STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIC AVENUE, BUILDING 69-1
CRANSTON, RHODE ISLAND 02920

***In re*: Blue Cross & Blue Shield of R.I. RH-2012-01**
Class Direct Rates
(Filed November 18, 2011-0)

DECISION

Findings of Fact

Based upon consideration of the entire record of testimony and exhibits introduced into evidence in these proceedings, the undersigned Hearing Officer finds as fact as follows:

1. On November 18, 2011 Blue Cross and Blue Shield of Rhode Island ("Blue Cross") filed with the Office of the Health Insurance Commissioner ("OHIC") a request for approval of an average increase of 4.5% in its premium rates for the Direct Pay line of products, to be effective for the period of April 1, 2012 to December 31, 2013.

2. The Commissioner assumed jurisdiction of the request pursuant to R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13.

3. The proceedings were conducted in accordance with R.I. Gen. Laws Title 42, Chapter 35, the R.I. Administrative Procedures Act.

4. On November 23, 2011 the Commissioner appointed the undersigned as Hearing Officer, in accordance with R. I. Gen. Laws §§ 27-19-6(d), 27-20-6(d), and 42-62-13(b).

5. Appearances were entered on behalf of Blue Cross by Normand G. Benoit, Esq., and on behalf of the R.I. Attorney General ("Attorney General") by Genevieve Martin, Assistant Attorney General and Eric Batista, Assistant Attorney General.

6. The Department of Business Regulation ("DBR"), moved to intervene in these proceedings in order to fulfill DBR's responsibility under R. I. Gen. Laws § 42-14.5-1 to provide OHIC with reasonable access to appropriate professional staff, and specifically to permit the analysis and testimony of OHIC's contracted actuary to be entered into the record of these proceedings and considered by the Commissioner. The other parties did not object to DBR's intervention, and by Pre-Hearing Order dated December 15, 2011, the Hearing Officer granted DBR's Motion to Intervene.

7. The Pre-Hearing Order, issued in accordance with Central Management Regulation 2, "Rules of Procedure for Administrative Hearings", Section 6 (adopted by OHIC pursuant to OHIC Regulation 1), set forth procedures and time-lines for conducting discovery, the publication of notice, the submission of pre-filed testimony and exhibits, service on parties, and the time and place of the hearing.

8. On December 29, 2011 a Protective Order was issued by the Hearing Officer, with the agreement of the parties, in connection with Blue Cross' pharmacy benefit manager contract.

9. Pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6, notice of the filing and the hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, on January 4, 2011.

10. The parties filed pre-filed testimony and exhibits on January 9, 2012, and supplemental pre-filed testimony and revised exhibits during the week of January 9, 2012.

11. Public hearings were held on January 17, 2012 and January 19, 2012. Public comments were entered into the record on both hearing dates, as were written public comments submitted to OHIC's website. Public comments are an important element of OHIC's rate

proceeding, and are carefully considered by the Hearing Officer in issuing his Recommended Decision. Members of the public who make comments are not placed under oath, however; therefore their comments, while valuable, cannot be considered as evidence under the law.

Public Comment

Approximately 86 Rhode Island residents, individuals and sole proprietor businesses, filed comments with OHIC concerning Blue Cross' proposed rate increase. All comments were in opposition to the proposed rate increase. In summary, the members of the public commented on the rate filing as follows:

- Both existing and proposed premiums are unaffordable for subscribers.
- Increased deductibles, and especially the new 20% co-insurance cost sharing requirements, make Direct Pay products unaffordable even after the premium has been paid.
- The proposed premiums are especially onerous during these economic times, in which the Rhode Island economy is especially poor.
- Premium increases greatly exceed inflation in general, wage increases, and the ability of small businesses to increase prices to keep up with the cost of health care coverage.
- Even with the AccessBlue program, Blue Cross Direct Pay premiums are unaffordable for the unemployed, and those with low incomes.
- Blue Cross should be doing more to reduce medical costs as it asks Direct Pay subscribers to pay more for health care coverage.

- Blue Cross has not done enough to reduce its administrative costs, and should become more efficient. Individual commenters cited high employee salaries and benefits, high executive compensation, the cost of Blue Cross' new building, and excessive reserves.
- Several commenters stated that premiums for different categories of subscribers are not established in an equitable manner. Subscribers in older age brackets should not have double digit premium increases, while younger subscribers have double-digit premium reductions.
- There should be health insurance company competition in the Direct Pay market, so that subscribers have more and better choices for products than what is offered by Blue Cross.

12. Upon the conclusion of public hearings, the parties filed proposed findings of fact, conclusions of law, and other argument. The Hearing Officer made a report of his findings to the Commissioner within 80 days from the filing of the rate request.

The Blue Cross Filing and Rate Request

13. There are several noteworthy facts and circumstances in evidence with respect to the Blue Cross rate filing. First, the rate request is proposed for an 18 month period, rather than the usual 12 month period. This change reflects the transition to new programs and requirements which will occur when the federal Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act") becomes effective on January 1, 2014. For example, current Direct Pay subscribers will be offered coverage through a new Rhode Island Health Insurance Exchange, and Exchange subscribers will be eligible for income-sensitive, federal subsidies in an effort to make access to health insurance affordable, notwithstanding the subscriber's income. Also, rates must be

effective for a calendar year, necessitating a change from the current 12 month Direct Pay cycle beginning April 1.

14. A second significant set of circumstances in evidence in the Blue Cross filing is that it assumes a comprehensive change in products offered to Direct Pay subscribers. The new products will increase deductible and out of pocket requirements for five out of the six products. The sixth product (BlueValue Direct 2500) is intended to be offered to individuals only, not to families, and is designed to attract younger subscribers with fewer anticipated medical expenses. Blue Cross plans to discontinue offering current products. In the absence of an express subscriber choice, Blue Cross has described in its filing how subscribers will be transfer to new products that Blue Cross believes most closely fit the subscriber's current product.

15. Blue Cross is proposing to require subscribers to pay, after their deductible has been met, a co-insurance amount of 20% for four products (VantageBlue Direct 1000,2000, VantageBlue direct 1500/3000, HealthMate Coast-to-Coast Direct 2500/5000, and BlueSolutions for HSA Direct 3000/6000), and 50% for a fifth product (BlueValue Direct 2500). The sixth product, BlueSolutions for HSA Direct 5000/10000 does not have a coinsurance requirement, but this is clearly a high deductible product with benefit design features and the financial attributes of a tax-sheltered Health Savings Account.

16. The benefit value of the new products with revised benefit designs is 92.8% of the value of the current products in Pool 1, and 92.3% of the value of the current products in Pool 2. In other words, Blue Cross expects to pay 7 to 8% less in subscriber claims payments as a result of the lower benefit value of the new products, and as a result of lower utilization expected from the higher cost sharing, lower benefit products than Blue Cross would expect to pay if the current

products were continued to be offered. According to Blue Cross' calculations, if the current products were continued to be offered, an average rate increase of 12.5% would be needed to support subscriber claims payments for the current products.

17. Another way to consider the effect on subscribers of the new products proposed by Blue Cross is to consider the "actuarial value" of the new products. When Direct Pay subscribers receive coverage through health insurance policies offered by the Exchange after January 1, 2014, in accordance with the Affordable Care Act, carriers must disclose to subscribers the "actuarial value" of the policies, meaning the percentage of the total cost of care that will be paid for by the carrier (after enrollment and payment of the premium by subscribers), as opposed to being paid for out of pocket by subscribers in the form of cost sharing, such as co-payments, deductibles, and coinsurance payments. A policy with a "Gold" designation means that the policy has an actuarial value of 80%; i.e. the carrier will pay, overall, 80% of the health costs of all of the subscribers who have purchased that product; subscribers of a Gold product will pay the remaining 20% of the aggregate costs of their health care through cost sharing requirements. "Bronze" means an actuarial value of 60%; "Silver" means an actuarial value of 70%; and "Platinum" means an actuarial value of 90%. Blue Cross has calculated that the actuarial value of none of the six products it intends to offer under this rate filing is greater than 70%, meaning that no "Gold" or "Platinum" policies will be offered to subscribers. There is a direct correlation between the actuarial value of a policy, its premium, and the cost sharing requirements for subscribers. A higher actuarial value policy costs the subscriber more in premium, and requires less in cost sharing, than a plan with a lower actuarial value.

18. A third significant event in these proceedings is that during the week of January 9, 2012 Blue Cross filed supplemental pre-filed testimony and revised exhibits as a result of the conclusion of negotiations for a new pharmacy benefit management contract. Health insurance companies enter into contracts with pharmacy benefit managers in order to reduce prescription drug costs for subscribers, through a combination of benefit design features (e.g. cost sharing requirements and utilization procedures), and direct and indirect bargaining with pharmaceutical manufacturers and retail pharmacies. As a result of the new contract, Blue Cross' average rate increase request for all Direct Pay products has been reduced from 4.4% to 2.4%.

