Actuarial Analysis of Charles C. DeWeese, FSA, MAAA
Actuarial Staff for the Office of the Health Insurance Commissioner

I. Introduction.

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

A. My name is Charles C. DeWeese. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I am a consulting actuary in private practice with the major part of my practice devoted to health insurance issues.

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

A. I began my consulting career with Tillinghast, a predecessor company to Towers Watson, in 1982. I formed my own firm in 1990 and have been in private practice since then. My firm is DeWeese Consulting, Inc.

Q. What was your experience in life and health insurance prior to becoming a consulting actuary?

A. I was employed by Connecticut General Life Insurance Company, a predecessor of CIGNA, from 1968 through 1982. Among other assignments, I was the pricing actuary for group life and health insurance products from 1973 through 1980. I had other actuarial assignments at Connecticut General in the areas of group pensions, life insurance accounting, reinsurance and mergers and acquisitions.

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

A. I have served as an expert witness in health insurance rate hearings in Massachusetts, Maine and Connecticut. I have also appeared in Federal Tax Court on insurance matters on four occasions, where I was qualified as an expert in life insurance, multiple employer plans and experience rating.

Q. What is your experience with regard to the Rhode Island health insurance market?

A. I have served as consulting actuary to the Office of the Health Insurance Commissioner and the Department of Business Regulation on a variety of health insurance matters, including rate filing review, market conduct examinations, financial examinations and assistance at rate hearings. I have previously provided actuarial support to the hearing panel and as a member of the hearing panel at past Direct Pay and Plan 65 rate hearings, most recently in 2008.

Q. Please identify the document that has been marked as DeWeese Exhibit 1.

A. It is a copy of my curriculum vitae.

II. Material Reviewed

Q. Mr. DeWeese, did you review the filing Blue Cross submitted for Individual Health Insurance Rates on April 15, 2013?

A. Yes.

Q. What other materials did you review in reaching your conclusions and forming your opinions?

A. I reviewed all of the materials submitted in response to questions submitted by the Attorney General and the Department of Business Regulation. In addition I reviewed the Class DIR filing submitted by Blue Cross on November 18, 2011, as well as the decision rendered by the Health Insurance Commissioner.

Q. Did anyone help you with your review?

A. Yes, I worked with Ms. Bela Gorman, FSA, MAAA, who is also an experienced health actuary. She also reviewed the filing, and she has assisted me in coming to my conclusions. However, the conclusions are ultimately my own.

Q. Were there particular documents provided in discovery that you relied upon?

A. Yes, I particularly relied upon the following responses from Blue Cross, although I found all of the responses helpful: AG 1-04, 1-06, 1-09, and DBR 2-01, 2-05, 3-01 and 5-01.

Q. Can you describe generally the rating approach for Direct Pay currently?

A. Yes, Direct Pay currently has two rating pools, Pool 1 and Pool 2. During 2012, each of Pool I and Pool 2 had approximately 90,000 member months, so there were about 15,000 Direct Pay members in total in 2012. In addition, Blue Cross has covered approximately 1,800 member months or approximately 150 members under the high risk pool PCIP program. These members will also be eligible to be part of the new Individual Pool. Pool 2 eligibility is subject to meeting certain underwriting criteria, and Pool 2 members have much more favorable average claims experience or morbidity than Pool 1 members, who have not passed underwriting. In addition, Pool 2 rates vary by both age and gender, while Pool 1 rates vary only by age. The rates for the two pools involve some degree of cross subsidy, in that Pool 1 rates are reduced slightly below the full rate need, while Pool 2 rates are correspondingly increased.

III. Background of this filing

Q. What changes in the Individual market did Blue Cross consider in setting premium rates for this filing?

A. There are several changes reflected in the premium rates in this filing.

First, Blue Cross will no longer be able to underwrite members to assign them to a pool. Instead, all individual customers will be in a single rating pool with one set of rates to apply to all customers. Second, it is anticipated by Blue Cross that the Individual pool will be much larger in 2014. Blue Cross projects that there will only be 56,000 Pool I member months and 48,000 Pool 2 member months in the Individual Pool for 2014, primarily because of another carrier entering the market. They are also

projecting that approximately 21,000 member months or 1,800 members who were formerly insured as sole proprietors in the small group market will change to Individual insurance. They are also projecting that approximately 12,000 member months or 1,000 members formerly insured as employees of small groups will lose small group coverage and enroll as individuals. Blue Cross has projected that the largest portion of the new individual pool will be approximately 266,000 formerly uninsured member months, or approximately 22,000 members.

