STATE OF RHODE ISLAND
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

In Re: Blue Cross & Blue Shield of Rhode Island	)	
Rates Filed for 2025 Individual Market Plans	)	OHIC-2024-1

POST-HEARING MEMORANDUM OF BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

Blue Cross & Blue Shield of Rhode Island ("Blue Cross") respectfully submits this Post-Hearing Memorandum in support of its rates requested in the individual market. Blue Cross seeks approval for an overall 14.3% increase in the weighted average premium, which accounts for two modifications, as set forth more fully below: (1) updating the risk adjustment transfer payment amount as reported on July 22, 2024 (which results in an increase to the rate request of 0.3%) and (2) updating the cost trend to account for the 3.3% CPI-U as reported on July 11, 2024 (which results in a decrease to the rate request of 0.3%). For the reasons stated more fully below, Blue Cross has met its burden of demonstrating that this requested rate increase is consistent with both the proper conduct of its business and the interests of the public. As a result, the rate increase requested by Blue Cross should be approved.

FACTS AND TRAVEL

Blue Cross submitted its filing for individual health insurance products to the Office of the Health Insurance Commissioner ("OHIC") via the System for Electronic Rate and Form Filing Access (SERFF) on May 13, 2024 (the "Rate Filing"). Tr. I at 35; Blue Cross Ex. 1, 2.[1]

[1] Citations to "Blue Cross Ex.", "AG Ex." and "OHIC Ex." refer to the exhibits offered by the respective parties. Citations to "Tr. I" refer to pages in the transcript of the Public Hearing for July 2, 2024. Citations to "Tr. II" refer to pages in the transcript of the Public Hearing for July 3, 2024.

The Rate Filing requests a 14.3 percent increase in the weighted average premium and was approved by Blue Cross's Board of Directors. Tr. I at 35.

The Health Insurance Commissioner ("Commissioner") presided over the public hearing required by Rhode Island Laws Section 27-19-6 and Section 27-20-6 and retained Raymond Marcaccio to act as his legal advisor. The public hearing was held on July 2 and July 3, 2024 ("Public Hearing"). *See generally* Tr. I and Tr. II.

Blue Cross, the Rhode Island Office of the Attorney General ("AG"), and OHIC submitted witness lists and proposed exhibits on June 21, 2024. OHIC and the AG submitted reports of their respective consulting actuaries, Brian Stentz, ASA, MAAA on behalf of the AG, and Jennifer Smagula, FSA, MAAA on behalf of OHIC. *See* AG Report;[2] OHIC Ex. 1.[3]

At the Public Hearing, the parties stipulated that (1) Brian Mackintosh (chief actuary for Blue Cross), Ms. Smagula, and Mr. Stentz were each experts in the field of actuarial science and could testify as such; (2) the Commissioner, assisted by his legal advisor Raymond Marcaccio, had jurisdiction to hear this matter; and (3) published notice of the Public Hearing was satisfied in accordance with the statutory requirements set forth in R.I. Gen Laws § 27-19-6(b) and § 27-20-6(b). Tr. I at 7-11; *see also* Blue Cross Ex. 3 (attesting that the notice of Public Hearing was published in the Providence Journal on June 20, 2024).

Mr. Mackintosh, Ms. Smagula and Mr. Stentz each testified at the Public Hearing in their expert capacitates as actuaries. Tr. I. Public comment was taken from 6:00 p.m. to 7:00 p.m. on July 2, 2024 and from 9:00 a.m. to 9:30 a.m. on July 3, 2024. Tr. I at 357-58; Tr. II at 4, 11-12.

[2] The AG Report is a reference to the "L&E BCBSRI 2025 Ind Filing Final 6-21-24" document, provided to the parties on June 21, 2024. The AG Report was not separately numbered as an exhibit.

[3] OHIC Ex. 1 is a reference to the report of OHIC's actuary, Jennifer Smagula, provided to the parties on June 21, 2024.

No members of the public provided any oral comment. *Id.* Written comments were required to be submitted to OHIC on or before July 19, 2024, and OHIC provided to the written comments to the parties on July 23, 2024. Each of the exhibits of the parties, including the actuarial reports of OHIC and the AG, were entered into evidence in full. Tr. I at 7, 289-92, 355. This includes Blue Cross Exs. 1-3, AG Exs. 1-32 and OHIC Exs. 1-120.[4] Certain of those exhibits (AG Exs. 12-22, AG Exs. 31 and 32, and OHIC Exs. 77-114) were marked as confidential and sealed from the public record in accordance with R.I. Gen Laws §38-2-2(4)(B), as ordered by the Commissioner on July 1, 2024. *See* Stipulated Order Regarding Confidential Exhibits (stating that the parties agree that those exhibits contain confidential and proprietary information of Blue Cross, and that Blue Cross has sufficiently proffered that those exhibits satisfy the requirements set forth in R.I. Gen Laws § 38-2-2(4)(B), and thereby ordering that the exhibits must be sealed and excluded from the public record).

Following the Public Hearing, on July 11, 2024, the U.S. Bureau of Labor Statistics released its Consumer Price Index for all Urban Consumers figures inclusive of the June 2024 data. The CPI-U (less food and energy) ("CPI-U") 12-month percent change through June 2024 is 3.3%. *See* Stipulation of the Parties Regarding (1) The Final Risk Adjustment Transfer Payment and (2) CPI-U 12-Month Percentage Change Through June 2024, and the Corresponding Impacts to the Requested Rate Increase ("Stipulation") at par. 1. To the extent that the 3.3% CPI-U figure is substituted in Blue Cross's pricing model related to its cost trend projections, Blue Cross estimates that this would result in a 0.3% decrease to the overall rate request. *Id.* at par. 2.

[4] OHIC Ex. 63 was admitted as an exhibit in full, over the objection of Blue Cross, and OHIC Exs. 115-118 were admitted in full, over the objection of the AG. Tr. I at 289-92, 355.

Additionally, on July 22, 2024, the Centers for Medicate & Medicaid Services (CMS) issued the final Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2023 Benefit Year, indicating that Blue Cross is entitled to a risk adjustment transfer payment for calendar year 2023 in the individual market in the amount of $12,252,585.48. *Id*. at par. 3. Blue Cross estimates that substituting this final risk adjustment transfer payment (and trending that forward to 2025) results in a 0.3% increase to the overall rate request. *Id.* at par. 4.

Blue Cross submits this Post-Hearing Memorandum in support of the assumptions and methodologies underlying the rate increase it requested in the Rate Filing, with the above-referenced modifications related to the CPI-U and the risk adjustment transfer payment (and as explained more fully below), which results in a net 0% change to the overall 14.3% rate increase requested in the Rate Filing.

ARGUMENT

Blue Cross must establish by a preponderance of the evidence that the rates proposed for the individual market are "consistent with the proper conduct of its business and with the interest of the public." R.I. Gen Laws §§27-19-(6)(d)(1) & 27-20-6(d)(1); *Miele v. Bd. of Med. Licensure & Discip*., 1991 WL 789899, C.A. 90-1390, at *2 (Oct. 9, 1991). As a non-profit hospital and medical services corporation, Blue Cross is obligated to both "[e]mploy pricing strategies that enhance the affordability of health care coverage" and also "[p]rotect the financial condition" of the company. R.I. Gen Laws § 27-19.2-10. Indeed, protecting the financial solvency of Blue Cross is part of OHIC's mandate as well. R.I. Gen Laws § 42-14.5-2(1). To satisfy the preponderance of the evidence standard, Blue Cross must present "evidence which is of greater

weight than its opposition. It is evidence which, on the whole, shows that the fact to be proved is more probable than not." *Miele*, 1991 WL 789899, at *2.

The parties are in agreement as to most of the calculations and assumptions in the Rate Filing. *See* AG Report; OHIC Ex. 1. Indeed, there is no dispute that the Rate Filing submitted by Blue Cross used standard and appropriate actuarial methods and practices, and was consistent with the instructions provided by OHIC. OHIC Ex. 1 at 26; Tr. I at 269-70, 310 (testifying that Blue Cross used "actuarially appropriate methods" in the methodology and in following instructions and "answered all of our questions in a timely and professional manner").

The Public Hearing focused on the handful of areas where the parties have certain differing methodologies or assumptions. In this regard, Ms. Smagula's report suggested five (5) alternative assumptions to consider. OHIC Ex. 1. At the hearing, she testified that three (3) of those assumptions were "equally as reasonable" to the assumptions and methodologies proffered by Blue Cross. Tr. I at 311-12; OHIC Ex. 1 at 26. At the Public Hearing, Ms. Smagula added another alternative recommendation for consideration, which deviated from her report. She testified that although her report does not challenge Blue Cross's methodology related to projecting high cost risk pool ("HCRP") recoveries, she had changed her view and agreed with Mr. Stentz's recommendation to project a higher recovery amount, thereby reducing the rate increase. Tr. I at 253.

The testimony of Mr. Stenz made clear that he and Blue Cross are aligned related to two of the three recommendations he included in his report: modifying the rate request to account for: (1) the most recently reported CPI-U and (2) the final risk adjustment transfer payment amount for 2023, as reported on July 22, 2024. Tr. I at 173, 204, 205-06 (testifying that the CPI-U used for the Rate Filing should be the best available, which would be reported as of July 2024)

and 176, 207-08 (acknowledging that his approach aligns with that of Blue Cross as to the risk adjustment transfer projection, which is to substitute the final risk adjustment transfer payment amount for 2023 and trend that forward to 2025). Blue Cross therefore understands that Mr. Stentz's only area of disagreement on the Rate Filing methodology is with respect to the projections related to the HCRP.

Additionally, the Public Hearing also focused on two additional areas where the parties are aligned and do not disagree: the inclusion of a 2% contribution to reserves, and the 11.7% administrative charge included in the Rate Filing. Neither Ms. Smagula nor Mr. Stentz challenge Blue Cross as to either of these methodologies or assumptions and do not recommend any changes or modifications to the Rate Filing in either regard. Tr. I at 221, 223, 314. As set forth more fully below, any consideration to reduce the administrative charge or the contribution to reserves should be rejected.

As further set forth below, with respect to the alternative assumption proffered by Ms. Smagula to update the claim runout period for the 2023 base year, Blue Cross does not necessarily disagree with the recommendation, provided that it applies to all carriers, is a consistent requirement in the rate filing instructions going forward, and applies regardless of whether it results in a rate increase or decrease.

Finally, as discussed more fully below, the following alternative approaches to the Rate Filing should be rejected in favor of the more reasonable methodology that Blue Cross used: (1) projecting a lower utilization trend than Blue Cross included in the Rate Filing; (2) projecting higher pharmacy rebates for 2025 than Blue Cross included in the Rate Filing; (3) adjusting the risk adjustment transfer payment projection to account for shifting platinum membership; (4) projecting a CPI-U that is lower than the currently reported CPI-U of 3.3%; and (5) projecting a

greater HCRP recovery for 2025 and a lower HCRP charge for 2025 than Blue Cross included in the Rate Filing.

I. THE SUGGESTION TO UPDATE THE CLAIM RUN-OUT PERIOD FOR BASE YEAR 2023 THROUGH MAY 2024 IS LIKELY REASONABLE

In projecting its rates for 2025, Blue Cross used the claim runout for the 2023 base year through the end of March of 2024 and made an estimate as to the completion of the runout period, which was the most recent claim information available to Blue Cross at the time of the Rate Filing. Tr. I at 61, 62; 319. This approach is consistent with its past rate filings, and has not been challenged by either OHIC or the AG in their review of Blue Cross's past rate filings. Tr. I at 62, 320.

In her report, Ms. Smagula suggested that Blue Cross refresh its view of the 2023 base period by updating the claim run out period through May of 2024, as this would include "a more accurate reflection of Blue Cross' actual 2023 claims experience." OHIC Ex. 1 at 5; Tr. I at 260. Mr. Stentz did not include this suggestion in his report, although he testified that updating the claim runout period to include the most recent data available was reasonable insofar as there was "an even playing field" – meaning that it would need to apply across carriers and regardless of whether it resulted in an increase or decrease to the rate. AG Report; Tr. I at 196, 228.

In principle, Blue Cross does not object to the concept of using the most recent data available to update the claim runout for base year 2023. However, practically speaking, at the time it submitted the Rate Filing (May 13, 2024) information on claim runout through the end of May 2024 was not available. Because the timing of the rate filing each year occurs in early May, a requirement that the claim runout period be through May is essentially a requirement that a carrier modify its rate request from its original filing for each year. The materiality of the rate impact associated with the update could vary year to year.

To the extent that the claim runout period is required to be refreshed to include the 2023 base year claim runout through May 2024, the testimony of the actuaries at the Public Hearing made clear that consistency is imperative. Indeed, the actuaries agree that such a requirement would need to (1) apply across carriers, (2) apply on a going forward basis (such that there is not an open question each year as to whether this will be required to be refreshed) and (3) apply regardless of whether the update results in a rate increase or decrease. Tr. I at 63, 196, 228, 321-22. In Blue Cross's estimation, updating the claim runout period to include claims paid through May 2024, would result in a 0.5% decrease to the overall requested rate increase. Tr. I at 64.[5]

II. BLUE CROSS'S PROPOSED UTILIZATION TRENDS ARE REASONABLE AND APPROPRIATE AND SHOULD BE USED IN CALCULATING THE REQUESTED RATE

Blue Cross has demonstrated that the utilization trend included in the Rate Filing is reasonable and appropriate and should not be reduced to lower the rates. Although Ms. Smagula has proffered an alternative methodology to consider in the development of the utilization trend, she conceded that her methodology is not more reasonable than what Blue Cross had done, but it was an "equally reasonable assumption for the Commissioner to consider." Tr. I at 311-12.

In developing the utilization trend for the Rate Filing, Blue Cross used the claim experience for its entire fully insured commercial experience across the individual market, large group market and small group market, consistent with the approach of its past rate filings. Tr. I

[5] The rate impacts as estimated by Blue Cross are more accurate than the rate impact estimates in the respective reports of Ms. Smagula and Mr. Stentz because Blue Cross has run the alternative assumptions into its proprietary pricing model. There is no disagreement among the actuaries that any modifications would need to be run through Blue Cross's pricing model to produce the accurate rate impact. Tr. I at 153, 261, 348; OHIC Ex. 1 at 26 (stating that "[i]f any changes are determined to be appropriate, BCBSRI can make more precise calculations, using their internal rate development model and more refined assumptions").

at 37, 38. Blue Cross developed each utilization trend separately for inpatient, outpatient, professional and pharmacy.[6]

Mr. Mackintosh testified that Blue Cross's standard methodology is to look at the three most recent years of claims data, which shows how trends have developed in terms of use and severity. Tr. I at 38. The claims are divided into four separate buckets: inpatient, outpatient, professional and pharmacy, and a regression analysis is performed on each category. *Id.* To adjust for seasonality effects, Blue Cross looks at a rolling 12-month period using that 3 years of data, which produces 25 distinct 12-month continuous periods for analysis. *Id.* Using those 25 periods, Blue Cross looks at a year over year percent change in utilization and severity. *Id.* at 39. This gives Blue Cross 13 separate year over year 12-month periods to analyze. *Id*. Then, using those 13 data points, Blue Cross runs a linear regression analysis to produce a line that will best fit those points of data. *Id.*

Mr. Mackintosh further testified that the best fit regression trend for the 2025 projection actually resulted in a higher trend than the trend Blue Cross ultimately included in the Rate Filing for three out of the four categories: inpatient, outpatient, and professional. Tr. I at 39-40. Because the best fit regression trend provided more weight to the 2023 claims experience than Blue Cross deemed reasonable due to the unusual uptick in trend in 2023, Blue Cross employed actuarial judgment to deviate from the best fit regression trend and reduced the trend *downward*. *Id.* at 40. Across those three categories, Blue Cross reduced the trend by 1.8%. *Id*. at 41-42. Significantly, the lower trend pick chosen by Blue Cross across these categories resulted in a

[6] The pharmacy trend is not challenged by Ms. Smagula or Mr. Stentz. Tr. I at 58. Moreover, Mr. Stentz does not challenge any of the other utilization trends in the Rate Filing, either. Tr. I at 198-99.

4.7% decrease to what the rate impact would have been had the best fit regression trend been included the Rate Filing. *Id.* at 41-42.

Turning more specifically to the breakdown of the trend as to those three categories, Mr. Mackintosh testified that Blue Cross included a 0% trend for inpatient, which was *8.7% lower* than the best fit trend for the inpatient category. Tr. I at 42 -44; Blue Cross Ex. 2. As Mr. Mackintosh testified, this 0% trend assumption – which assumes that the inpatient claim trend will not increase in 2025 – is aggressive and adds risk to the Rate Filing, especially given the volatility of inpatient experience and the fact that the best fit regression trends projected an increase in trend for 2025. *Id.* As to the outpatient and professional trends (4.5% and 3.2%, respectively), Mr. Mackintosh explained that the trends chosen by Blue Cross likewise deviated from the best fit regression trend, which would have otherwise resulted in higher trends for each of those categories than Blue Cross included in the Rate Filing. Tr. I at 45-46; Blue Cross Ex. 2.[7]

Blue Cross disagrees with the alternative approach employed by Ms. Smagula in projecting utilization trend, which is to further reduce the utilization trend from 2.8% to 2.4%. First, her methodology in developing trend fails to develop a trend for each category separately. Tr. I at 47.[8] There is no credible reason to have not developed trend by service category, as Blue

[7] In developing the utilization trends for professional and outpatient, Blue Cross excluded all Covid 19 testing and vaccine costs from the experience data when analyzing historical professional and outpatient utilization trends because those costs are not expected to repeat to that degree. Tr. I at 37. Ms. Smagula and Mr. Stentz agree that doing so is reasonable and do not challenge it. *Id.* at 275.

[8] Mr. Mackintosh testified that her analysis is a "great check" on Blue Cross's trend methodology, which ultimately is very similar to the overall utilization trend Blue Cross included in the Rate Filing. Tr. I at 50. Ms. Smagula agrees that her methodology is conducted to "test for reasonableness" and that she considers her approach to be "equally as reasonable" to that of Blue Cross. Tr. I at 276, 282.

Cross had done, and as Blue Cross has done consistently in its past rate filings. *Id.* at 50. Indeed, Ms. Smagula conceded that there is sufficient credible data for each category to be developed on its own, rather than in aggregate. *Id.* at 327-28. It is not clear from her report or testimony whether she has previously recommended that trend be developed in aggregate as opposed to by service category, which appears to be a deviation. *Id.* at 327-28. Indeed, the rate filing template itself provides a separate breakout for the trend for each category, rather than as an aggregate category. *Id*. at 326-37.

Blue Cross further disagrees with the aggregate trend pick developed by Ms. Smagula for the additional reason that it only accounts for the years 2019 and 2023, ignoring the years in between. Tr. I at 47; 329-30. Ms. Smagula states that she excluded the years 2021 through 2022 on the grounds that the years 2019 and 2023 have a similar make-up of high cost claim levels, which she defines as claims over $500k. *Id.* at 280. Although it is correct that these two years have similar high-cost claims in that range, Ms. Smagula's methodology ignores that the range of high-cost claims as compared to total allowed claims for the years 2019 through 2023 has been consistent, within the range of 3.1 to 3.7%. *Id.* at 136.[9] Therefore, it is not reasonable for Ms. Smagula to have outright removed entire years of claims experience from the development of utilization trend. *Id.*

While Blue Cross disagrees with the methodology employed by Ms. Smagula to develop the utilization trend for the 2025 rates, Blue Cross submits that to the extent her methodology is required to be included, it must be updated to account for the most recent two months of claim runout now available, consistent with her recommendation to update the 2023 base year with

[9] This figure can be derived by reviewing the continuance table in response to the questions on the rate review. *See* OHIC Confidential Ex. 106.

claims runout through May 2024. Tr. I at 52. When comparing the most recent claims data, her methodology shows that the trend is *higher* than the 2.4% trend she recommended in her report. *Id.* at 53-55. The revised trend would be 2.6%. *Id.* Moreover, the rolling 6-month average view would produce an even higher trend (3.2%) which is not only higher than Ms. Smagula's 2.4% trend pick, but higher than the 2.8% trend Blue Cross included in the Rate Filing. *Id.* at 55. As Mr. Mackintosh testified, because the rolling 6-month view gives "more credence to the emerging trend," the fact that this trend view shows a "higher rate than we had even put in our rate filing puts our filing at risk" potentially rendering the requested rate as "inadequate." *Id.* at 56. At the Public Hearing, Ms. Smagula testified that she has no reason to disagree with Blue Cross regarding the result of updating her own analysis in this regard. *Id.* at 330.

For the above stated reasons, Blue Cross has shown by a preponderance of the evidence that its methodology in developing the utilization trend included in the Rate Filing is reasonable and appropriate. Accordingly, the alternative methodology suggested by Ms. Smagula (we she herself deems to be "equally as reasonable" to the methodology use by Blue Cross) should be rejected. To the extent that Ms. Smagula's methodology to include the 2.4% trend pick noted in her report is required to be used, Blue Cross has estimated that this would result in a 0.7% decrease to the rate. Tr. I at 57.

III. BLUE CROSS'S METHODOLOGY IN PROJECTING 2025 PHARMACY REBATES IS REASONABLE AND APPROPRIATE

As a threshold matter, neither Mr. Stentz nor Ms. Smagula challenge the 10.6% pharmacy trend Blue Cross included in the Rate Filing. OHIC Ex. 1; AG Report; Tr. I at 58. In developing the pharmacy trend, Blue Cross used the traditional 3-year regression model and analyzed pharmacy claims from 2021 through 2023, which includes both cost and utilization/severity. *Id.* at 57-58.

In projecting the extent to which pharmacy rebates will offset the total pharmacy spend in 2025, Blue Cross used its 2024 rebate estimates projected forward with the 10.6% pharmacy trend, and included that figure in the Rate Filing. Tr. I at 65. Blue Cross's methodology accounts for the fact that pharmacy rebates have historically aligned with total pharmacy spend, such that in a year where pharmacy spend is high it would also expect to receive higher rebates; on the other hand, when pharmacy spend is lower, the rebates are lower. *Id*. at 64-65. Mr. Stentz does not challenge Blue Cross's development of the pharmacy rebate projection and agrees with it. *Id*. at 221-22, 223.

As Mr. Mackintosh testified, from 2020-2023, comparing the total receivable in pharmacy rebates to the gross total pharmacy spend in a given year, rebates have been within the range of 25-28% of gross pharmacy spend. Tr. I at 67. This range has not been increasing year to year, but instead has shown variation – the range has not been "monotonically increasing like a ratchet only upwards." *Id.* at 155. The rebate projection included in the Rate Filing is 28% of projected total pharmacy spend, which is at the high end of that historical range.[10]

By contrast, Ms. Smagula suggests an alternative approach to estimating 2025 pharmacy rebates by just taking the average dollar value of pharmacy rebates from 2020 through 2023, which is a trend of 16%. OHIC Ex. 1 at 6. As Mr. Mackintosh testified, this approach of looking at pharmacy rebate dollar values in isolation from pharmacy spend is flawed and should be rejected. Tr. I at 66. In contrast to the methodology of Blue Cross, Ms. Smagula's approach

[10] Blue Cross's rebates as a percentage of total spend is derived from (1) OHIC Ex. 20, which shows the Direct Pay - Paid & Allowed PMPMs with Membership by Month from 2020 through 2023, separated between medical and pharmacy, and (2) Confidential Ex. 89, which shows the pharmacy rebates for this market for those same years. Tr. I at 68-70.

looks at rebates as a dollar value in isolation from any relationship to total pharmacy spend. *Id*. at 66-67. Using her 16% upward trend as to the dollar value of pharmacy rebates, 2025 is rendered an outlier year from how rebates have performed relative to pharmacy spend historically. *Id.* Indeed, using her recommendation, rebates as a percentage of total spend would be at 29.3% for 2025, which is outside of the 25-28% historical range discussed above. *Id.* at 67-68.

Mr. Mackintosh testified that Blue Cross does not have an indication that rebates will somehow outperform relative to total spend in 2025. *Id*. at 68. Ms. Smagula's methodology merely speculates that specialty drugs, which "tend to have higher rebates," will increase in 2025, rendering 2025 an outlier from prior years. *Id*. at 267. On the other hand, when asked whether she considered how the use of generics would impact pharmacy rebates, she acknowledged that generic drugs would "lead to less rebates, but stated that she did not quantify these assumptions and did not explain how either would offset the other. *Id.* Ms. Smagula's approach to projecting 2025 pharmacy rebates should therefore be rejected.

For the above-stated reasons, Blue Cross has shown by a preponderance of the evidence that its methodology in projecting rebates for 2025 is reasonable and appropriate. Accordingly, the alternative methodology suggested by Ms. Smagula should be rejected. To the extent that Ms. Smagula's assumption that pharmacy rebates will increase at an annualized trend of 16% is required to be included, Blue Cross estimates that the rate impact would be a 0.5% decrease to the rate request. Tr. I at 70.

