. The QIA process establishes baseline results for targeted measures, and identifies barriers and implements interventions aimed at supporting the improvement of the clinical practice or outcome, as defined by the evidence based practice.

Blue Cross has multiple QIA activities running concurrently. An example of the application and dissemination of evidence based medicine through the QIA process is demonstrated in the HEDIS Adult BMI Assessment measure and weight assessment and counseling for nutrition and physical activity for children/adolescents. The dissemination of information and tools to activate providers to collect BMI and to counsel children and adolescents regarding weight, nutrition and physical activity have resulted in statistically significant improvements in these metrics, as mentioned previously. It also demonstrates the

dissemination of action-oriented evidence based guidelines to providers.

Blue Cross also conducts studies on targeted clinical populations for aspects of care that support evidence based practices. Some examples include:

- Measurement of consistency between Diagnostic and Statistical Manual (DSM) IV diagnosis and behavioral treatment plan
- Measurement of care coordination between behavioral health provider and primary care provider
- Measurement of coordination of care between specialists and primary care providers (e.g. members with diabetes who receive ophthalmology services and communication of results from opthalmologist to primary care provider).

For each study, results are shared with providers along with guidance for improvement.

Another way Blue Cross supports use of evidence based care has been through our Quality Counts Program. This program provided funding for physician practices to purchase, and implement their EHRs, and included a component for P4P. This P4P component provided incentives for measuring their practice in relation to evidence-based quality processes or outcomes of care. Providers who participated in the Quality Counts Program demonstrated a median rate of improvement of 24% on several important primary care measures; the median rate of improvement for measures related to women's care was 35%; the median rate of improvement for family practice and pediatric practices was 44%. Moreover, several measures actually exceeded the goals established for this program. These measures are all evidence based care measures and this program provided the tools to activate providers to measure and improve. Many of the Quality Counts practices have now transitioned into our PCMH program and are continuing to engage in quality improvement activities through that initiative.

Q. Does Blue Cross continue to have a Disease Management Program?

A. Yes. Blue Cross's Disease Management Programs provide a vehicle for dissemination of evidence based medicine for Primary Prevention and several chronic conditions such as Coronary Artery Disease, Congestive Heart Disease, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Diabetes and Behavioral Health. The guiding principles and basis for all of these programs are nationally accepted practice guidelines and each program is measured with key clinical quality measures (HEDIS) and resource use measures (Inpatient and Emergency Room events).

Primary prevention activities such as cancer screening (colorectal cancer, cervical cancer, and breast cancer) reminders, and immunization reminders are sent via Automated Televox calls. These reminder calls close gaps in care by increasing screening of our members. Blue Cross members have experienced an improvement of adherence to recommended testing by 7-10% for cancer screenings and 22-24% for select adolescent immunization reminders.

Examples of significant improvements our members have experienced over the last year through the efforts of our Disease Management program are outlined below:

- LDL cholesterol less than 100 has demonstrated a 22% improvement over the past two measurement years.
- Controlling high blood pressure demonstrated a 5% improvement from 2009 to 2010.
- Members with Chronic Obstructive Pulmonary Disease (COPD) have experienced an increase in spirometry testing to identify members earlier in the disease process and avoid advancement of this chronic condition.
- Fifty percent of members with hyperlipidemia and heart disease or diabetes with gaps in care for refill of a statin prescription have closed this gap as a result of a member reminder program.

- Thirty-five percent of our members with diabetes who had HbA1C and LDL out of control brought their LDL and HbA1C levels into control as a result of our diabetes program.
- Members with diabetes who had gaps in care for important screening tests had a 9% improvement subsequent to the multilevel intervention strategy to close those gaps.
- In the measurement year 2011 (data year 2010), the plan has also seen a 7% improvement in the timeliness of prenatal and postpartum care which can be attributed to the Blue Cross Little Steps Maternity program.
- A 4% improvement was seen across all measured age groups for the use of appropriate medications for members with asthma.

Q. Does Blue Cross provide support for members with behavioral health diagnoses?

A. Yes. Blue Cross Behavioral Health Specialists reach out to members who have just been discharged from a mental health hospitalization to ensure that they receive the proper follow up care. HEDIS scores have significantly improved for this measure as seen below.

- Behavioral Health follow-up values: Members who have a follow-up after hospitalization for mental illness appointment for 7 days and 30 days upon discharge. Results on the Behavioral Health measures show a combined increase of 16%
- 7 day follow up saw an improvement of 9% while the 30 day follow up measure increased by 6% resulting in the above stated combined score of 16%.

Furthering the support of behavioral health, Blue Cross also supports the collocation of a Behavioral Health provider in 8 of its PCMH practices. This provider complements the care team in the PCMH by helping manage the behavior change needs of the PCMH patient population. By having the Behavioral Health provider on site, primary care providers within the practice become

more attuned to when it is appropriate to refer members to a Behavioral Health provider and patients benefit by having the behavioral health provider more readily available.

Additionally, Blue Cross has collaborated with the Rhode Island Hospital (RIH) Psychiatry Department and Gateway Healthcare to create access to available open psychiatric consultation appointments for adult patients. Open slot appointments are available every weekday on a first come first serve basis. Next-day appointments may be available, and every effort is made to facilitate appointments on a timely basis if a next-day appointment is not available. These appointments are available at the RIH campus in Providence.

These open slot appointments are available to Blue Cross members who may be experiencing a psychiatric crisis or may be in need of a consultation for medication management and stabilization that are not able to be managed in a PCMH office. Following the psychiatric consultation, recommendations from the RIH psychiatrist are made available to the referring provider for ongoing follow-up and treatment. This program also allows for a Gateway Healthcare case management evaluation of the patient's needs and limited coordination related to the follow-up plan.