Second, there are changes in the rating variables to comply with the requirements of the Affordable Care Act ("ACA"). Blue Cross will now use the federal age curve for age rating, and will not be able to vary rates by gender.

Third, Blue Cross is offering new benefit plans. While there will be a number of different plans with different cost sharing elements, Blue Cross expects that the average plan chosen will have approximately 4.2% more member cost sharing than the average plan currently held[1]. Blue Cross is offering new benefit plans to conform to the benefit requirements of the ACA. Ultimately, Individuals will choose the plans they want and can afford. The projected level of cost sharing is based on Blue Cross's estimate of the plans that Individuals will choose. The actual plans chosen may be higher or lower cost.

Fourth, there are additional costs that must be recovered, including insurer fees, reinsurance premiums, etc., and other items to consider including anticipated reinsurance recoveries under the ACA, and potential risk adjustment payments either to or from Blue Cross.

Q. Please describe Blue Cross's general methodology for developing its proposed Individual rates?

A. Blue Cross's rate development generally followed the format of the OHIC Rate Review template. Blue Cross started with allowed claims from the experience period, calendar year 2012. The claims are separate by each of five main categories of benefits, inpatient hospital expense, outpatient hospital expense, primary care expense, other medical/surgical expense, and pharmacy claims. In addition, Blue Cross analyzed amounts paid to the Rhode Island Departments of Health and Human Services in assessments required by law. Each of these kinds of allowed claims was then divided by the number of member months in the experience period, in order to get claims by category per member per month (PMPM). As part of the development of PMPM allowed claims, Blue Cross separately determined for each category of benefits the rates of utilization per 1,000 members per year and the average cost per service.

They then projected the PMPM claims to the rating period, calendar year 2014. In order to do so, they made adjustments to reflect expected differences in the population covered, savings they expect from their new Pharmacy Benefit Manager (PBM) contract, and two years of medical expense trend. They applied separate trend factors to each of the average cost per service and the utilization per 1,000 to reflect anticipated price increases and anticipated utilization changes, over the two year period between the experience period and the rating period.

[1] Blue Cross response DBR 2-05.

Multiplying the experience period PMPM claims times the appropriate trend and morbidity factors resulted in projected allowed PMPM claims for the rating period, separately by category of benefits. These were added up to develop projected total allowed claims PMPM for the rating period. They then applied a factor to reflect the anticipated ratio of paid claims to allowed claims to obtain projected incurred claims. They adjusted the incurred claims to add the risk adjustment fee required by the ACA and to subtract the net reimbursement they expect under the Transitional Individual Market Reinsurance Program provided under the ACA. The filing included supporting documentation. Blue Cross's calculation of expected reinsurance recoveries uses standard actuarial methodology, and it is reasonable.

The next step was to add anticipated administrative expenses, premium and other taxes, and contribution to reserves to get the Single Risk Pool average Gross Premium rate.

Blue Cross adjusted that average premium to an age 21 Essential Health Benefits (EHB) basis by dividing by the average benefit factor (.6958), the average age factor (1.6829) and an adjustment to reflect that Blue Cross will not collect premium to cover children beyond three children in a family (.998). This was consistent with the instructions provided by OHIC to the issuers filing individual and group insurance premium rates for 2014. The result of this step was Blue Cross's EHB Base Rate, proposed at $330.97. That rate will be used with approved benefit and age factors to determine the rate a customer of Blue Cross will pay for Individual health insurance coverage in 2014.

Finally, Blue Cross priced each of the Individual benefit plans it intends to offer using the Federal AV model (adjusted where appropriate) and utilization factors to reflect the relative utilization anticipated based on the cost sharing characteristics of each plan. The method is reasonable, and I reviewed Blue Cross's calculations.

Q. In the course of your review, did you form an opinion about Blue Cross's general methodology for developing its proposed Individual rates?

A. The general methodology is consistent with the instructions provided by OHIC and it uses standard actuarial methods. In my opinion, the methodology is appropriate.

Q. What rate increase has Blue Cross proposed for current Direct Pay members?

A. Blue Cross has proposed an average rate increase of 18.1% for current members on an equivalent same benefits basis. It is unlikely that any current member would experience exactly an 18.1% increase, because of all the changes to age factors and benefit plans. Blue Cross also anticipates that enrollment in the newer plans being offered will result in average benefits that have approximately 4.2% more Individual cost sharing, so that the average rate for new benefits will be approximately 13.1% more than the rates being paid now for existing benefits.

