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 19, 2010

PRE-FILED DIRECT TESTIMONY OF
JOHN LYNCH

I. INTRODUCTION

Q. Please state your name and professional qualifications.

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

Q. By whom are you employed?

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

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

A. My title is Chief Actuary and I oversee Blue Cross' actuarial department. 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 and overseeing all other actuarial functions.

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

A. I have been employed in that capacity for the last 5 years. I was hired into this position on July 27, 2005.

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

A. Yes. Last year's Direct Pay rate filing was resolved without a rate hearing. However, my pre-filed testimony was admitted in evidence, and it was stipulated that I was accepted as an expert on actuarial matters in that proceeding. Previously, I had been accepted as an actuarial witness and testified as such at the previous three rate hearings pertaining to Blue Cross' request to increase rates for class DIR. Additionally, numerous filings have been submitted to the OHIC over my signature during the last 5 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 19, 2010, 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 limited 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.

Q. Please describe the goal behind this rate structure.

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

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

A. Yes. Since the AccessBlue program was introduced to Preferred (Pool II) members in April 2007, the number of members enrolled in Preferred (Pool II) has steadily increased. In April 2007, there were approximately 13,900 members enrolled in Class DIR. Of these, approximately 7,400 were enrolled in Basic (Pool I) (53%) with 6,500 in Preferred (Pool II) (47%). In April 2008, the number of Preferred (Pool II) members had increased to approximately 6,900, with approximately 7,000 enrolled in Basic (Pool I). In April 2009, Preferred (Pool II) membership had increased to approximately 7,300 (53%), however, Basic

(Pool I) enrollment had declined to 6,600 members (47%). In April 2010, Preferred (Pool II) enrollment had increased to approximately 7,700 members while Basic (Pool I) enrollment had further eroded to 6,400. As of September 2010, the number of Preferred (Pool II) members stands at approximately 7,600 (53%), while the number of Basic (Pool I) members is approximately 6,900 (47%).

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

A. Assuring that Preferred (Pool II) is attractive in the market is critical to sustaining the Direct Pay market. The financial stability of the entire Class DIR is dependent to a significant degree on the continuing ability of Blue Cross to attract subscribers into Preferred (Pool II) since they help to subsidize Basic (Pool I). As a consequence, it is important that Preferred (Pool II) rates bear a reasonable relationship to the pool's own underlying experience level and not be higher than necessary. 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. What is Blue Cross' goal with regards to enrollment in its Direct Pay products?

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

Q. What has Blue Cross done to improve Basic (Pool 1) enrollment.

A. Effective April 2010, Blue Cross introduced rate structure changes for Basic (Pool I) subscribers in order to make its rates more attractive in the market. Previously, all subscribers who failed medical underwriting paid the same individual or family rate for the same set of benefits, with the exception of subscribers ages 65 and older. Effective April 2010, Basic (Pool I) rates now vary by four age categories; under 40, 40-49, 50-64, and 65 and older. While it is too early to make a definitive judgment, it appears that this rating change may be having the desired effect of improving the Pool 1 enrollment trajectory. As discussed above, the Basic (Pool I) enrollment increased from 6,400 members in April 2010 to 6,900 members in September 2010. After a number of years of decline, our Pool 1 enrollment is starting to show some growth. Effective April 2011, Blue Cross is proposing to introduce age rating in 5 year age intervals and further differentiate Basic (Pool I) rates by age. Specifically, Blue Cross is proposing to increase the rate differential between the 60-64 age category and the under 25 age category to 25% while maintaining the relationship between the 65 and older rates and the age 60-64 rates. This rate structure change will improve the financial equity between young and old Pool 1 subscribers and have favorable enrollment effects. We believe that by stratifying Basic (Pool I) rates by age, the relatively younger applicants who are not able to pass medical underwriting will be more likely to purchase health insurance rather than go uninsured. Also, by reducing the health status adjustment for younger members, we believe the average age of the Basic pool should decline over time, helping to moderate future increases in health care costs. Finally, by having similar rate structures in both rating pools, there should be less rate shock to Direct Pay subscribers when the Patient Protection and Affordable Care Act is fully implemented in 2014.

Q. You mentioned the Patient Protection and Affordable Care Act's ("PPACA") requirements for Direct Pay. Can you describe those requirements in more detail?

A. Yes. PPACA requires changes to the benefits covered under direct pay plans as well as changes to the rating structure used for direct pay. More specifically, for this filing, all of our direct pay products will be updated to include coverage for preventive services in accordance with specific recommendations of the US Preventive Services Task Force (USPSTF), screenings for infants, children, adolescents and women recommended by the Health Resources & Services Administration (HRSA), and immunization recommendations of the Centers for Disease Control and Prevention (CDC) without cost-sharing and to cover dependents up to the age of 26. In 2014, direct pay products will have to comply with additional coverage requirements including the "essential health benefit package" which is yet to be fully defined.

PPACA also 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.

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

A. Blue Cross' strategy regarding making these changes is to make them gradually over the next few rate filings, 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 the market, in order to maintain the financial stability of Class DIR.

Q. Are there any other impacts to Class DIR as a result of PPACA requirements?

A. Yes. Beginning September 23, 2010, insurers cannot decline to issue coverage to children under 19 due to a pre-existing condition nor decline to cover treatments of pre-existing conditions. As a result of these new federal requirements, some insurers have decided to cease writing child-only policies or to write them only during a defined open enrollment period. We have decided that we will write child-only policies throughout the year on a guaranteed issue basis. We will medically underwrite the child applicant in our normal fashion and assign the child to the appropriate rating pool based on the results.

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

A. Contemporaneous with this rate filing, Blue Cross has filed with the Office of the Health Insurance Commissioner (OHIC) proposed revisions to the contract forms for each of the five products currently available to Class DIR. These proposed forms provide detailed descriptions of the benefits and other terms of the subscriber agreements. The five existing products are: HealthMate Coast-to-Coast Direct Plan 500/1000, HealthMate Coast-to-Coast Direct Plan 1000/2000, HealthMate Coast-to-Coast Direct Plan 2000/4000, HealthMate for HSA Direct Plan 3000/6000 and HealthMate for HSA Direct Plan 5000/10000. Blue Cross is not proposing any major benefit changes to these products effective April 1, 2011. However, in addition to the benefit changes mandated by PPACA as outlined above, we are also proposing to make some modest changes to mental health

benefits so that our Direct Pay plans comply with the Federal Mental Health Parity legislation. Of the current portfolio of products, this legislation impacts only the benefits for the HealthMate Coast-to-Coast Direct Plan 1000/2000. In addition, we are proposing to cover in-network outpatient mental health substance use (MHSU) services at 100% rather than being subject to the deductible and coinsurance. The changes to the MHSU benefit reflect federal regulations to implement the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The MHPAEA will apply to Class DIR beginning in 2014, however Blue Cross is implementing these important changes early. The rates submitted in this rate filing reflect the benefit changes discussed above.