Q. Does Blue Cross provide any programs for members suffering from catastrophic health care events?

A. Care Coordinators work with members who may require catastrophic care. Some examples of a catastrophic event may be:

- a brain or spinal cord injury,
- cerebral infarction, or
- significant birth defect.

Catastrophic conditions often require close monitoring and coordination of multiple services. Care Coordinators assist with identifying available community resources, and provide support to members and their families. For example, a care coordinator was involved with a Neonatal Intensive Care Unit (NICU) member who needed coordination of a pre-service review for Synergis prior to discharge. The discharge planner at the hospital enlisted the services of the NICU nurse to facilitate pre-service authorization of Synergis and other important equipment necessary for a timely and safe discharge home.

Q. Does Blue Cross provide other education to its members?

A. Yes. Blue Cross has contracted with Healthwise, a member health education materials company, to help inform and educate our members about his/her health concerns. Healthwise materials are composed by a team of physicians, nurses, medical writers and researchers who work with top medical specialists from key centers of excellence, referenced to reliable evidence sources, regularly updated as new research is reported and are accredited by the URAC Health Website Accreditation Program. To offer consistency across our member population, PCMH practices have access to these materials and provide them to their patients readily, either by the NCM or provider treating the patient. Blue Cross disseminates health information to our members using various communication channels such as the BCBSRI.com web site, interactive voice recordings (Televox, as described above), one-on one telephonic interactions and print materials.

Quality Management staff also disseminates information through its quality management activities that focus on improving awareness of tools available to assist members to improve health. One example of this is our focus on improving the measurement of BMI. To achieve this goal, a kit ("The Good Health Club Kit") is distributed to physicians, which includes social

media such as posters for the physician's office, pamphlets and tools such as discussion guides and BMI charts for boys and girls. Physicians are encouraged to use these guides and tools to increase awareness of the importance of maintaining or achieving a normal BMI in children.

Additionally, launched July 2010, My Blue Community is a safe, secure online forum where Blue Cross members can interact with other Blue Cross members, support each other on their health journeys, learn about the healthcare industry, and find resources and information on a variety of health topics.

In addition to connecting more than 30,000 healthy-minded individuals who are eager to share experiences and offer support, the site also offers message boards, member posts, and member-generated discussions. Today, there are more than 50,000 health-focused discussions under way. Members talk about a range of topics on My Blue Community – from diet and exercise to other everyday wellness tips.

In 2011, MyBlueCommunity has received over 3,000 Rhode Island visitors to the site.

Q. How does Blue Cross measure the performance of its programs and make appropriate changes based on this evaluation?

A. Blue Cross has a rigorous project management process, which actively monitors the progress for each project as well as its performance against defined goals, milestones, and budget. Deviation from these goals, milestones and budget must be justified to multidisciplinary governing bodies within the company. In some instances, such deviations result in a modification to how a project will be executed. An example of such a modification occurred with our care coordination program. As a result of engagement rates being lower than expected, we piloted alternative methods of engagement including partnering with external agencies, (e.g., home health agencies) as well as placing a Blue Cross care coordinator within a PCP office.

Blue Cross also actively looks at ways to improve efficiencies with how we interact with PCMH practices. As an example, at the onset of our program, Blue Cross allowed for a reconciliation of members considered 'complex' by the PCMH practice each quarter, This required a back and forth exchange of data between Blue Cross and each PCMH practice, as well as significant time spent reconciling the addition and deletion of 'complex' members. Blue Cross then decided that this reconciliation process was not achieving the benefit intended, but rather caused an onerous process for both the PCMH practice and Blue Cross. Blue Cross modified its process to simply provide a total listing of members to each PCMH practice each quarter and designate each member's health status. This modification was seen as a welcome change by both practices and internal departments at Blue Cross.

Q. Are all of the initiatives and programs you've described available to Direct Pay members?

A. Yes.

Q. You've described a comprehensive program to comply with OHIC's affordability standards as well as Blue Cross's own initiatives. Can you describe Blue Cross's reasoning for taking these steps?

A. Blue Cross has taken these steps in order to improve the quality of care our members and all Rhode Islanders receive with the ultimate goal of improving the affordability of health insurance. As the largest health insurer in Rhode Island, we understand that we have a unique opportunity to drive change and that we have a responsibility to take these actions.

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Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
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TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: A&H Experience
Bypass Reason: Filing letter and exhibits attached
Comments:

Item Status: **Status Date:**

Bypassed - Item: Actuarial Certification - Life & A&H
Bypass Reason: Filing letter and exhibits attached
Comments:

Item Status: **Status Date:**

Bypassed - Item: Actuarial Memorandum - A&H Rate Revision Filing
Bypass Reason: Filing letter and exhibits attached
Comments:

Item Status: **Status Date:**

Bypassed - Item: Health Insurance Checklist
Bypass Reason: Filing letter and exhibits attached
Comments:

Item Status: **Status Date:**

Bypassed - Item: Premium Rate Sheets - Life & A&H
Bypass Reason: Filing letter and exhibits attached
Comments:

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Filing Company:	*Blue Cross & Blue Shield of Rhode Island*	*State Tracking Number:*	
Company Tracking Number:	*DP 4-1-2012*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*Direct Pay*		
Project Name/Number:	*Direct Pay 2011 Filing/DP 11-18-11*		

Item Status: **Status Date:**

Bypassed - Item: Rate Summary Worksheet
Bypass Reason: Filing letter and exhibits attached
Comments:

Item Status: **Status Date:**

Bypassed - Item: Consumer Disclosure Form
Bypass Reason: Filing letter and exhibits attached
Comments: