Blue Cross Blue Shield of Rhode Island

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November 19, 2010

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

Subject: Filing of Subscription Rates for Class DIR

Dear Commissioner Koller:

This letter, together with the actuarial schedules enclosed, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs. This filing includes proposed rates to become effective April 1, 2011.

The rates proposed in this filing will affect the approximately 14,500 members enrolled in Class DIR as of September 2010.

Definition of Class DIR

Class DIR is the rating classification for persons not eligible for employer-based (other than as a self-employed individual), nor State or Federal programs. Enrollment is on a non-group basis either through direct application to the Plan or through conversion from prior group coverage. Group conversions occur monthly and an annual open enrollment period is conducted for the Basic Pool (Pool I), while enrollment in the Preferred Pool (Pool II) is available continuously throughout the year for applicants passing a health screening. Two rating pools are employed in the Class -- the Basic Pool (Pool I) with rates determined based on the age of the subscriber and the Preferred Pool (Pool II) with rates determined based on the age and gender of the subscriber. It should be noted that we are proposing rate structure changes to the Class DIR Basic Pool (Pool I) effective with this rate filing that would introduce 5-year age categories and increase the rate differential between young and old subscribers. These rate structure changes are discussed further below.

Benefit Changes Effective With This Filing

There are no major benefit changes being proposed in conjunction with this filing. Some minor benefit changes are being proposed so that the products will comply with the benefit requirements of the Patient Protection & Affordable Care Act ("PPACA"). Specifically, we are removing cost sharing provisions on all plans for certain preventative services as defined by the U.S. Department of Health & Human Services (HHS) regulations. Second, we are changing the maximum age to be eligible as a dependent on a family policy. Effective April 1, 2011, members will be eligible to be a dependent on a

BLUE CROSS EXHIBIT 1

Direct Pay family policy up to age 26, regardless of student status. In addition, we are also making some modest changes to mental health benefits so that our Direct Pay plans comply with the Federal Mental Health Parity regulations. Finally, Blue Cross made changes to its drug formulary effective November 1, 2010. These benefit changes are further explained in my pre-filed testimony and detailed in the policy forms filed contemporaneously with this rate filing. The following Class DIR products will be available effective April 1, 2011:

- *HealthMate Coast-to-Coast Direct Plan 500/1000:* Includes a $500 per individual/$1,000 per family deductible, 20% member paid coinsurance in-network for hospitalization and outpatient hospital services, lab tests, and x-rays, $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid coinsurance of 20% tier 1/25% tier 2/50% tier 3, and $75 specialty prescription drugs at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $2,500 per individual / $5,000 per family. In general, member cost share is greater at out-of-network providers.

- *HealthMate Coast-to-Coast Direct Plan 1000/2000:* Includes a $1,000 per individual/$2,000 per family deductible, 20% member paid coinsurance in-network for hospitalization and outpatient hospital services, 100% coverage for lab tests and x-rays, $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid copayments of $7 tier 1/$30 tier 2/$50 tier 3, and $75 specialty prescription drugs at participating pharmacies. Note that certain medications for diabetes, asthma, and COPD are covered with a $2 copayment when members work with a Blue Cross care coordinator. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $3,000 per individual / $6,000 per family. In general, member cost share is greater at out-of-network providers.

- *HealthMate Coast-to-Coast Direct Plan 2000/4000:* This plan is comparable to HealthMate Direct 500/1000. The differences include the deductible and out of pocket maximums. The deductible is $2,000 per individual / $4,000 per family under HealthMate Direct 2000/4000, and the member paid coinsurance is 20% for in-network benefits. The out of pocket maximums for the HealthMate Coast-to-Coast Direct Plan 2000/4000 are $3,000 and $6,000 for individual and family, respectively for in-network services. Pharmacy coverage does not apply toward the deductible. Members have the option of engaging in the Wellness Reward Program and may receive a reward equal to 10% of their annual paid premiums if they meet certain wellness requirements. In general, member cost share is greater at out-of-network providers.

- *HealthMate for HSA Direct Plan 3000/6000:* The HealthMate for HSA Direct Plan 3000/6000 includes deductibles of $3,000 per individual / $6,000 per family. These deductibles apply to all covered services except certain preventive care services.

Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs. For prescription drugs, members will pay co-payments of $7 for tier 1 drugs, $30 for tier 2 drugs, $50 for tier 3 drugs, and $75 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $4,000 per individual and $8,000 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

- *HealthMate for HSA Direct Plan 5000/10000:* The HealthMate for HSA Direct Plan 5000/10000 is comparable to HealthMate for HSA Direct Plan 3000/6000. The only differences are the amount of the deductibles and the out of pocket maximums. The deductibles are $5,000 per individual / $10,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services except prescription drugs. For prescription drugs, members will pay co-payments of $7 for tier 1, $30 for tier 2 drugs, $50 for tier 3 drugs, and $75 for specialty drugs. Members would pay these co-payments after they satisfied the deductible until they satisfy the out of pocket maximum of $5,950 per individual and $11,900 per family. The out of pocket maximum includes the deductible. In general, member cost share is greater at out-of-network providers.

Rating Structure Changes Effective With This Filing

With this rate filing, Blue Cross is proposing to introduce rate structure changes for the Basic Pool (Pool I). Effective April 1, 2011, Basic (Pool I) rates will vary by age using 5 year age bands. Also, the maximum rate differential by age for subscribers under age 65 will be increased from 1.1 to 1 to 1.25 to 1. These changes will improve the financial equity between young and old Pool 1 subscribers and will lessen the rate shock to Direct Pay subscribers in 2014 when PPACA requires the removal of rating by health status.

Reserve Contribution

Blue Cross is requesting a reserve contribution of 1% from Class DIR subscribers in this rate filing. Historically, Blue Cross and its Directors have 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. However, in prior filings, Blue Cross has foregone contribution to reserves for Class DIR based upon our financial performance. As of September 30, 2010, Blue Cross corporate reserves were at 15% of annual premium, well below the minimum of the Blue Cross surplus range recommended by the Lewin report of 23% of annual premium. Our reserve levels are precipitously close to the 12% benchmark used to trigger monitoring status by the Blue Cross and Blue Shield Association. We run the serious risk of financial insolvency if current premium

deficiencies continue. It is for this reason that we must include a reserve contribution in rates from all market segments, including Direct Pay.

State Premium Tax and Assessments

In the previous rate decision for Class DIR for rates effective April 1, 2010, the Office of the Health Insurance Commissioner ("OHIC") disallowed charges for the state premium tax and state assessments. The required rates in this filing include these rate components.

It should be noted that Direct Pay subscribers benefit from the state assessment program and are eligible to receive immunizations for children and adults as well as certain child services as administered by the Rhode Island Department of Human Services. The state premium tax is assessed on a premium base that includes Class DIR and the determination of the assessments to Blue Cross is based on premium reported on annual financial statements, including premium for the Class DIR line of business. If Blue Cross is continued to be denied a mechanism to collect these taxes and assessments from Class DIR subscribers, Blue Cross subscribers in other market segments would be assessed a disproportionate share of these fees.

The inclusion of these taxes and assessments in Class DIR premiums is fair and makes practical business sense. State premium tax and assessments are borne by all fully insured subscribers in Rhode Island, in accordance with State law. The state premium tax and assessment requirements combined add approximately 3.5% to the cost of insurance coverage in all markets, including Class DIR.

Affordability as Addressed in the Rate Filing

In consideration of previous rate decisions issued by the OHIC, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Among these are changes in our Formulary and various administrative expense reductions which reduce the requested average rate increase by approximately 1.5%. Specifics of these programs will be detailed in the pre-filed testimonies of Dr. Manocchia and me. In addition, along with this rate filing, we are submitting as Exhibit 3 the "Resources for Health System Improvements - Survey". Exhibit 3 outlines Blue Cross' strategies regarding improving the overall affordability of health care in Rhode Island.

Required Rates

Blue Cross last filed rate changes for its Class DIR subscribers on November 20, 2009 for an effective date of April 1, 2010. In its decision rendered on February 8, 2010, The OHIC approved an aggregate increase of 6.1%.

The overall average required rate increase projected in this filing, exclusive of any AccessBlue (premium assistance) amounts, is 8.1%. All rates included in this filing will remain in effect for the twelve-month period commencing April 1, 2011. The Class DIR

Basic (Pool I) required monthly rates and the Preferred (Pool II) required monthly rates for the five Direct Pay products are included in the following tables. Please note that all subscribers aged 65 and over receive the Basic (Pool I) rate. Rates for subscribers aged 65 and over are therefore not displayed in the table below for Preferred (Pool II) subscribers.

Class DIR Basic (Pool I)
Required Rates Effective April 1, 2011

		HM 500	HM 1000	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Individual	$640.11	$569.91	$487.63	$417.43	$329.11
	Family	$1,205.12	$1,072.95	$918.05	$785.89	$619.62
25-29	Individual	$647.05	$576.08	$492.91	$421.95	$332.68
	Family	$1,217.83	$1,084.27	$927.73	$794.18	$626.15
30-34	Individual	$658.60	$586.37	$501.71	$429.49	$338.62
	Family	$1,239.79	$1,103.82	$944.45	$808.49	$637.44
35-39	Individual	$671.31	$597.69	$511.40	$437.78	$345.15
	Family	$1,264.05	$1,125.42	$962.94	$824.32	$649.91
40-44	Individual	$678.24	$603.86	$516.68	$442.30	$348.72
	Family	$1,276.76	$1,136.74	$972.62	$832.61	$656.45
45-49	Individual	$700.20	$623.40	$533.40	$456.61	$360.01
	Family	$1,318.36	$1,173.77	$1,004.31	$859.73	$677.83
50-54	Individual	$734.86	$654.27	$559.81	$479.22	$377.83
	Family	$1,383.06	$1,231.38	$1,053.60	$901.93	$711.10
55-59	Individual	$781.08	$695.41	$595.02	$509.36	$401.59
	Family	$1,470.88	$1,309.56	$1,120.49	$959.19	$756.25
60-64	Individual	$796.10	$708.79	$606.46	$519.15	$409.31
	Family	$1,498.61	$1,334.25	$1,141.62	$977.28	$770.51
65+	Individual	$1,252.50	$1,115.13	$954.14	$816.78	$643.97
	Family	$2,358.25	$2,099.62	$1,796.49	$1,537.87	$1,212.50

Class DIR Preferred (Pool II)
Required Rates Effective April 1, 2011

		HM 500	HM 1000	HM 2000	HM for HSA 3000	HM for HSA 5000
Under 25	Male	$211.12	$187.96	$160.83	$137.67	$108.55
	Female	$295.20	$262.83	$224.88	$192.50	$151.78
	Family	$707.37	$629.80	$538.87	$461.29	$363.70
25-29	Male	$233.51	$207.90	$177.88	$152.27	$120.06
	Female	$334.49	$297.81	$254.82	$218.13	$171.98
	Family	$792.37	$705.48	$603.62	$516.71	$407.40
30-34	Male	$265.95	$236.79	$202.60	$173.43	$136.74
	Female	$397.56	$353.96	$302.86	$259.25	$204.41
	Family	$840.35	$748.20	$640.17	$548.00	$432.07
35-39	Male	$304.34	$270.96	$231.84	$198.46	$156.48
	Female	$394.36	$351.11	$300.42	$257.17	$202.76
	Family	$886.96	$789.70	$675.68	$578.40	$456.04
40-44	Male	$325.36	$289.68	$247.85	$212.17	$167.28
	Female	$431.37	$384.07	$328.62	$281.30	$221.79
	Family	$906.61	$807.19	$690.65	$591.21	$466.14
45-49	Male	$393.44	$350.30	$299.72	$256.57	$202.29
	Female	$477.98	$425.57	$364.12	$311.70	$245.76
	Family	$955.50	$850.72	$727.90	$623.10	$491.28
50-54	Male	$498.54	$443.87	$379.79	$325.11	$256.33
	Female	$558.41	$497.17	$425.39	$364.14	$287.11
	Family	$1,064.26	$947.55	$810.75	$694.02	$547.20
55-59	Male	$638.83	$568.78	$486.66	$416.59	$328.46
	Female	$637.46	$567.56	$485.61	$415.70	$327.76
	Family	$1,191.29	$1,060.66	$907.52	$776.86	$612.51
60-64	Male	$683.16	$608.24	$520.42	$445.50	$351.25
	Female	$683.16	$608.24	$520.42	$445.50	$351.25
	Family	$1,294.57	$1,152.61	$986.20	$844.21	$665.61

Filing Schedules

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

The underlying actuarial methodology used in the preparation of the required rates in this filing is similar in nature to the previous Class DIR rate filing submitted to the OHIC.

The filing schedules and supporting actuarial pre-filed testimony detail the rating methodology.

Pre-Filed Testimony

For this filing, we will be submitting, no later than November 24, 2010, the pre-filed testimony of Augustine Manocchia, MD, Chief Medical Officer, who will be Blue Cross' witness with regards to affordability and medical management issues. I will be Blue Cross' actuarial and policy witness at the upcoming rate hearing on this matter, and my pre-filed testimony is being submitted along with this letter. We believe submitting the pre-filed testimony near contemporaneously with the rate filing will make the discovery process more efficient and decrease the length of time of all aspects of the hearing process.

Conclusion

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

In accordance with the filing fee requirements contained in section 42-14-18 of the General Laws of Rhode Island, a filing fee of $125 ($25 for each policy) has been included with this submission via electronic funds transfer (EFT). This filing pertains to the following direct pay products: *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.* The policy form numbers for these products, which have been submitted to the Department under separate cover, are:

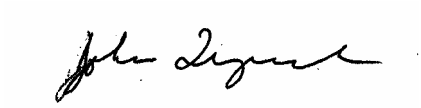
- FRONT DIRECT (04-11)
- SUMMARY DIRECT (04-11)
- INTRODUCTION DIRECT (04-11)
- ELIGIBILITY DIRECT (04-11)
- COVERED DIRECT (04-11)
- EXCLUSIONS DIRECT (04-11)
- PAYMENT DIRECT (04-11)
- COB DIRECT (04-11)
- APPEALS DIRECT (04-11)
- GLOSSARY DIRECT (04-11).

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

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

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

Sincerely,



John Lynch, F.S.A., M.A.A.A.
Chief Actuary

JL/swl

Enclosures

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