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

A. Yes. Effective April 1, 2008, the HealthMate Direct 2000 product was designated as a Wellness Health Benefit Plan. Subscribers who elect this plan option have the opportunity to receive a reward equal to 10% of paid premium if they meet the program requirements. Blue Cross has issued $44,398 in rewards as of September 2010.

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 low incomes (their annual gross household income is less than 350% of federal poverty levels (FPL)) with which to purchase coverage. A separate report discussing our experience to date with AccessBlue has been submitted under separate cover to the OHIC contemporaneous with this filing.

Q. Is AccessBlue part of the rates?

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

Q. Why is Blue Cross offering the program?

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

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

A. There are two levels of assistance provided through AccessBlue. Subscribers with an annual household income less than or equal to 200% of the FPL qualify for Level 1 subsidy status. During the rating period beginning April 1, 2011, 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 7% to 76% of the total proposed premium depending on the pool and the selected product.

Additionally, Direct Pay subscribers who have incomes between 201% and 350% FPL are eligible for Level 2. During the rating period beginning April 1, 2011, Level 2 will provide a subsidy of $54 for each eligible individual subscriber and $102 for each eligible family, on a monthly basis. This equates to assistance ranging from 4% to 50% of the total proposed premium depending on the pool and the selected product.

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

A. The 2011 federal poverty levels are expected to be released in late January 2011. Once released, Blue Cross intends to implement the new levels on the income guidelines for April 1, 2011. The 2010 federal poverty levels are as follows:

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

Approximately 8,100 or 79% of Direct Pay contracts are for individual coverage. With respect to family coverage, the average size family in Direct Pay is 3.3 persons. Approximately 29% 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. 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. As of September 30, 2010, Blue Cross had provided over $8 million is assistance through the AccessBlue program.

Q. How long will Blue Cross continue AccessBlue?

A. AccessBlue is entering its sixth year and Blue Cross continues to study it, and adapt the program as its effectiveness and Blue Cross' means of support warrant. Underpinning the program's ongoing viability is the need for Blue Cross to be able to implement actuarially justified, adequate premium rates – for Direct Pay, as well as all other segments of business. The program is monitored closely by Blue Cross, and future funding, payment levels, and eligibility will be modified or terminated as appropriate. Based on the current expenditure level, funding for the program is expected to run out in 2012. Blue Cross will continue to evaluate the viability and appropriateness of the program, taking into account the company's financial condition as well as changes in legislation, such as the recently enacted 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. The most common way is through Rhode Island Gen. Laws § 27-18.5-3, which provides that coverage is guaranteed for our Pool 1 Basic rate for eligible individuals and families who have had creditable coverage that ended less than 63 days prior and was in force for 12 continuous months or was in force for 18 months with no breaks of more than 63 days. The Pool II plans are available to any eligible individual or family who can meet our medical underwriting guidelines throughout the year. Finally, Blue Cross also offers guaranteed coverage during open enrollment.

Q. Has Blue Cross recently conducted an open enrollment?

A. Yes. The last open enrollment was held between May 15, 2010 and June 15, 2010 for a July 1, 2010 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 12, 2010. On the radio open enrollment was promoted on eight local stations from May 10, 2010 through June 11, 2010. Open enrollment was also advertised in banner ads on google.com, yahoo.com and the projo.com between May 2, 2010 and June 3, 2010. 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 694 new applications were received. Subscribers who pass the health screen can enroll at any time during the year into Preferred rates (Pool II).

We sent postcards to our existing members notifying them about open enrollment and our new HealthMate Coast-to-Coast Plan 1000/2000 as well as plan change forms so that they could easily elect to change to the new plan. During open enrollment we received 322 plan

change forms, and of those 201 elected to change to the new HealthMate Coast-to-Coast Plan 1000/2000.

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

A. The last rate increase was effective April 1, 2010. This was the result of a filing for Class DIR that was submitted to the OHIC on November 20, 2009 and approved on February 8, 2010 with some modifications.

Q. As a result of the February 8, 2010 decision by the OHIC, can you quantify what modifications were made?

A. Yes. As a result of the decision by the OHIC, the aggregate filed rate increase was reduced by 4.1% - from 10.2% to 6.1%. This reduction included an adjustment for large claims, a reduction to the filed administrative expenses, and the exclusion of the 2% state premium tax as well as assessments to cover child immunizations, adult immunizations, and CEDARR, CIS, and Home Services.

Q. Had the rating components for the state premium tax and assessments been approved in previous Class DIR rate filings, except for the most recent Class DIR filing?

A. Yes.

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

A. Yes. 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. The state premium tax and 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.

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 these taxes and assessments in Class DIR premiums is fair and makes practical business sense.

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.

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, in lieu of claims expenses that would otherwise be incurred by insured members.

Our claim records indicate that between June 2009 and May 2010 about 4,000 Class DIR members (2,300 adults and 1,700 children) directly benefited from the medical services funded by these state assessments. That is, they received an immunization covered by these state programs. The biological agents administered were funded by the assessments levied by the state. In the absence of the state programs our Class DIR claim costs would have been higher.

Q. What is the reserve contribution component being requested for Class DIR in the proposed filing effective April 2011?

A. Blue Cross is proposing a 1% reserve contribution in its Direct Pay rates effective April 2011. 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. We are aware that in recent filings OHIC has disallowed an inclusion of a reserve contribution in Direct Pay rates. However in light of the very significant decline in our overall reserve position, we are requesting a modest reserve contribution be allowed in this and future filings at least until our overall reserve position is restored to more appropriate levels. Although last year's Direct Pay rate filing did not include a reserve contribution component, given the current financial condition of the company, Blue Cross cannot continue to absorb losses from its Direct Pay line of business in its other market segments. To keep the Direct Pay rates as affordable as possible,

however, the reserve contribution being requested from Direct Pay subscribers is 1%, as compared to 2% for our group products.

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. They apply to Class DIR for the rate year commencing April 1, 2011. Blue Cross Exhibit 2 consists of schedules 1 through 50.

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, 2011 billing cycle as well as to introduce the new benefit plan outlined above. The filing schedules are intended to provide actuarial justification for the required rates needed by Blue Cross in order for the products to be financially self-supporting, both in the interest of its subscribers and its mission to provide quality health insurance programs.

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

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

A. Yes. The Blue Cross Board of Directors met on November 4, 2010, at which time the rate increases reflected in this filing were considered, discussed, and approved for submission. The Directors' Finance Committee, which has primary oversight of all rate matters, also reviewed and authorized these rate increases at its meeting, held on October 28, 2010.

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

A. Schedules 1 through 3 constitute the table of contents for the actuarial schedules in Exhibit 2 that display and support the calculations of the required subscription rates for the April 1, 2011 billing cycle for the existing products within Class DIR. The actuarial schedules are grouped into sections, labeled as section I through section VII.

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

A. Section I consists of schedules 4 through 10, which summarize the calculations of the Basic (Pool I) monthly subscription rates for the April 2011 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 11 through 17, which summarize the calculations of the Preferred (Pool II) required monthly subscription rates for the April 2011 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 18 through 22, 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 23 through 25, which summarize the claims impacts from state assessments and coverage for dependents up to age 26. Schedule 24 shows the calculation of the claims impact from the child immunization, adult immunization, and children's health account. Schedule 25 displays the calculation of the claims impact for covering dependents up to age 26.

Section V consists of schedules 26 through 35, which show the projected claims by plan for Direct Pay and calculate the rate period projected incurred claims expense for Basic (Pool I) and Preferred (Pool II) subscribers. Schedule 27 summarizes the projected claims expense by pool and plan for Direct Pay while schedules 28 through 35 calculate the projected claims expense by plan for Basic (Pool I) and Preferred (Pool II).

Section VI consists of schedules 36 through 37, providing the administrative expense estimates and calculations.

Section VII consists of schedules 38 through 50, 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 existing products within Class DIR?

A. Yes. The actuarial development of required rates for this filing is similar to the methodology used last year. The basic approach was to begin with base period incurred allowed claims, separately for Basic (Pool I) and Preferred (Pool II) and by benefit plan. To avoid seasonality concerns we chose a twelve month base period, which is our usual practice. We chose a base period that consists of allowed claims incurred over the June 1, 2009 to May 31, 2010 time period. These allowed claims, expressed on a per contract per month (PCPM) basis, were then projected to the rate period using projection factors which reflect anticipated trends in allowed claims levels. Next, the projected rate period allowed claims were adjusted by a factor that represents the ratio of net claims paid to allowed claims for each benefit plan as well as a utilization adjustment factor to reflect anticipated changes in utilization of services due to changes in member cost sharing. The net-to-allowed factors were calculated based on the projected rate period claims so that the effect of trend leveraging would be accounted for. A more thorough description of trend leveraging is included later on in my testimony. Finally, adjustments were made to reflect pharmacy rebates anticipated for the rate period and also the impact of changes made to our drug formulary effective November 1, 2010. This process produced projected paid claims PCPM for each of the products within Basic (Pool I) and Preferred (Pool II). The composite projected paid claims PCPM was then calculated for each pool.

The next major stage in the rate development was to determine the required monthly base rates for each of the five products within Basic (Pool I) and Preferred (Pool II). This stage begins with the composite projected incurred claims expense PCPM for each pool, which I have just described. The impact of state assessments and covering dependents up to age 26 was then applied to the projected incurred claims cost. The detail behind the state assessments is in Section IV. Retention (administrative expense, new system expense, reserve contribution, and taxes) was added to this expense to calculate required income PCPM by pool and then overall for Class DIR. Consistent with the required monthly income PCPM values, required loss ratios for each pool and overall for Class DIR are calculated.

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

Rates (Pool I) are being revised with this year's rate filing. In last year's rate filing, age rating was introduced in Basic rates (Pool I) on a limited basis. This year, we are proposing to increase the age slope within Basic (Pool I) from the current 1.1 to1 ratio to 1.25 to 1 for subscribers under age 65. We are also proposing to introduce age rating in 5-year intervals, expanding on the current three age bands for subscribers under age 65. To develop the age factors for Basic (Pool I), first the current factors were reset so that the factor for individual under age 25 rates was equal to the average of the Preferred (Pool II) male and female age factors for individual under age 25 rates. Next, the age slope was adjusted so that rates for subscribers aged 60-64 were 25% higher than rates for subscribers under age 25. For this step, the rate relationships among the age categories were based on the current Preferred Rate (Pool II) rate structure, with a flatter overall slope. Note that the relationship between family and individual rates within Basic (Pool I) is the same as in previous filings. 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-payments amounts, which are the responsibility of the subscriber. Claims expense reflects the benefit payment amounts under the terms of the particular product. Allowed claims include both claims expense amounts and subscriber cost-sharing amounts. It is the total cost of covered services under the provider contracts maintained

by Blue Cross prior to the determination of subscriber cost-sharing, versus Blue Cross benefit payments.

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

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

A. No. The projection factors are composed of anticipated price changes, 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 last year's rate filing, 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 a change in the way Blue Cross reimburses pathologists, mandated benefits, the impact of contractual changes with our pharmacy benefit managers, the impact of anticipated new brand name drugs being introduced to the market, and the anticipated availability of new generic drugs.

Blue Cross is changing the way it reimburses pathologists at certain hospitals. Previously, the pathologist payment was included in the reimbursement to the hospital. Blue Cross anticipates that, going forward, reimbursements will be sent directly to the pathologist, in accordance with our negotiated fee schedule. This change in payment policy is reflected in the claims adjustment factor for surgical/medical at April 2010.

Also impacting the claims projections for Direct Pay are the benefit changes being implemented to come into early compliance with the federal Mental Health Parity and Equity Addiction Act of 2008. Health plans are now required to cover unlimited visits for residential substance abuse and child & family intensive treatment programs (CFIT). The impacts of these

mandates are reflected in the claims adjustment factors for inpatient and surgical/medical, respectively.

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

Q. Have these claims adjustment factors been included in the definition of the projection factors in previous filings?

A. No. The claims adjustment factors had been applied elsewhere in the rate development in previously filings. They are included in the definition of projection factors in this year's filing so that the projection factors more accurately reflect all of the factors affecting claim costs. It should be noted that neither the calculation of the claims adjustments factors nor its impact on rates has changed, only the order in which they are applied.

Q. Could you now explain the development of 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 type of service used. For example, an increase in an emergency room copay would likely disincent members from using the emergency room in non-emergent situations. Similarly, an increase in the deductible amount could discourage members from getting an elective outpatient surgery since the member has more financial stake in the procedure. The utilization adjustment factors used in the Direct Pay filing are consistent with those Blue Cross uses for developing rates in the Commercial Group market.

The net-to-allowed factors and utilization adjustment factors used in this rate filing implicitly include the impact of any benefit changes between the base period and the rating period. This includes the impact of covering certain preventive services in accordance with specific recommendations of the USPSTF, the HRSA, and the CDC without cost-sharing as mandated by PPACA. The impact of these benefit changes is approximately 1.1% increase to the projected claims cost. This includes both the removal of the cost sharing provisions for these services and the expected increase in utilization due to the removal of subscriber cost sharing.

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 impact of changes made to the drug formulary. Could you explain these adjustments?

A. Yes. Due to the provisions of our contract with our pharmacy benefit manager and 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 rebates factor displayed on schedules 28-35 of Exhibit 2. Note

that in previous rate filings, the impact of prescription drug rebates was not shown explicitly, but was reflected in the incurred allowed claims amount. The impact of prescription drug rebates is explicitly shown in this rate filing in the interest of providing more clarity and transparency on the matter.

An adjustment was also made to the incurred claims to reflect prescription drug formulary changes that Blue Cross made effective November 1, 2010. These changes include moving some high cost generic drugs to the second formulary tier and removing some drugs from the formulary altogether. It should be noted that in cases where a particular drug is no longer covered, there are multiple therapeutic alternatives, either prescription or over-the-counter, available within the particular therapeutic class. These formulary changes are being made as part of Blue Cross' commitment to lowering healthcare costs while preserving high quality care. These savings are passed directly to our Direct Pay subscribers in the form of lower premium rates and the impact is shown in column (6) of schedules 28-35 of Exhibit 2. These changes also seek to bring our formulary more in line with industry standard.

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

A. Yes. Briefly, trend leveraging describes the phenomenon that for benefit plans with fixed-dollar cost sharing, claims on a net paid dollar basis increase at a faster rate than claims on an allowed dollar basis if the fixed-dollar cost sharing (i.e. deductibles and co-payments) does not change from year to year. For example, let's say that the underlying increase in medical costs (i.e. the trend in allowed claims) is ten percent annually. Let's further assume that in a given year, one hundred dollars of allowed claims is incurred. As mentioned earlier, the

trend in allowed dollars is ten percent and one hundred ten allowed dollars are incurred in the following year. However, if we impose a fifty dollar deductible on the benefit plan, the net claims expense becomes fifty dollars ($100-$50) in the first year and sixty dollars in the following year ($110-$50). The annual trend in claims expense in this case has been leveraged to 20% ($60 divided by $50). The same phenomenon occurs in the Direct Pay products due to the upfront deductibles and other fixed-dollar co-payments in the benefit provisions. Since members do not utilize benefits consistently, the effect of trend leveraging is best handled by projecting and re-adjudicating claims at the member level. This is the process involved in the calculation of the net-to-allowed factors.

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

A. Allowed claims PCPM were developed separately for Basic (Pool I) and Preferred (Pool II) and projected to the rate year using projection factors that were appropriate for each pool. Next, contract months over the rate year were projected for each pool by looking at recent historical enrollment changes. The separate rate period claims expense PCPM for each pool were weighted together by the projected rate period contract months to arrive at a composite projected claims expense for Class DIR over the rate year. Similarly, the present rate income PCPM was developed separately for Basic (Pool I) and Preferred (Pool II) and weighted by projected rate period contract months to arrive at a composite present rate income PCPM for Class DIR. Finally, required income PCPM was calculated for each pool using the current pool rate alignment. These calculations are displayed on Schedules 21 and 22 of Exhibit 2. By projecting the claims costs and present rate income separately for the two pools and recalculating

the composite based on the projected enrollment over the rate year, the issue of enrollment shifting amongst the pools is dealt with explicitly in the rating methodology.

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

Q. Please turn to schedule 27 of Blue Cross Exhibit 2 and describe that schedule.

A. Schedule 27 is entitled "Calculation of Composite Paid Claims Expense Per Contract Month for April 1, 2011 Billing Cycle." The purpose of this schedule is to display the base period contract months and the projected incurred claims PCPM by pool and plan. It uses the projected claims expense for each product from schedules 28 through 31 for Basic (Pool I) and schedules 32 through 35 for Preferred (Pool II). Calculations are documented in the footnotes.

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

A. Schedule 28 is entitled "Calculation of Projected Paid Claims per Contract Month for April 1, 2011 Billing Cycle for HealthMate Direct 500." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the projected paid claims PCPM for HealthMate Direct 500 for Basic (Pool I). Calculations are documented in the footnotes.

Q. How does schedule 28 compare with schedules 29 through 31?

A. Schedules 29 through 31 are comparable in nature. They also apply to Basic (Pool I) only. The difference is that within Basic (Pool I) they apply to HealthMate Direct 2000, HealthMate for HSA 3000, and HealthMate for HSA 5000, respectively, whereas schedule 28 applies to HealthMate Direct 500.

Q. On a column-by-column basis, would you explain what is contained in schedules 28 through 31? Please note any relevant differences among them.

A. The first and second columns of each of these schedules show base period incurred allowed claims for each of the respective products. As indicated in the applicable footnotes, allowed claims were tabulated prior to the application of deductibles, coinsurance, or copayments. We used a base period for tabulating these allowed claims, and for the contract months underlying column (2), of June 2009 through May 2010. Incurred allowed claims amounts for this base period reflect actual claim submissions through July 2010, adjusted to a fully complete basis.

Column (3) shows the projection factors used to incorporate trends into the projection of allowed claims PCPM for the rate period. The projection factors are developed in schedule 39, as indicated in the footnotes. Consistent projection factors are used in all four schedules.

Column (4) displays the projected allowed claims PCPM. This column is the product of columns (2) and (3).

Column (5) displays the Net-to-Allowed factors by benefit. These factors convert the projected allowed claims to paid claims for the rate year, including additional coverage for preventive services, as mandated. The factors are unique to each combination of pool and plan since these factors are calculated using the actual claims experience for each pool and plan combination. Since the HealthMate Direct 500 and HealthMate Direct 2000 products have first dollar coverage for drug benefits (i.e. drug benefits are covered without members first having to meet a deductible), separate drug and non-drug net-to-allowed factors are calculated for these products. The HealthMate for HSA 3000 and HealthMate for HSA 5000 products cover drug

benefits only after the deductible has been met. Therefore, net-to-allowed factors for these products are calculated in aggregate for drug and non-drug benefits.

Column (6) shows the anticipated reduction to pharmacy claims due to the formulary changes that were implemented November 1, 2010.

Column (7) represents a rate reduction to pharmacy claims due to anticipated rebates from our pharmacy vendor, CVS/Caremark, over the rate period. In previous rate filings, pharmacy rebate factors were not shown separately, but were instead accounted for within the Incurred Claims.

Column (8) is the anticipated utilization change due to the redesigned benefits effective April, 1 2010 and additional preventive services effective April 1, 2011.

Column (9) is the product of columns (4) through (8). Column (9) represents the projected paid claims PCPM by benefit for the rate year.

Q. You state that schedules 28 through 31 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 32 through 35.

Q. Are there any differences between schedules 32 through 35 and schedules 28 through 31, 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 39 and describe that schedule.

A. Schedule 39 is entitled “Projection Factors for Allowed Claims for April 1, 2011 Billing Cycle.” It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the projection factors used to project base period allowed claims to the

rate period. The base period for allowed claims is June 2009 through May 2010, while the rate period is April 2011 through March 2012. The difference between these two periods is 22 months. The projection factors reflect Blue Cross' expectation for cumulative trends over this 22-month period. These trends have a price component, 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. The calculations in schedule 39 are documented in the footnotes.

Q. On a column-by-column basis, would you please explain what is contained in schedule 39?

Column (1) of schedule 39 shows the price trend factor components of the projection factors. These price trend factors apply to the 22-month projection period from the base period to the rate period. They were provided by Blue Cross' Contract Support Department, based on actual unit cost increases, estimates of price increases based on negotiated prices, and any planned or estimated increases and adjustments.

Column (2) contains the Basic (Pool I) utilization/mix trend factor components of the Basic (Pool I) projection factors. These utilization/mix trend factors also apply to the 22-month projection period from the base period to the rate period. They were developed from an analysis of Basic (Pool I) historical claims trends. For Basic (Pool I), the graphs and corresponding data points displayed in schedules 41 through 44 formed the foundation for this analysis, along with actuarial judgment. For pharmacy, these trends also include price. The footnotes in schedule 39 document the annual trend assumptions for utilization / mix selected by Blue Cross.

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 federal mental health parity, direct payments to pathologists, 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. Was any recognition of leveraging of trend factors caused by the HealthMate deductibles needed? If so, please explain how this was handled.

A. The term leveraging, when used in the context of price trend factors, refers to the fact that deductibles or other fixed dollar subscriber cost-sharing generally causes price trends in benefit claims expense to be greater than the underlying price trends in allowed claims. The materiality of such leveraging depends on the proportionate magnitude of the deductible or other fixed dollar cost sharing provisions; relatively large deductibles and fixed co-payments have greater leveraging impact on benefit claims expense trends than relatively small cost sharing amounts. The materiality of leveraging also depends on the magnitude of the underlying price trends in allowed claims; relatively higher price trends in allowed claims generally have a greater leveraging impact on benefit claims expense trends than lower price trends.

The projection factors developed in schedule 39 reflect trends in allowed claims, rather than benefit claims expense. They are then applied to base period allowed claims, to produce projected allowed claims. As a result, trend leveraging is not a factor affecting the price trend factor in column (1). It should be noted that the net-to-allowed factors contained in column (5) of schedules 28 through 31, for Basic (Pool I), and schedules 32 through 35 for Preferred (Pool II), deal with the changing impact over time of deductibles and fixed dollar co-payments. These net-to-allowed factors address the impact of the deductibles and fixed dollar co-payments

by re-adjudicating allowed claims that have already been projected. This direct treatment avoids the need for leveraged trend factors.

Q. You state that schedules 39 and 41 through 44 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 40 and 45 through 48, respectively.

Q. Are there any differences between schedules 40 and 45 through 48 and schedules 39 and 41 through 44, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

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

Q. With regard to the utilization / mix trend factors shown in schedules 39 and 40, 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 2007, 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 2008. Twenty-five data points, which equates to three years of experience, were looked at. Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, a statistical technique for quantifying trend levels. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the

data points using the most recent 13 or more data points, with a minimum R-squared value of 0.70 to help assure reasonable fit to the data points.

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

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

A. This is the method that has been utilized and presented in past rate filings for quantifying trends. It has been discussed extensively in previous rate hearings. Briefly, by plotting a number of historical observations on a graph, the average change over a specified time period may be calculated using a statistical technique referred to as the method of linear least squares.

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

The principle of least squares states that the line of best fit to a series of observed values is the line where the sum of the squares of the deviations (the differences between the line and the actual values) are minimal, or the least possible. While one may attempt to draw a straight line through the observations by visual interpretation to denote a trend, the method of

least squares obtains that minimum sum of squared deviations necessary to give a best linear fit of the data.

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

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

Once the number of 13 or more of the most recent data points that provides the best fit is found, the trend indication based on those data points is what we utilize in the rate calculations, provided that the best fit is actuarially acceptable. A trend line with an r-squared value of 0.70 or higher is generally considered statistically acceptable to us; however, a non-credible experience base, an erratic or biased pattern of data points, a low r-squared value, or otherwise unreasonable result, may provide reasons to utilize actuarial judgment in trend determination.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. Yes. Certain adjustments were made to normalize for changes in benefits or pricing policies that have occurred over the experience period used to measure trend. Also, certain modest adjustments were made to the allowed claims PCPM under pharmacy, in order to

reflect global changes in the pricing, quantities, and over-the-counter dispensing of certain specific prescription drugs.

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

A. Yes.

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

A. Schedule 41 is entitled "Class DIR Basic Rate (Pool I): Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points, for Class DIR Basic (Pool I). The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares, as I described earlier. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent 13 data points or more). As shown in schedule 41, the line with the best fit is based on the last 18 data points with an r-squared value of 0.6091 and an annual trend of 7.43%. The r-squared value does not meet the minimum criteria of 0.70. Recent Commercial Group inpatient trend factors imply an annual trend of 0.00% for utilization and mix. We believe Group's inpatient trend is a reasonable proxy for future Class DIR

inpatient trend. This annual trend assumption is documented in the footnotes contained in schedule 39.

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

A. Schedule 42 is entitled "Class DIR Basic Rate (Pool I); Hospital Outpatient: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 41 earlier. Similarly, following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 42, the line with the best fit is based on the last 24 data points, with an r-squared value of 0.9324 and represents a calculated annual trend of -7.57%. Although the r-squared value met our minimum criteria of 0.70, we do not believe that a -7.57% annual trend can reasonably be expected to continue. Recent Commercial Group outpatient trend factors imply an annual trend of 4.04% for utilization and mix. We believe that, for both Basic (Pool I) and Preferred (Pool II), Group's outpatient trend is a reasonable proxy for future Class DIR outpatient trend. Due to the indicated dichotomy, based on valid r-squares, between Basic (Pool I) and Preferred (Pool II), we have selected to reduce the Commercial Groups indicated trend by about 4%, resulting in a neutral

selected Basic (Pool I) outpatient utilization/mix trend of 0.00%. This annual trend assumption is documented in the footnotes contained in schedule 39. Additionally, since we are projecting from a base period that consists of the twelve months ending May 2010, we are fully recognizing the decreases in outpatient utilization that have occurred to date.

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

A. Schedule 43 is entitled "Class DIR Basic Rate (Pool I): Surgical/Medical: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed PMPM values used.

Again, trend lines were fit to a number of sets of data points utilizing the method of linear least squares. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 43, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.1727 and represents a calculated annual trend of 0.67%. The r-squared value does not meet the minimum criteria of 0.70. Recent Commercial Group Surgical/Medical trend factors imply an annual trend of 4.04% for utilization and mix. Although the Class DIR data does not fully meet our credibility standards, we do not want to wholly discard it. Therefore we have elected to use a 2.00% trend factor which is a mitigation of Commercial Group's 4.04%

annual trend. This annual trend assumption is documented in the footnotes contained in schedule 39.

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

A. Schedule 44 is entitled "Class DIR Basic Rate (Pool I): Pharmacy: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. These values have not been depriced, so their trends reflect both price and utilization/mix.

As shown in schedule 44, the line with the best fit is based on the last 22 data points, which has an r-squared value of 0.9931 and represents a calculated annual trend of 13.40%. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 13.40%. This annual trend assumption is documented in the footnotes contained in schedule 39.

Q. Would you turn now to schedule 49, and describe what is contained in that schedule?

A. Schedule 49 is entitled "Class DIR Basic Rate (Pool I): Point Values Utilized in Development of Trends." This schedule displays the allowed claims PMPM values utilized to calculate trends in schedules 41 through 44. 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 41 through 44 for each of the applicable lines of business.

Q. You state that schedules 41 through 44 and 49 apply to Basic (Pool I) only. Are there comparable schedules for Preferred (Pool II)?

A. Yes. They are schedules 45 through 48 and 50, respectively

Q. Are there any differences between schedules 41 through 44 and 49 and schedules 45 through 48 and 50, respectively, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

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

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

A. Schedule 45 is entitled "Class DIR Preferred Rate (Pool II): Hospital Inpatient: Historical Allowed Claims PMPM and Utilization/Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points, for Class DIR Preferred (Pool II). The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 41 earlier. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data (the most recent 13 data points or more). As shown in schedule 45, the line with the best fit is based on the last 13 data points with an r-squared value of 0.6404 and an annual trend of -16.44%. The r-squared value does not meet the

minimum criteria of 0.70. Recent Commercial Group inpatient trend factors imply an annual trend of 0.00% for utilization and mix. We believe Group's inpatient trend is a reasonable proxy for future Class DIR inpatient trend. This annual trend assumption is documented in the footnotes contained in schedule 40.

Q. Please turn to schedule 46, and describe what is contained in that schedule.

A. Schedule 46 is entitled "Class DIR Preferred Rate (Pool II); Hospital Outpatient: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims per member per month (PMPM) for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed claim PMPM values used.

Trend lines were fit to a number of sets of data points utilizing the method of linear least squares referred to in describing schedule 41 earlier. Similarly, following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 46, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.9568 and represents a calculated annual trend of 11.82%. Although the r-squared value met our minimum criteria of 0.70, we do not believe that an 11.82% annual trend can reasonably be expected to continue. Recent Commercial Group outpatient trend factors imply an annual trend of 4.04% for utilization and mix. We believe, for both Basic (Pool I) and Preferred (Pool II), Group's outpatient trend is a reasonable proxy for future Class DIR outpatient trend. Due to the indicated dichotomy, based

on valid r-squares, between Basic (Pool I) and Preferred (Pool II), we have selected to increase the Commercial Groups indicated trend by about 4%, resulting in a selected Preferred (Pool II) outpatient utilization/mix trend of 8.00%. This annual trend assumption is documented in the footnotes contained in schedule 40.

Q. Please turn now to schedule 47, and describe what is contained in that schedule.

A. Schedule 47 is entitled "Class DIR Preferred Rate (Pool II): Surgical/Medical: Historical Allowed Claims PMPM and Utilization / Mix Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. In order to reflect only changes in utilization and mix of services, the allowed claims amounts have been adjusted, or depriced, to June 2007, so that intervening price increases have been removed from the allowed PMPM values used.

Again, trend lines were fit to a number of sets of data points utilizing the method of linear least squares. Following standard Blue Cross procedures, calculations were made to determine the line that best fit the data points with a minimum of the most recent two years of data. As shown in schedule 47, the line with the best fit is based on all 25 data points, which has an r-squared value of 0.8170 and represents a calculated annual trend of 3.12%. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 3.12%. This annual trend assumption is documented in the footnotes contained in schedule 40.

Q. Please turn to schedule 48, and describe what is contained in that schedule.

A. Schedule 48 is entitled "Class DIR Preferred Rate (Pool II): Pharmacy: Historical Allowed Claims PMPM and Allowed Claims PMPM Trends." This schedule contains a graph displaying allowed claims PMPM for 25 monthly 12-month moving periods or data points. The data points begin with the 12-month period ending May 2008 and continue through the 12-month period ending May 2010. These values have not been depriced, so their trends reflect both price and utilization/mix.

The line exhibiting the best fit produced an annual trend of 5.42%. It consists of all 25 data points, with an r-squared value of 0.9384. Since the r-squared value meets our minimum criteria of 0.70, and the result seems reasonable, we selected to utilize the calculated annual trend of 5.42%. This annual trend assumption is documented in the footnotes contained in schedule 40.

Q. Would you turn now to schedule 50, and describe what is contained in that schedule?

A. Schedule 50 is entitled "Class DIR Preferred Rate (Pool II): Point Values Utilized in Development of Trends." This schedule displays the allowed claims PMPM values utilized to calculate trends in schedules 45 through 48. 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 45 through 48 for each of the applicable lines of business.

Q. Turning back to schedules 28 through 35, column (5) shows net-to-allowed factors. Could you please describe generally the method used to develop these net-to-allowed factors?

A. Sure. To determine net-to-allowed factors, the allowed claims for each Direct Pay member are re-adjudicated to simulate members having each of the plan designs for the rate year April 2011 to March 2012. The most recent full rate year claims, April 2009 to March 2010, were broken out by each pool and product combination and each category was used in the calculation of the net-to-allowed factor for that particular cohort. For example the April 2009 to March 2010 claims for Basic (Pool I) HealthMate Direct 400 were re-adjudicated in the calculation of the net-to-allowed factor applicable to Basic (Pool I) HealthMate Direct 500. Since the period used begins in the middle of the calendar year and deductibles are aggregated on a calendar year basis, a multi-step process was utilized to project and re-adjudicate the claims.

First, allowed claims for the period January 2009 through December 2009 were projected to the period January 2011 through December 2011 and re-adjudicated to the net payment level for the applicable benefit plan. Next, allowed claims for the period January 2010 through March 2010 were projected to the period January 2012 through March 2012 and re-adjudicated to the net benefit level. This data was combined with the last nine months of projected net claims data from the previous step to form the net claims for the rating period. The net-to-allowed factor is then the ratio of the projected net claims expense to the projected rate year allowed claims. The prescription drug net-to-allowed calculations for the HealthMate for HSA 3000 and the HealthMate for HSA 5000 products are incorporated into the medical net-to-allowed calculations, since prescription drug claims for these plans apply towards the deductible.

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

Q. Column (6), of schedules 28 through 35, shows prescription drug formulary factors. Could you please describe generally the method used to develop these factors?

A. The prescription drug formulary factors were calculated by using 12 months of Direct Pay pharmacy experience. This claims experience was adjusted on a therapeutic class level to reflect the expected market share within each class due to the November 2010 formulary changes. The adjusted experience was compared to the base claims expense to calculate the formulary savings factor.

Q. Column (7), of schedules 28 through 35, shows prescription drug rebate factors. 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/script guarantees from our Pharmacy Benefits Manager. These projected rebates were increased to reflect the additional rebates expected from the November 2010 formulary changes. The projected rebates were divided by projected claims expense to calculate the prescription drug rebate factors.

Q. Column (8), of schedules 28 through 35, shows utilization adjustment factors. Could you please describe generally the method used to develop these utilization adjustment factors?

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

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

As discussed previously in my testimony, the net-to-allowed factors and utilization adjustment factors implicitly adjust for the impact of benefit changes between the base period and rating period, including approximately 1.1% due to the preventive service provision of PPACA.

Q. You have now described and explained the columns in schedules 28 through 35, along with the various schedules supporting them. You have stated that schedules 28 through 35 develop the projected paid claims PCPM for each of the current products. Now I would like to turn to section III of the rate filing and the development of the monthly base rates. Please turn to schedule 19 and describe that schedule.