Q. What factors contribute to the 18.1% average increase?

A. According to the filing, approximately 13.5% of the average increase relates to increased price and utilization of medical services, offset by savings associated with Blue Cross's new PBM contract. This is

also offset by anticipated reimbursements under the Transitional Individual Market Reinsurance Program. Blue Cross has estimated those savings as being equivalent to approximately 12.7% of premium.

Blue Cross describes administrative expense as contributing approximately 3.2% of the average rate increase. At this time, I have not been able to reconcile that with information provided elsewhere that indicates administrative expenses as anticipated to decrease.

Blue Cross had not built in a contribution to reserves in the rates currently in effect for Direct Pay. The proposed contribution to reserves in these rates adds 3% to the premium increase. Taxes and assessments associated primarily with the implementation of the ACA add 6%. Finally, Blue Cross has assumed that population changes, including the entry of previously uninsured and previously small group members will add approximately 5.1% to the cost.

IV. Analysis

Q. In the course of your review, did you analyze Blue Cross's factors to reflect changes in population morbidity?

A. Yes, Blue Cross considered various changes it expects in the composition of the new Individual market as compared to the existing Direct Pay and PCIP market, and proposed adjustments to expected claims based on the anticipated characteristics of people expected to purchase Individual coverage in 2014.

First, Blue Cross assumed that existing Direct Pay Pool 1, Direct Pay Pool 2 and PCIP members would stay in the market, but that some Direct Pay Pool 2 members, facing higher than average rate increases, because rates can no longer reflect their better health status after January 1, 2014, would drop coverage and become uninsured. Blue Cross assumed that 15% of DP Pool 2 members would become uninsured. Because they are relatively healthier, those members leaving would result in average morbidity for the remaining population to be 3.4% higher than the current DP and High Risk morbidity.

Blue Cross has estimated (DBR 3-01) that Pool 1 members will experience an average rate decrease of 4.7% if the proposed rates are approved, while Pool 2 members will experience an average increase of 55.2%. This is somewhat inconsistent with other information provided at AG 1-09, which shows changes by age and sex, and would appear to support a lower but still substantial average increase for Pool 2 members. In either case, it is clear that many Pool 2 members will see large increases. While it is reasonable to assume that some DP Pool 2 members will be afflicted by sticker shock and will drop coverage, these are people who value health insurance. At a time when many uninsured people are expected to enter the market (tripling the size of the market according to Blue Cross's estimate), it seems overly conservative to assume that so many DP Pool 2 members will go the other way. I made an alternative assumption that only 10% of DP Pool 2 members would become uninsured.

Blue Cross also did not consider the possibility that some Direct Pay Pool 1 members might become eligible for Medicaid under new rules, and might therefore also drop Individual coverage. If the

relatively less healthy DP Pool 1 members drop coverage, the average morbidity would decrease. However, I made no assumption about DP Pool members leaving.

It is impossible to say that Blue Cross's assumptions are wrong, because so much about the composition of the individual market is unknown. However, I think a more reasonable assumption would involve fewer DP Pool 2 people leaving the market.

Blue Cross has estimated that approximately 1,800 sole proprietors currently insured in the small group pool will leave the small group pool and enroll in individual coverage. They have analyzed the claims experience of these people in small group and based on their allowed claims, they have assumed that these members will have morbidity approximately 14% higher than the current DP Pool 1 and Pool 2 members. BC does not appear to have considered that those members currently have richer benefit plans than the DP population, and richer benefit plans than small group in aggregate. In addition, they may also be generally older than the average of small group members. In addition, since sole proprietors and small group members are employed, they should generally be expected to have better morbidity than Direct Pay members, many of whom may not be employed. Massachusetts experience with merging the small group and individual markets six years ago showed that sole proprietors had better morbidity than individual customers, although there was only one individual pool in Massachusetts. I have made an alternate assumption about the morbidity of any sole proprietors who enter the Individual market, by adjusting Blue Cross's projection as shown in Appendix B of the filing's actuarial memorandum by the utilization factors shown in Blue Cross's response DBR 2-01.