19. The term "average rate increase" means an average, overall rate increase across all products offered by Blue Cross to its Direct Pay subscribers. Blue Cross has proposed Pool 1 rates that will vary from a rate decrease of 10.2% to a rate increase of 17.3%; and Blue Cross has proposed Pool 2 rates that will vary from a rate decrease of 25.6% to a rate increase of 12.4%.

20. A fourth noteworthy element of this filing is that, in response to prior orders of the Commissioner, Blue Cross has proposed that Direct Pay subscribers will not pay any portion of their premium as a contribution to Blue Cross reserves. Financial reserves are necessary in order for a health insurance company to maintain its financial solvency in the event company expenses are unexpectedly high. As a result of this Direct Pay filing, the cost of contributions to reserves which Direct Pay subscribers would otherwise pay as part of their premium will be accounted for either in a reduction of reserves or cost savings elsewhere in Blue Cross' operations. The cost cannot be shifted to small group or large group subscribers, because the contribution to reserves factor for group subscribers has already been approved and fixed in rates.

21. Fifth, in response to prior orders of the Commissioner, Blue Cross is not proposing to require Direct Pay subscribers to pay the full share of the state assessment used to support several public health and human services programs. The entire state assessment for the next premium payment cycle, imposed in accordance with R.I. Gen. Laws § 42-12-29, is 1.8% of premium. Blue Cross instead has proposed to assess Direct Pay subscribers 0.6% of their premium for the state assessment obligation, reasoning that the 0.6% represents the cost of services which are actually used by Direct Pay subscribers, such as immunizations. As a result of this Direct Pay filing, the portion of the assessment cost which Direct Pay subscribers would otherwise pay as part of their premium will be accounted for either in a reduction of reserves or cost savings elsewhere in Blue Cross' operations. The cost cannot be shifted to small group or large group subscribers, because state assessments for group subscribers have already been approved and fixed in rates.

22. Sixth, in response to the Commissioner's Direct Pay decision last year, Blue Cross has proposed to reduce from 49% to 24% the rate differential between subscribers aged 65 and older and subscribers aged 60-64. Blue Cross is also proposing to add an additional age rating band for subscribers over age 65. Both changes will have the effect of reducing the magnitude of the sharp increase in premiums which subscribers turning 65 would otherwise experience.

Issues and Analysis

23. The parties have not engaged in factual or legal disputes with respect to the six elements of the Blue Cross filing summarized above. The parties have identified ten (10) factual or legal issues in dispute, concerning which the parties have either offered conflicting evidence, or made arguments which would affect in different ways the average rates for Direct Pay

subscribers. The ten (10) issues in dispute by the parties, and concerning which the Hearing Officer must analyze the conflicting evidence or arguments and make a recommendation to the Commissioner, are summarized below:

A. What time period of subscriber claims experience should be used to predict future Direct Pay subscriber expenses?

B. Were any errors made in the calculation of the BlueValue Direct 2500 product rate?

C. Should Blue Value Direct 2500 subscribers benefit by means of a decrease in average rates from the overall reduction in pharmacy cost projections attributable to Blue Cross' new pharmacy benefit management contract?

D. Should any adjustment be made to Blue Cross' medical trend assumptions?

E. Has Blue Cross adequately demonstrated how it accounts for provider price increases in its Direct Pay subscriber rates?

F. Should Direct Pay subscribers be charged a proportionate share of the 2% tax on insurance premiums?

G. Should Direct Pay subscribers be charged a proportionate share of the cost of BlueTransIT, Blue Cross' information technology systems modernization?

H. Should additional reductions be made to Direct Pay subscribers' share of Blue Cross administrative costs?

I. Should Direct Pay subscribers be offered a choice of enrolling in products with a higher actuarial value?

J. Should the Commissioner make orders requested by the AG: (a) to seek the Commissioner's approval of a plan to communicate product changes and choices to subscribers; (b) to encourage Blue Cross to increase employee contributions to health benefits; (c) to require an accounting of the costs and benefits of Blue Cross' affordability initiatives; and (d) to require Blue Cross to continue to administer the AccessBlue premium subsidy program?

Base period claims.

24. Blue Cross used Direct Pay subscriber claims data from June 1, 2010 to May 31, 2011 as the basis for projecting future trends in subscriber medical expenses. Both the AG and DBR make the observation, and introduced testimony that if claims data between May 31, 2011 and November, 2011 is included in the base claims period, the projected medical trend factor would be significantly lower than is proposed by Blue Cross. The AG would also not include in the claims base payments to providers for "pay for performance" incentives. The AG would lower the average rate increase by 1.6% if later subscriber claims were included in the base, and if pay for performance payments were excluded from the base. DBR would lower the average rate increase by 1% if later subscriber claims were included in the base. DBR has concurred with the manner in which BCBS calculated adjustments to base claims for "pay for performance" incentives.

25. The Hearing Officer finds as fact, based on the testimony and reasoning of the actuaries for the AG and DBR, that a longer base claims period that includes more recent claims will more accurately reflect the future claims costs of Direct Pay subscribers.

26. The Hearing Officer also finds as fact, based on the testimony of the AG's actuary, that pay for performance incentive payments should not be included in the claims base, but the Hearing Officer is persuaded by the testimony of DBR's actuary that Blue Cross effectively and accurately adjusted for the pay for performance incentive payments in the course of making adjustments for pharmacy benefits.

27. Accordingly, the Hearing Officer finds, based on the weight of the evidence and the persuasiveness of the testimony of the actuaries for the AG and DBR, that Blue Cross' rates should be decreased by 1.0% to reflect a longer and more recent base claims period, and to more accurately reflect the future expenses and claims of Direct Pay subscribers.

BlueValue Direct 2500 claims and rate calculation.

28. The AG introduced testimony through its actuary that Blue Cross made errors in calculating the projected claims experience for subscribers who are anticipated to enroll in the Blue Value 2500 product. The AG's actuary opined that Blue Cross assumed a combination of individual and family experience to project claims for subscribers choosing this product, and assumed that families would enroll in the product for rate calculation purposes, notwithstanding Blue Cross' intention to offer this product to individuals only, not families. From the AG's actuary's perspective, the first error overstated projected claims, while the second error cause premiums to be understated. The AG asserts the net impact of the two errors should result in a 0.1% increase in average Direct Pay rates.

29. The Hearing Officer is persuaded by the observation of DBR's actuary that the apparent errors observed by the AG are not material. Blue Cross is not requesting an increase in average rates by 0.1% to reflect these apparent errors.

30. Accordingly, the Hearing Officer finds, based on the evidence and Blue Cross declining to support the requested increase, that no adjustment should be made to average rates because of the apparent errors in calculation of BlueValue Direct 2500 projected claims and rates.

Pharmacy benefit contract adjustment and BlueValue 2500 rates.

31. The AG argues that subscribers who chose to enroll in the BlueValue 2500 product should not benefit from the reduction in average rates resulting from Blue Cross' new pharmacy benefit contract. No actuarial analysis has been provided in support of this proposal, which is based on an argument that the result would be more fair to subscribers not enrolled in the BlueValue 2500 product. The Hearing Officer is unable to find sufficient evidence in the record to support this result, and therefore finds that the AG's proposed adjustment should not be made.

Medical trend.

32. Three separate trend factors are at issue: hospital inpatient utilization trend, hospital outpatient utilization trend, and pharmacy trend. With respect to pharmacy trend, the AG's actuary does not dispute Blue Cross' calculations, based on actual Direct Pay subscribers' pharmacy claims, used to develop Blue Cross' proposed pharmacy trend. The AG's actuary also does not dispute that Direct Pay subscriber policy claims are sufficiently numerous to permit the use of standard actuarial calculation methodologies to arrive at a projected pharmacy trend. Nevertheless, the AG argues that because Blue Cross' trend projections in general in the recent past have been over-estimated, a downward adjustment in pharmacy trend should be made, resulting in a decrease in average rates of 0.5%. DBR's actuary disagrees with the AG's projection for pharmacy trend, instead agreeing with Blue Cross that it has made an appropriate

and reasonable calculation of Direct Pay pharmacy trend based on over 50,000 pharmacy claims, without the need to use actuarial judgment.

33. While the actuarial evidence is conflicting, the Hearing Officer finds, based on weight of the evidence of actuarial opinion, including the sufficiently-credible number of pharmacy claims of Direct Pay subscribers (as compared to the non-credible number of Direct Pay hospital inpatient and outpatient claims), that the pharmacy trend assumed by Blue Cross based on standard actuarial methodologies is reasonably accurate, and therefore no downward adjustment based on actuarial judgment should be made.

34. Accordingly, and based on the weight of the opinion evidence of the actuaries for the AG and DBR, the Hearing Officer finds that no decrease should be made to average rates based on an "actuarial judgment-based" downward adjustment in pharmacy trend.

35. With respect to hospital inpatient utilization trend and hospital outpatient utilization trend, all parties agree that the number of Direct Pay subscriber claims in these two categories are insufficient for the use of standard actuarial methodologies to project trends, and therefore that some type of actuarial judgment must be made. The actuaries for Blue Cross and the AG have used different methods of actuarial judgment to reach different conclusions in projecting trend in these two categories. Blue Cross used a 0.0% factor (no increase or decrease in trend) for hospital inpatient utilization trend, and a 1.9% factor for hospital outpatient utilization trend (one-half of the hospital outpatient utilization trend approved for Blue Cross' hospital outpatient utilization trend in June 2011, for the January 1, 2012 to January 1, 2013 renewal period. The AG in contrast, through testimony of its actuary, reasons that Blue Cross has overestimated medical trends in previous rate filings for Direct Pay subscribers, because it has failed to

properly credit the recent efforts by Blue Cross to improve the overall experience of Direct Pay subscribers, efforts that are not relevant to the experience of the commercial markets. The AG's actuary would reduce average rates by 1.7%, based on the considerations summarized above, and also based on the observed, albeit non-credible (from an actuarial perspective) claims data. DBR's actuary testified that both non-standard calculations made by both the actuary for Blue Cross and the actuary for the AG are reasonable.

36. The Hearing Officer is persuaded by the observation of the AG's actuary that Blue Cross is recent filings has overestimated projected trend for Direct Pay subscribers, for reasons sometimes ascribed to the current poor economic environment, and for reasons relating to benefit design changes made by Blue Cross designed to attract healthier subscribers into the Direct Pay experience pools. In light of this evidence supporting a lower trend factor for hospital utilization, the Hearing Office finds that Blue Cross has failed to sustain its burden of proof with respect to this particular trend issue. The Hearing Officer therefore finds based on the weight of the opinion evidence that a reduction of average rates of 1.7% is reasonable for hospital inpatient utilization trend and hospital outpatient utilization trend.

Provider Price Increases

37. DBR through its actuary has observed that Blue Cross' price trend factors for hospital inpatient, hospital outpatient, and medical surgical services are not adequately supported by Blue Cross' testimony and exhibits entered into evidence, and that its price trend factors are therefore inconsistent with actuarial standards. DBR does not appear to positively recommend that a downward adjustment in average rates should result from inadequate support for Blue Cross' price trends; rather, DBR suggests that if the Hearing Officer determines a downward adjustment

is warranted, the decrease in average rates would be 5.6% if average rates reflected no provider price increase for the rating period, a decrease in average rates of 4.5% if average rates reflected no increase in hospital inpatient prices and hospital outpatient prices, but the price increase for medical surgical services proposed by Blue Cross for the rating period, and a decrease in average rates of 2.4% if it is assumed that OHIC's hospital contracting conditions (which contain limits on annual hospital price increases reimbursable in contracts with health insurance carriers) are in effect for contracts entered into before the effective date of OHIC's hospital contracting conditions. Currently OHIC's hospital contracting conditions apply only to contracts entered into between carriers and hospital after the effective date of the OHIC conditions. The AG agrees with DBR that Blue Cross' hospital price trends are inadequately supported, but argues merely that the Hearing Officer should give weight to this information. Blue Cross responds to these critiques by observing that it has described how the provider price trends were developed, and by further arguing that no evidence has been offered to rebut Blue Cross' evidence and analysis with respect to provider price trends.

38. The Hearing Office finds as fact, based on the weight of the opinion evidence, that generally-accepted actuarial standards require the demonstration of some level of data showing how provider price trends were developed, so that other actuaries reviewing the data can determine whether the proposed trends are reasonable. This finding of fact as to actuarial standards does not mean that Blue Cross has failed to meet its burden of proof on this contested matter. Blue Cross has introduced evidence, however thin, of their projected provider price trends. DBR and the AG have introduced evidence of actuarial standards which diminishes the

weight of Blue Cross' evidence on provider price trends, but neither DBR nor the AG has introduced evidence that contradicts the Blue Cross provider price trends.

39. Based on the foregoing, the Hearing Officer finds that no adjustment should be made to Blue Cross provider price trends.

Premium tax.

40. The 2% premium tax imposed by Rhode Island law is a real cost incurred by Blue Cross. From a standard actuarial perspective, the parties are in agreement that the cost of the premium tax should be included in Direct Pay subscriber premiums. The AG argues, however, that the 2% premium tax should not be allocated to Direct Pay subscribers because affordability considerations affect these subscribers more heavily than group subscribers because Direct Pay subscribers must pay the entire premium, without any employer contribution.

41. The Hearing Officer observes that the Commissioner in recent Direct Pay rate filings has deviated from the usual actuarial standard in order to ensure that Blue Cross fulfills its obligation to improve the affordability of health insurance offered to Direct Pay subscribers.

42. In the context of this specific rate filing, however, the facts in evidence in this proceeding do not warrant the exclusion of the premium tax in the average rates of Direct Pay subscribers. While current and proposed Direct Pay premiums are by no means affordable for subscribers: (a) a small increase, or a decrease in average rates is contemplated; (b) Blue Cross has reduced its allocation of the state assessment on Direct Pay subscribers to that portion of the assessment attributable to utilization of services by Direct Pay subscribers, (c) Blue Cross has declined to allocate any portion of Direct Pay premium towards a contribution to reserves, and (d) the uncontroverted evidence demonstrates Blue Cross' commitment to actively implement

OHIC's Affordability Standards, designed to improve the efficiency, quality and affordability of Rhode Island's health care system. All of these factors and efforts by Blue Cross should be acknowledged, and when considered together mitigate against the exclusion of the premium tax from subscriber rates.

43. The Hearing Officer therefore finds based on the evidence of accepted actuarial standards and principles that the 2% premium tax imposed by Rhode Island law should be included in the average rates of Direct Pay subscribers.

BlueTransIT costs.

44. BlueTransIT is the term used to describe the on-going modernization of Blue Cross' information technologies system. While no party has disagreed on the need for IT modernization to improve Blue Cross' administrative efficiency over the long term, the AG argues that Blue Cross should not recover from Direct Pay subscribers any amount attributable to cost over-runs in the modernization project. The evidence in the record supports the observation that the Commissioner has in past rate decisions approved the 0.34% annual charge for the IT modernization project, which is contemplated to have a 15 year life. The argument that BlueTransIT costs should not be included in Direct Pay subscriber administrative costs is therefore premature prior to the end of the 15 year anticipated life of the charge. The argument would be timely if made after the anticipated 15 year term of the BlueTransIT charge, and event which has not yet occurred. Therefore, the Hearing Officer finds that the evidence does not support a downward adjustment in average rates based on BlueTransIT charges and costs.

Overall administrative costs.

45. The parties offered evidence concerning the administrative charge portion of Direct Pay subscriber premiums which appears upon initial review to be conflicting. Blue Cross asserts that its administrative costs for Direct Pay for the April 2011 billing cycle are $59.58, and that under its filing its 2012 projected administrative charge will be $58.38 and its 2013 charge $55.91. The impression left is that Blue Cross is reducing its administrative cost charge for Direct Pay subscribers. In contrast, both the AG and DBR assert that Blue Cross' filed 2011 administrative charge is $51.56, and its proposed administrative charges for the 18 months of the 2012 and 2013 rate period is a weighted average of $57.08, representing a 10.7% increase. Upon request for clarification or explanation dated by the Commissioner and the Hearing Office dated February 13, 2012, the parties clarified that Blue Cross' filed administrative cost charge for Direct Pay subscribers is indeed $51.56, and that the Direct Pay administrative cost charge actually approved by OHIC is lower than $51.56 (than actual charge expresses as a per contract per month figure was not entered into the record of these proceedings). After the filing and approval of its 2011 Direct Pay administrative cost charge, however, Blue Cross recalculated its allocation of administrative costs attributable to Direct Pay subscribers, resulting in a per contract per month cost (not charge) of $59.58. Blue Cross states that its allocation of increased costs to Direct Pay subscribers is "more equitable".

46. In one example of the allocation of increased administrative costs to Direct Pay subscribers, Blue Cross has changed its allocation of the Customer Service unit costs from an allocation based on enrollment, to an allocation based on call volume. The Hearing Officer is

not persuaded that Blue Cross' new methods of allocating administrative cost allocations is more equitable than its previous methods.

47. The Hearing Officer finds based on the uncontroverted evidence that Blue Cross' proposed administrative cost charge to Direct Pay subscribers has increase by at least 10.7%. The Hearing Officer also finds based on the uncontroverted evidence that a medical CPI index of 2.65% (the 2.65% medical CPI index is the only medical CPI index in evidence) is used as the standard for allowable health insurance expense increases, the maximum allowable administrative expense for Direct Pay subscribers would be $52.93 per contract per month, resulting in a decrease in average rates of 0.8%.

48. Based on the foregoing evidence and analysis, and the weight of the evidence, the Hearing Officer finds that the most reasonable Blue Cross' administrative cost charge for Direct Pay subscribers for the 25 month period beginning April 1, 2012 is $52.93, resulting in a decrease in average rates of 0.8%.

Subscriber choice of product.

49. The Hearing Officer is concerned that the new products proposed to be offered by Blue Cross, on which the rate filing is based, are significantly different from the current products offered to Direct Pay Subscribers. A major difference is the coinsurance requirement included in the benefit design of most new products, which imposes cost sharing obligations on subscribers even after their deductible obligation has been met. The Hearing Officer acknowledges the public comments entered into the record, which raised repeated questions concerning the benefit design of the new products proposed by Blue Cross, especially the coinsurance feature prevalent in most of the new products. Subscriber choice of a variety of products is an important

consideration for subscribers, even if the choice of a product without co-insurance requirements might result in higher premium costs.

50. Based on the weight of the evidence, the Hearing Officer finds that in order to offer adequate choice of products to Direct Pay subscribers, Blue Cross must offer additional products to Direct Pay subscribers with an actuarial value of "Gold", based on the standards established in regulations adopted under the Affordable Care Act. There is no evidence in the record, however, upon which to make adjustments to the existing Blue Cross rate filing should additional product choices be required by this Decision.

Other considerations.

51. The AG argues that, because of the significant changes in products offered to subscribers, Blue Cross must make clear and communications with its current prospective subscribers. The Hearing Officer agrees with the AG, and so finds based on the evidence of the significant differences in the new products to be offered, that effective and comprehensive disclosure and comparison tools for product choices will be needed.

52. The AG also argued that Blue Cross should be required to be accountable in its spending for efforts designed to improve the affordability of the health care system in general, and subscriber premiums in particular. The Hearing Officer finds, based on the uncontroverted testimony of Blue Cross' medical director, that Blue Cross has diligently implemented the Affordability Standard initiatives established by OHIC, compliance with which is required by carriers. While the AG engaged in extensive cross-examination of Blue Cross' medical director in an effort to discredit his testimony and minimize the benefits to subscribers of these cost containment initiatives, the witness' testimony was not significantly undermined: the benefits of

these cost containment substantially exceed their costs, even though the initiatives are still in their infancy, and a thorough collection and analysis of data with respect to the initiatives and programs have not yet been completed. The Hearing Officer agrees with the AG, however, that the public would benefit from better communication concerning the costs and benefits of the health system improvements required of carriers under OHIC's Affordability Standards.

53. The AG also "encourages Blue Cross to assure that all of its benefit plans are appropriately managed" (AG's Post-Hearing Memorandum, page 23), and suggests that the employees contribution percentage of Blue Cross employees for their health benefit plan is too low when compared to other employees of large employers in the state. The AG does not request that the Commissioner issue any specific order in connection with this issue, and accordingly the Hearing Officer finds no evidence to support such a recommendation or order.

54. Finally, the AG argues that the Commissioner should direct Blue Cross to retain its AccessBlue premium subsidy program. The Hearing Officer finds, however, that there is no evidence to support a finding that Blue Cross intends to discontinue the program. The Hearing Officer finds based on the evidence in the record that there will be time between now and October 2013, when Exchange policies (including income-sensitive premium subsidies) are offered to Direct Pay subscribers, to consider whether a state-based premium assistance program will be necessary or legally feasible under the Affordable Care Act.

55. All Conclusions of Law set forth below are also adopted as Findings of Fact.

Conclusions of Law

Based upon the Findings of Fact set forth above, the Hearing Officer makes the following conclusions of law:

56. All Findings of Fact set forth above are also adopted as Conclusions of Law.

57. The Office of the Health Insurance Commissioner ("OHIC") has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 42-62-13, 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6.

58. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq*.

59. The rates requested by Blue Cross must be "consistent with the proper conduct of the applicant's business and with the interest of the public . . . ." R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13. In 2004 the Rhode Island General Assembly established the meaning of "proper conduct of the applicant's business" with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq*. See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), aff'd, *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005). They decreed that Blue Cross' mission includes providing "affordable and accessible health insurance to insureds" (R.I. Gen. Laws § 27-19.2-3(1)), and "affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals." R.I. Gen. Laws § 27-19.2-3(5). The Board of Directors was specifically charged with "ensuring that the corporation effectively carries out the charitable mission for which it was incorporated . . . ." Under the new law, Blue Cross must also "employ pricing strategies that enhance the affordability of health care coverage . . . ." R.I. Gen. Laws § 27-19.2-10(3). These newly enacted legislative directives make clear that the "proper conduct of the applicant's business" is

no longer left solely to the management's discretion unless that discretion is exercised to provide "affordable" and "accessible" health insurance. R.I. Gen. Laws § 27-19.2-10(3).

The General Assembly also mandated that OHIC discharge its powers and duties to:

> (a) Guard the solvency of health insurers;
>
> (b) Protect the interests of consumers;
>
> (c) Encourage fair treatment of health care providers;
>
> (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
>
> (e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. R.I. Gen. Laws § 42-14.5-2. See also OHIC Regulation 2.

Accordingly, the Commissioner's decision in this matter must take these factors into account.