A. Schedule 19 is entitled "Class DIR Basic Rate (Pool I): Calculation of Required Monthly Base Rates for April 1, 2011 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the proposed monthly base rates for each of the products under Basic (Pool I). Calculations are documented in the footnotes.

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

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

Column (2) shows the composite required monthly base rate for Basic (Pool I). This value represents the projected overall average rate required from Basic (Pool I) subscribers. As indicated in the footnotes, this PCPM value is developed in schedule 21.

Column (3) displays the proposed plan relativity factor for each plan. These are used to distribute the Pool I rate need across plans. The proposed plan relativity factors are the same as those used in last year's rate filing.

Column (4) calculates the proposed monthly base rates for each plan. These are the base rates, by product, that correspond to the proposed plan relativities which are shown in column (3).

Q. You state that schedule 19 applies to Basic (Pool I) only. Is there a comparable schedule for Preferred (Pool II)?

A. Yes. It is schedule 20.

Q. Are there any differences between schedule 20 and schedule 19, other than applying to Preferred (Pool II) vs. Basic (Pool I)?

A. No.

Q. With regard to the composite required monthly base rate in column (2) of schedules 19 and 20, you refer to their development in schedule 21. Could you please turn to schedule 21 and describe that schedule?

A. Schedule 21 is entitled "Calculation of Required Loss Ratios on Current Pool Rate Alignment Basis for April 1, 2011 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss ratio, current pool rate alignment basis for each of the two pools. Calculations are documented in the footnotes.

The overall Class DIR required income PCPM is developed in schedule 22. The same overall Class DIR required income PCPM is preserved in schedule 21. The respective amounts by pool, however, differ between schedule 22 and 21. In schedule 22, the required

Income PCPM amounts by pool directly reflect the separate experience of each pool. Schedule 21 develops required income PCPM amounts by pool which reflect the current alignment of rates by pool, rather than pool experience. In both cases, schedules 22 and 21, the composite average required income PCPM must remain the same.

Q. On a column-by-column basis, would you explain what is contained in schedule 21?

A. Column (1) of schedule 21 shows the projected contract months for Basic (Pool I) and Preferred (Pool II). As discussed earlier in my testimony, projected contract months by pool were used in weighting various amounts in order to directly deal with the impact of enrollment changes over time. Column (2) shows the projected incurred claims including mandates amounts for each of the two pools. The sources of these values are documented in the footnotes.

Column (3) contains the composite required income PCPM amount for Class DIR as a whole. This amount is developed in schedule 22.

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

Column (5) contains the current pool rate alignment basis proposed income PCPM amounts for Basic (Pool I), Preferred (Pool II), and in total for Class DIR. The calculations are documented in the footnotes. The Class DIR composite in column (5) is required to be the same as in column (3). The respective required income PCPM amounts by pool in column (5) are calculated to maintain the same proportionate relationship as the PRI

values in column (4), i.e., no re-alignment in rates between pools. For this filing, these are the composite required monthly base rates used in developing the proposed monthly base rates for each product, by pool.

Column (6) contains the required loss ratios calculated for Basic (Pool I) and Preferred (Pool II), on a current pool rate alignment basis. This means that the Basic (Pool I) and Preferred (Pool II) values would retain the same relationship in required rates as is reflected in the present rates.

Q. With regard to the required income PCPM, you refer to the development in schedule 22. Could you please turn to schedule 22 and describe that schedule?

A. Schedule 22 is entitled "Calculation of Required Loss Ratios on Full Experience Basis for April 1, 2011 Billing Cycle." It applies to both Basic (Pool I) and Preferred (Pool II). The purpose of the schedule is to display the calculation of the required loss ratios, full experience basis for each of the two pools. Calculations are documented in the footnotes.

Q. On a column-by-column basis, would you explain what is contained in schedule 22?

A. Column (1) of schedule 22 shows the projected contract months for Basic (Pool I) and Preferred (Pool II).

Column (2) shows the projected incurred claims expense PCPM. As indicated in the footnotes, these amounts come from schedule 27.

Column (3) shows the state assessments impact. As indicated in the footnote, this factor comes from schedule 24.

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 developed on schedule 25.

Column (5) shows the projected incurred claims expense PCPM including the impact of state assessments 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 37.

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

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

Column (9) contains the contribution to reserve / tax liability PCPM values for the rate period. The contribution to reserve and tax liability component is the amount requested by Blue Cross to include in the Class DIR subscription rates in order to contribute to the establishment and maintenance of reserves maintained by Blue Cross for the protection of its subscribers. As mentioned earlier, the contribution to reserve/tax liability component includes 2% for the state premium tax assessment on health insurance premiums.

The factor used to calculate column (9) is based on the requested contribution to reserve as a percentage of income plus one quarter of the amount for federal income taxes plus an additional 2% for the aforementioned state premium assessment. Thus, in this case, the

contribution to reserve of 1% requires 0.25% for federal taxes (20% of the pre-tax gain). The combined contribution to reserve and tax PCPM is then calculated using a factor of 0.9675.

The remaining columns in schedule 22 are calculated using the values I just described. These calculations are documented in the footnotes. Column (11) then contains the required loss ratios calculated for Basic (Pool I) and Preferred (Pool II), on a full experience basis. That means that the Basic (Pool I) value reflects the projected required loss ratio based fully on Basic (Pool I) claims experience; and similarly, for Preferred (Pool II).

Q. You mention a state assessments impact factor in column (3) of schedule 22. Could you please explain the calculation of this factor?

A. Of course. Section IV shows the development of this factor. Section IV consists of schedule 24 and schedule 25. Schedule 24 is titled "Calculation of Claims Impact of State Assessments for April 1, 2011 Billing Cycle" and illustrates the different assessments that have an impact on the rates being filed for Class DIR. These three assessments will be made as a percentage of premium at an estimated rate of 0.825% for the Child Immunization Assessment, 0.20% for the Adult Immunization Assessment, and 0.493% for the CEDARR, CIS, and Home Services Assessment, for a total of 1.518%. This translates to 1.59% of projected claims.

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

A. Yes. These State Assessments were included and approved in the last several Class DIR rate filings, except for the most recent Class DIR filing.

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

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

Q. You also mention a claims impact factor for covering dependents up to age 26 in column (4) of schedule 22. Please explain how this factor is developed.

A. The development of this factor is shown on schedule 25. Schedule 25 is titled "Calculation of Claims Impact of Dependents to Age 26 for April 1, 2011 Billing Cycle." As displayed on this schedule, the claims impact for dependents up to age 26 for Class DIR is developed by starting with the premium impact recently approved for use in Commercial group accounts of 1.25%. This premium impact is then converted to a claims impact by dividing by the Commercial group loss ratio of 85%, resulting in a claims impact of 1.47%. This claims impact is then adjusted by the ratio of family contracts in Class DIR relative to Commercial group so that it is more applicable to the Direct Pay population. The resulting Class DIR claims impact factor is 1.0086. Calculations are documented in the footnotes of schedule 25.