Blue Cross has assumed that approximately 1,000 additional small group members will lose coverage because their employers drop group coverage, and those members will instead enroll in the Individual market. Similarly, Blue Cross has assumed that they will have morbidity that is 6% higher than the current DP members. I have made alternate assumptions about their morbidity consistent with Blue Cross's methodology, but incorporating the adjustment I made to sole proprietors.

Finally, Blue Cross has assumed that approximately 22,000 previously uninsured individuals will purchase Individual insurance, and that those individuals will have morbidity approximately 9.2% higher than the current Direct Pay members, including the same 6% difference attributable to small group transfers and an additional 3% representing pent-up demand among people who have not previously been insured. I find the assumption of pent-up demand reasonable. I have made alternate assumptions about their morbidity, however, and based it on the morbidity calculation for small group, adding the 3% pent-up demand figure. My adjustments to morbidity are shown in DeWeese Exhibit 2. They result in a revised morbidity factor of 1.0104, compared to Blue Cross's projected 1.0503.

Based on DeWeese Exhibit 2, I calculated the effect of my adjusted morbidity on the EHB rate and the average rate increase. The results are shown in DeWeese Exhibit 3. The effect on the average rate increase is a reduction from 18.1% to 13.2% or approximately 4.9%. The reduction in EHB base rate is from $330.97 as filed to $317.14. In my opinion, these high and low assumptions represent a reasonable range of alternate assumptions that could be considered along with the Blue Cross projections.

Q. In the course of your review, did you analyze Blue Cross's trend projection factors?

A. Yes, Blue Cross summarized its trend factors in Tab I of its OHIC Rate Review Template, and described the development in the Actuarial Memorandum and Appendices that were filed in SERFF.

Q. What conclusions did you reach about the trend factors?

A. Blue Cross's pricing methodology is to start with PCPM claims from the experience period (in this filing June 2006 through May 2011) and project them forward with trend projection factors. The projection factors cover 24 months of projection, from the midpoint of the experience period, 7/1/2010, to the midpoint of the rating period, 7/1/2014. This is a standard actuarial method.

Blue Cross develops its projection factors in two parts:

1. Cost Trend Factor. Annualized versions of these factors are shown in Tab I of the OHIC Rate Review Template and used in Tab II to project future claims cost. The development is described at a high level in the Actuarial Memorandum. The cost trend factors are based on known and anticipated contracting arrangements over the period January 2012 through December 2014. Blue Cross's response to AG 1-06 contains the results of the contracting information and support for the calculation of the trend factors. I was able to follow the calculations in the spreadsheet shown in response to AG 1-06 and confirm that they were the factors used by Blue Cross in their rate development. This is a standard actuarial method. While Blue Cross has advised that these values are determined based on actual and anticipated contracting with hospitals and physicians and other providers, the filing does not contain any documentary evidence of the contracts themselves. Therefore it is not possible for me to determine whether these projection factors are justified.

   The price trend factors used in the filing are annual factors, 3.66% for hospital inpatient, 4.03% for hospital inpatient, 9.87% for primary care and 1.51% for other medical/surgical. Pharmacy trend is analyzed on a combined price and utilization basis.

   OHIC's Rate Approval Conditions for Blue Cross (see DeWeese Exhibit 4) direct that hospital contracts should "limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index for all contractual and optional years covered by the contract." That equates to approximately 2% annually, based on the current Index information[2].

   If Blue Cross were held to a 2% annual increase in inpatient and outpatient hospital cost contract increases, that would reduce the average increase by approximately 3.2% to 15.9%. It

[2] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf

would reduce the Base EHB Rate from $330.97 to $324.81. A demonstration is shown in DeWeese Exhibit 5.

If other information becomes available to supplement the material provided about the cost trend factors, I will analyze it and amend my testimony as appropriate.

2. Utilization/Mix Trend Factor. These factors are based on actuarial analysis of three years de-priced PCPM allowed claims data, separately for hospital inpatient, hospital outpatient and surgical/medical allowed claims. In addition, pharmacy allowed claims are analyzed the same way, but not on a de-priced basis. The analysis is done on a least squares trend line, fitting a straight line to the data. This is a standard actuarial technique. It is also standard, as Blue Cross has done here, to consider experience in other lines of business where the amount of experience is small, and to apply actuarial judgment in setting the trend factor. Actuarial judgment is appropriate where the underlying data is not credible, where other credible information suggests the least squares line is incorrect, or where external events may lead to changes to the projection factors. Blue Cross described its methodology for developing utilization pricing trends in its Actuarial Memorandum and in Appendix C of the Memorandum. Blue Cross used least squares trend lines for all business types, but it modified the data used to include large group and small group claims in its analysis of inpatient (IP) and outpatient (OP) hospital claims.
    a. Hospital inpatient – There has been a general pattern of decreasing utilization during 2011 and increasing utilization in 2012, resulting in utilization as of the end of 2012 similar to the level of two years earlier. Blue Cross analyzed the data in several ways to try to find data that exhibited a reasonable least-squares fit. Ultimately, Blue Cross relied on inpatient admission data on a combined Direct Pay, Large Group and Small Group data set, because the Direct Pay data alone was not large enough in size to be adequately credible. This is a reasonable approach. Blue Cross's chosen least-squares line met the standard of at least a .70 r-squared value. It used only the data beginning in November 2011 and continuing through November 2012, and resulted in a projection of an annual 3.1% utilization trend, and Blue Cross has relied on this in setting its assumption of 3.0%. In my experience, the long term trend in inpatient utilization has been relatively flat, while going through periods of increase and decrease. Last year in its Direct Pay filing, Blue Cross observed a least-squares based trend of approximately -5% for its Pool 1 business and -35% for its Pool 2 business. Blue Cross rejected those results and argued for a 0% utilization assumption at the time, and I supported their conclusion. I think a similar conclusion would be appropriate here. I think a 0% utilization trend for inpatient claims is more reasonable than the 3.0% recommended by Blue Cross.
    b. Hospital outpatient – Similarly, Blue Cross relied on combined large group, small group and Direct Pay experience to project hospital outpatient utilization. This seems generally reasonable. Blue Cross chose the period of at least 13 months with the highest least-squares correlation, which was the period from October 2011 forward.

However, Blue Cross could have used the entire 25 months of trend data and achieved almost the same correlation, and observed a trend of 3.2%. Last year, Blue Cross used judgment to adjust its outpatient utilization trend factor up, and I supported that judgment. In my opinion, this year, I think 3.2% is a more reasonable assumption than 4.0% for OP utilization, and more consistent with the long term experience. If Blue Cross were to use a 3.2% assumption for OP utilization, it would result in a reduction in the filed rates.

c. Medical/surgical. Medical/surgical experience includes a large enough number of encounters to have statistical validity. Blue Cross used the least squares trends, and I see no reason to recommend anything different.
d. Pharmacy. Pharmacy experience includes a large enough number of prescriptions to have statistical validity. Blue Cross used the least squares trends, and I see no reason to recommend anything different. Blue Cross also included an adjustment to pharmacy claims to reflect a new PBM contract. That adjustment reduced projected pharmacy claims by 17.4%. The adjustment is reasonable.
e. Primary care. Blue Cross analyzed Primary Care and Medical/surgical together and used the same factors. They are reasonable.
f. Health Assessments. Blue Cross assumed that health assessments would increase at the same rate as medical/surgical utilization generally. This seems generally reasonable.

The effect on the average base rate of the changes to trend assumption I propose (a utilization trend rate of 0% for hospital inpatient and 3.2% for hospital outpatient) is a decrease of approximately 3.4% in the average increase, from 18.1% to 15.7%, and a reduction in the Base EHB Rate from $330.97 to $324.31, as shown in DeWeese Exhibit 6.

Q. In the course of your review, did you review the experience claim data that was the basis of Blue Cross's projections?

A. Yes.

Blue Cross's experience period allowed claims are shown in Tab 1 of its OHIC Rate Review template by type of care (IP, OP, M/S, Primary Care, Rx, and Health Assessments). The total claims include claims with dates of service during calendar year 2012 from Direct Pay Pool 1 and Pool 2, as well as claims associated with the High Risk PCIP program. In total, they add up to $82,966,694, with an additional $1,348,068 in incurred health assessments. They include payments through February 2013 and an estimate of remaining incurred but not reported claims. While the completion method is not described in detail, the level of the incurred claims adjustment is reasonable.

In response to AG 1-04, Blue Cross provided claims triangles which included allowed claims for the experience period with runout through March 2013. Those claims for the 2012 experience period, including the runout, amounted to $81,254,811.

I prepared a development method analysis of the allowed claims, and developed an estimate of remaining incurred but not reported claims as of February 28, 2013. My estimate was within a few percent of Blue Cross's estimate for the same incurred but not reported claims of $926,266. Blue Cross's estimate is reasonable, and I accept their experience period allowed claims without recommending any adjustment.

Q. In the course of your review, did you review the administrative expense Blue Cross included in its filing?

A. Yes.

Last year's Direct Pay filing included administrative expense of $57.08 Per Contract Per Month (PCPM), while this year's filing includes administrative expense of$39.16 PMPM (net of investment income credit, which was not netted out of last year's number. Blue Cross has described its administrative expenses as representing approximately 3.2% of the total 18.1% average increase in the cost of Individual Health Insurance. Blue Cross has provided additional explanation in its response DBR 5-01, but it is difficult to compare the expenses from one filing to the next because they were expressed differently (per contract versus per member) and because of the treatment of additional items required to conform with the ACA. If more information becomes available during the course of the hearing, I will supplement my testimony as appropriate.

Q. In the course of your review, did you review the charges included relative to state assessments?

A. Yes.

Blue Cross pays assessments to the Rhode Island Department of Health to support the adult and child immunization programs, and to the Rhode Island Department of Human Services to support the Children's Health Account, which finances a number of health services. These assessments are required by law, and are assessed based on premium volume. The amount of the assessments is determined by comparing the costs of the programs to assessable premium. While some forms of coverage are exempt from the assessment (for example, Medicare supplement premium is not assessed a share of the children's immunization program), Direct Pay is not exempt. From an actuarial standpoint, it is reasonable for Blue Cross to pass on these costs.

However, in each of the last few Direct Pay filings, Blue Cross had been directed by the Commissioner not to charge the assessments to Direct Pay premiums, except for benefits provided by the assessments that directly benefit Direct Pay members. This directive was taken in the interests of affordability for the very vulnerable Direct Pay population, and because the assessments primarily provide benefits for children, while Direct Pay has had served fewer children than Blue Cross's other lines of business.

In the context of the current Individual filing, the profile of membership will have changed, and the block is anticipated to be much larger. In addition, there will be at least one other issuer offering Individual insurance in Rhode Island. In that environment, it appears appropriate that Individual should bear the cost of the assessments imposed upon its premium by state law, from an actuarial perspective.

Blue Cross has not made any estimate of the portion of assessment expense expected to benefit only Individual members, but could presumably do so if directed by the Commissioner.

Q. In the course of your review, did you review the charges included with regard to premium tax?

A. Yes.

In two prior Direct Pay filings, Blue Cross was directed by the Commissioner not to include recovery of premium tax in the Direct Pay rates. While Blue Cross is required to pay premium tax on Direct Pay premiums, and it would otherwise be reasonable for Blue Cross to include the premium tax in its Direct Pay rates, the Commissioner directed them not to do so in the interests of affordability. Direct Pay premiums are not exempt from premium tax in Rhode Island.

There is nothing about the premium tax that makes it wrong for Blue Cross to charge it to Direct Pay customers, but it is reasonable for the Commissioner to determine that premium tax may not be recoverable in the context of a Direct Pay filing process. Blue Cross has included recovery of premium tax in this filing. The inclusion of premium tax makes the Direct Pay rate increase approximately 2.1% higher than it would otherwise be.

Q. In the course of your review, did you review the investment income credit included in Blue Cross's filing?

A. Yes.

The rates in this filing are approximately 0.41% lower than they would otherwise be because Blue Cross provided an investment income credit. This credit and the amount of the credit are reasonable.

Q. In the course of your review, did you review the amount allocated for contribution to reserves included in Blue Cross's filing?

A. Yes. Blue Cross has requested a contribution to reserves that totals 2.84%. There are three elements.

- Blue Cross proposes 0.34% contribution earmarked to amortize costs of its claims system development. This is an appropriate way of funding the claims system. It was first determined several years ago as the amount necessary to fund the development cost over approximately 15 years. Blue Cross has filed and OHIC has approved an amount of 0.34% in each of Blue Cross's business lines in each of the last several years.
- Blue Cross proposes a regular contribution to reserves of 2.0% of premium. In the past several years, Blue Cross has not included a contribution to reserves in its Direct Pay rates in the interest of affordability, and to protect the interests of the Direct Pay consumers, for whom Blue Cross Direct Pay has been the insurer of last resort. For 2014, the Individual market is expected to expand significantly with the addition of a large number of previously uninsured individuals. It is expected that beginning in 2014, Blue Cross will no longer be the only carrier offering coverage in Rhode Island to individuals.

- Blue Cross incurs Federal Income Tax on any contribution to reserves at a rate of approximately 25%. This does not apply to the portion used to fund the claims system, since that money is spent. It does mean that a contribution to reserves of 2% of premium, as Blue Cross has proposed, results in tax of 0.5% of premium.

Q. Do you have any recommendation about whether Blue Cross's proposed contribution to reserves is appropriate?

A. From an actuarial standpoint, Blue Cross's proposed contribution to reserves is reasonable. Blue Cross needs to fund its reserves in order to maintain financial solvency. Now that Individual is expected to be a larger line of business, it will be more important for it to contribute to Blue Cross reserves rather than to push that burden on to Blue Cross's other lines of business, predominately large and small group insurance. While affordability is very important, in 2014 there will be at least one other carrier offering Individual insurance in Rhode Island, and Blue Cross will not therefore be the insurer of last resort.

However, the Commissioner may want to consider grading in the full contribution to reserves over two or three years. Grading in over two years would reduce the increase by approximately 1.7%, from 18.1% to 16.4%. It would reduce the Base EHB rate from $330.97 to $326.08. The result is shown in DeWeese Exhibit 7. Grading in over three years would reduce it by another 0.6% or 2.3% in total, and would reduce the Base EHB rate further, to $324.48. I have not prepared a separate exhibit for three year grading..

Q. Can you summarize your findings and recommendations with regard to this filing?

A. Yes.

Blue Cross has done a competent and professional job in preparing this rate filing. It is a complex undertaking, requiring a number of important assumptions, interpretation of data and adjustments. I have identified a number of areas in which alternative methods or assumptions could be considered. I do not mean to suggest that Blue Cross's methods and assumptions are incorrect. I am identifying here in summary form items that could affect the overall rates, with an approximate value of each potential adjustment. The following chart shows a summary of the various potential changes I considered. My calculations are approximate, based on the data available to me. It is possible that Blue Cross may come out with a different value if they do the calculations themselves using better data or more refined assumptions. I do not present these changes as ones that should definitely be made. I believe that there is considerable uncertainty associated with the changes facing the Individual market and there is good reason to be at least somewhat conservative. These changes represent a range of potential modifications that could be considered. A summary of the effects of the alternate assumptions discussed above is shown in DeWeese Exhibit 8. A more abbreviated summary is shown here, comparing the adjustments to the filed Base EHB Rate of $330.97 and the filed average rate increase of 18.1%.

Item	Effect on EHB Rate	Effect on Rate Increase
Revised adjustment for morbidity	$ (13.83)	-4.90%
Revised IP and OP Cost Trend	$ (6.16)	-2.20%
Revised IP & OP Utilization trend	$ (6.66)	-2.40%
Grade in contribution to reserves over 2 years	$ (4.89)	-1.70%
Sum of all potential adjustments	$ (31.54)	-11.20%
Adjusted Result	$ 299.43	6.90%

I do not consider these changes to represent errors in Blue Cross's analysis. They are instead areas where I believe alternate assumptions are equally valid to those Blue Cross has made. While none of these changes appear necessary to me from an actuarial perspective, they are reasonable policy choices for the Commissioner to consider.

There may be additional information that becomes available during the course of the hearing, and I will consider it as it becomes available, and reserve the ability to supplement my testimony if I am asked to do so.

Q. What rates will Blue Cross's low income customers pay for Individual insurance?

A. There are Federal subsidies available under the ACA for people with low incomes. The amount of the subsidy will vary based on how a person's income compares to the Federal Poverty Limit. DeWeese Exhibit 9 gives some examples of rates that a person of varying ages and FPL status would pay before after consideration of Federal subsidies. As DeWeese Exhibit 9 shows, there is a sliding scale of maximum contribution for an individual depending on where the individual's income falls.

For example, a person at up to the 133% FPL level would pay $38.20 per month for insurance. The Federal premium subsidy would make up the difference to the full Blue Cross Premium, ranging in this exhibit from $244.82 at age 21 to $664.44 at age 60. A person at up to the 300% FPL level would pay a monthly premium of $272.89. This would not reduce premiums for a 21 year old, but would be a significant benefit to an older person. In addition, people below 200% of FPL would be eligible for enhanced benefits, including reduced copays and deductibles, for which the claims difference is made up by the Federal Government.

Q. Do you reach your conclusions with a reasonable degree of actuarial certainty?

A. Yes.