60. In addition, OHIC must comply with the requirements of these statutes when rendering a decision in this matter. These statutes require the Commissioner to render a decision so as to, among other things, protect consumer interests, encourage policies that improve the quality and efficiency of health care delivery, and encourage and direct Blue Cross toward policies that advance the welfare of the public.

61. OHIC is authorized to approve, disapprove or modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6. The authority to modify rates includes the authority to modify any of the components or factors used to develop rates, if warranted by the evidence in the record.

62. Blue Cross bears the burden of proving that the proposed rates are consistent with the proper conduct of its business and in the interest of the public.

63. For all the reasons set out above, the proposed average rate increase of 2.4% is not supported by the record, is not within the proper conduct of Blue Cross' business, and is not in the public interest.

64. An average rate decrease of 1.1% is supported by the record, is within the proper conduct of Blue Cross' business, and is in the public interest. Such a rate also protects consumer interests and advances the welfare of the public. The recommended average rate decrease of 1.1% is calculated based on and represented by the evidence offered and arguments made by the parties, summarized in the table below:

Item or Issue	**Rate Factor: Increase/Decrease**	**Resulting Average Rate Increase/Decrease**
Blue Cross initial filing	NA	+4.4%
Blue Cross PBM factor	-2.0%	+2.4%
Base period factor	-1.0%	+1.4%
Hospital IP/OP Utilization	-1.7%	-0.3%
Administrative charge	-0.8%	-1.1%
Totals	**-5.5%**	**-1.1%**

65. The need for additional product choices for Direct Pay subscribers is supported by the record, is within the proper conduct of Blue Cross' business, and is in the public interest. Requiring such additional protects consumer interests and advances the welfare of the public.

66. The need for an effective subscriber disclosure and a product choice tool is supported by the record, is within the proper conduct of Blue Cross' business, and is in the public interest.

Subscriber disclosure and assistance protects consumer interests and advances the welfare of the public.

Recommended Order

Accordingly, and based on the foregoing Findings of Fact and Conclusions of Law, the Hearing Officer recommends that Commissioner issue the following order:

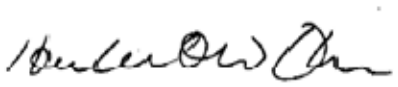
A. Blue Cross shall amend and re-file its Direct Pay filing so as to decrease its average rates by 1.1%.

B. Blue Cross shall file additional product options for subscribers, to be effective beginning January 1, 2013, including at least one product in each pool with an actuarial value of at least 80%.

C. Blue Cross shall file with OHIC for approval, disapproval or modification a plan to make for effective and comprehensive subscriber disclosures in connection with its new products, and to provide for subscribers a product choice tool.

D. The parties shall file any motions to correct clerical or calculation errors reflected in this Decision on or before 12:00 noon on February 20, 2012.

Dated at Cranston, RI this 16th day of February, 2012.



Herbert W. Olson
Hearing Officer

ORDER AND DECISION OF THE COMMISSIONER

Christopher F. Koller, Health Insurance Commissioner of the State of Rhode Island, hereby issues his Order and Decision with respect to the Rate Filing made by Blue Cross and Blue Shield of Rhode Island, dated November18, 2011, in connection with its Direct Pay subscribers, after having first carefully reviewed the Recommended Decision of the Hearing Officer, the testimony and exhibits entered into evidence, the arguments of the parties, and the comments of members of the public.

The Commissioner hereby adopts and accepts the Findings of Fact, Conclusions of Law, and Recommended Order of the Hearing Officer.

Wherefore, it is hereby ORDERED:

A. Blue Cross shall amend and re-file its Direct Pay filing so as to decrease its average rates by 1.1%.

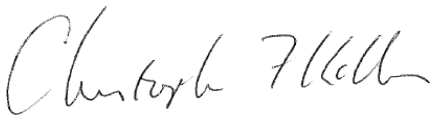
B. Blue Cross shall file additional product options for subscribers, to be effective beginning January 1, 2013, including at least one product in each pool with an actuarial value of at least 80%.

C. Blue Cross shall file with OHIC for approval, disapproval or modification a plan to make for effective and comprehensive subscriber disclosures in connection with its new products, and to provide for subscribers a product choice tool.

D. The parties shall file any motions to correct clerical or calculation errors reflected in this Decision on or before 12:00 noon on February 20, 2012.

E. The Commissioner shall retain continued jurisdiction and may make such orders as are necessary to carry out the purposes of this Order.

Dated at Cranston, RI this 21st day of February, 2012.



Christopher F. Koller, Commissioner

THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS DECISION MAY BE APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.