Q. With regard to the administrative expense PCPM shown in column (6) of schedule 22, you refer to its development in schedule 37. Could you please turn to schedule 37 and describe that schedule?

A. Schedule 37 is entitled "Calculation of Administrative Expense per Contract Month for April 1, 2011 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 2011 and 2012, in aggregate and PCPM. Then the PCPM amounts for 2011 and 2012 are weighted together to produce an appropriate amount for the April 1, 2011 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 CY2010, CY2011, and CY2012 developed internally by Blue Cross for Class DIR.

Q. How are the 2010, 2011, and 2012 Class DIR operating expense budget amounts determined?

A. In preparation for this Class DIR filing, we developed estimated budgets for Class DIR calendar years 2010, 2011, and 2012. Attached hereto as Blue Cross Exhibit 5 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of CY11 Budget to CY10 Projected Actual by Natural Account." Blue Cross Exhibit 5 compares by natural account (1) 2010 Projected Operating Expenses to (2) the 2011 Operating Expense Budget. The CY10 Budget is based on actual reported expenditures in 2010, with an estimate for the remainder of the year. The CY11 amounts reflect the budget for the calendar year. The third column of Blue Cross Exhibit 5 shows the dollar increase or decrease between CY10 Projected and CY11 Budget. The fourth column shows the percentage increase or decrease. The methodology used to create the 2011 budget was to use the 2010 allocations by department as of September and then multiply those against the preliminary 2011 budget (as of October). We then allocated a pro rata share of an anticipated reduction to the 2011 budget.

For purposes of this filing, the calendar year 2011 budget results in a total budgeted amount for Class DIR of $6,178,522, as reflected in column 2 of schedule 37 of Blue

Cross Exhibit 2. This in turn was divided by total projected Class DIR contract months for 2011 of 120,441 for a projected total Class DIR operating expense per contract month figure of $51.30 for calendar year 2011. See column 4 of schedule 37 of Blue Cross Exhibit 2.

For 2012 attached hereto as Blue Cross Exhibit 6 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of CY12 Budget to CY11 Budget by Natural Account." Exhibit 6 employs the same format as Exhibit 5, except that it compares CY12 to CY11. The CY12 budget amount of $6,297,278 as reflected in column 2 of schedule 37 of Blue Cross Exhibit 2 is divided by the total projected Class DIR contract months for 2012 of 120,321, for a projected total Class DIR operating expense per contract month figure of $52.34. Attached hereto as Blue Cross Exhibit 7 is a detailed narrative breaking down the administrative expenses for the Direct Pay budget.

Q. Please turn back to schedule 22. In your testimony regarding column (9) of this schedule, you described the nature of the contribution to reserve / tax liability PCPM and its calculation. You also indicate that a factor of .9675 was used, in order to produce an after-tax contribution to reserve of 1% of subscription income. Is that correct?

A. Yes.

Q. Why is an after-tax contribution to reserve of 1% appropriate for this line of business?

A. Although we believe that the Direct Pay population should contribute their fair share to reserves, given the current economic climate and other considerations we have chosen to request only a 1% contribution to reserves at this time. In the future, we do intend to request a higher contribution to reserves from this population that is in line with their fair share. As of September 30, 2010, Blue Cross' surplus levels as a percent of annual premium are at

14.9% of annual premium, well below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium.

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

A. Blue Cross' reserve position at September 30, 2010 was $247,199,104, or 1.70 months in reserve, on a SAP basis. As of December 31, 2009 Blue Cross & Blue Shield of Rhode Island was ranked 34th out of 37 Blue Cross plans nationally in health risk-based capital.

Q. What is the reserve target for Blue Cross?

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

for Blue Cross. In our view, the Lewin Report validated the necessity of adequate reserves and the reasonableness of our established reserve target.

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

A. Schedule 5 is entitled "Calculation of HealthMate Direct 500 Required Monthly Subscription Rates for April 1, 2011 Billing Cycle." It applies to Basic (Pool I) only. The purpose of this schedule is to display the calculation of the monthly subscription rates for individual and family subscribers in Basic (Pool I) by age category. Monthly subscription rates in schedule 5 are shown separately on a required rate basis. The Basic (Pool I) age categories are identical to the Preferred (Pool II) age categories with the exception of an age 65 and older category for Basic (Pool I). In addition, proposed rates for Basic (Pool I) do not vary by gender.

Q. How does schedule 5 compare with schedules 6 through 9?

A. Schedules 6 through 9 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 5 applies to HealthMate Direct 500.

Q. On a column-by-column basis, would you explain what is contained in schedules 5 through 9?

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 19.

Row (ii) is labeled "Rate Tier Normalization Factor." This is the normalization factor that corrects any imbalance in the rate factors contained in columns (1) and (3) of

schedules 5 through 9, determined across the entire pool. The rate tier normalization factor is developed in schedule 10.

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.

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

Q. With regard to the rate tier normalization factor in row (ii) of schedules 5 through 9 you refer to its development in schedule 10. Could you please turn to schedule 10 and describe that schedule?

A. Schedule 10 is entitled "Calculation of Rate Tier Normalization Factor". Column (1) is the "Rate Factor" that converts monthly normalized base rates to monthly subscription rates for individuals and families, by age category

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

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

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

Row (22) represents the proposed rate relativity factors for each plan that are calculated on schedule 19, as mentioned in the footnote.

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

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

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

Q. Schedule 5 applies to the HealthMate Direct 500 product under Basic (Pool I). You testify that schedules 6 through 9 are comparable, for the other four current product rates for Basic (Pool I). Is that also correct?

A. Yes.

Q. You state that schedules 5 through 9 apply to Basic (Pool I), for each of the current five products being offered. Are there comparable schedules for Preferred (Pool II)?

A. Yes. Schedules 12 through 16 correspond to schedules 5 through 9, for Preferred (Pool II) versus Basic (Pool I). Schedule 17 also corresponds to schedule 10

Q. Please turn to schedule 12. Are the same calculations carried out for the HealthMate Direct 500 product in schedule 12 for Preferred (Pool II) as in Schedule 5 for Basic (Pool I)?

A. The same types of calculations are carried out in schedule 12 for Preferred (Pool II) as in schedule 5 for Basic (Pool I). I would note that the format and structure of schedule 12 differs slightly from schedule 5; labeling and rate development is consistent, however. The structural difference occurs since Preferred (Pool II) does not have rates for

subscribers age 65 and over, but does have separate individual rates for male vs. female subscribers.

Q. You state that schedules 12 through 16 for each of the Preferred (Pool II) products correspond to schedules 5 through 9 for Basic (Pool I). You have just described schedule 12. Are there any differences between schedules 13 through 16 and schedule 12, 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 5 through 9, and 12 through 16 consistent with rates presented in your letter dated November 19, 2010 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 50 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 50 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 50 reflects fair, accurate and reasonable computations of required rates for the Class DIR Basic (Pool I) and Preferred (Pool II) products?

A. Yes.