IV. BLUE CROSS'S PROPOSAL FOR PROJECTING THE 2025 RISK ADJUSTMENT PAYMENT IS REASONABLE AND APPROPRIATE AND SHOULD BE USED IN CALCULATING RATES

There is no disagreement among the actuaries that the appropriate methodology for projecting the 2025 risk adjustment payment includes substituting the risk adjustment payment Blue Cross is entitled to receive for the 2023 base year (as reported by CMS), and then trending that amount to 2025 using an assumed statewide premium trend assumption. OHIC Ex. 1 at 20; AG Report at 7-8; Tr I. at 206.[11]

On July 22, 2024, CMS published the final 2023 risk adjustment report, which provides that Blue Cross is entitled to a risk adjustment payment for 2023 in the amount of $12,252,585.48. *See* Stipulation at par. 3. Consistent with its representations at the Public Hearing, and consistent with the recommendations of both Ms. Smagula and Mr. Stentz, Blue Cross has substituted that final payment amount into its pricing model and trended that to 2025, which Blue Cross has estimated results in a 0.3% increase to the rate request. *See* Stipulation at par. 4. This rate impact estimate is consistent with the estimation of Mr. Stentz.[12] AG Report at 8, 13.

Both Ms. Smagula and Mr. Stentz agree with this approach for estimating the risk adjustment payment for the Rate Filing. OHIC Ex. 1 at 20, AG Report at 7-8. This should end the inquiry; however, Ms. Smagula's report also provides an alternative methodology to further

[11] At the time of the Rate Filing, this figure was not yet published. As a result, Blue Cross estimated the risk adjustment transfer payment for 2023 as the basis for its projected payment for 2025 in the Rate Filing, but indicated that it intended to later amend the Rate Filing to reflect the final 2023 payment amount once it was published. Blue Cross Ex. 1; Tr. I at 73-74. Blue Cross's estimated 2023 risk adjustment payment included in the Rate Filing was higher than the amount published on July 22, 2024. Given that the actual risk adjustment transfer payment is lower, the Rate Filing, without modification, is inadequate in this regard. *Id.* at 75.

[12] Mr. Stentz's estimate of the 2023 risk adjustment transfer payment of $12,252,585 nearly matched the amount reported by CMS on July 22, 2024 ($12,252,585.48). *See* AG Report at 8.

adjust the projected risk transfer payment for 2025 by looking at a shift in platinum membership as of a snapshot in time (March of 2024). She concedes that her alternative approach is equally as reasonable to the approach of not applying this methodology at all. Tr. I at 311 (stating that her "revised risk adjustment transfer amount . . . [is] an equally reasonable assumption to consider"). Ms. Smagula's analysis "accounts for the shift in enrollment toward platinum plans from CY2023 to March 2024." OHIC Ex. 1 at 21. The impact of this adjustment is an increase in the projected 2025 risk adjustment receivable of 5.6%.[13]

The AG Report does not include this alternative approach to project the 2025 risk adjustment transfer amount, and when asked at the Public Hearing whether such methodology should be used, Mr. Stentz testified that he stood by his approach and would *not* include it. Tr. I at 206-07.

Consistent with Mr. Stentz's view, Blue Cross disagrees with Ms. Smagula's alternative methodology to project the 2025 risk adjustment transfer amount. Accounting for the platinum membership as of March 2024 in estimating the 2025 risk adjustment transfer amount implies a false level of precision. Tr. I at 79. As an initial matter, using 2024 platinum membership deviates from the base period of 2023, which is the requisite base period that is used in the Rate Filing, and is the base period used for the risk adjustment transfer projection. *Id.* at 78-79. Moreover, there is no evidence that the 2024 membership related to platinum plans is more reliable than the distribution in 2023. *Id.* at 79. The 2024 membership is just a snapshot in time as of March of 2024, and does not account for any of the volatility in plan enrollment shifts or the tier level of the plan from which those members are moving from, which is a market dynamic

[13] This is derived from using all three of her suggestions on page 21 of the report ($72.03 PMPM) compared to the 2025 estimate using only Ms. Smagula's first two suggestions on page 20 ($68.18 PMPM). 72.03/68.18 = 5.6%.

that would impact the risk adjustment transfer amount. *Id.* at 90-92, 95 (testifying that "[e]ach spot they transition from into a Platinum, it would, in theory, have a different impact" on the risk adjustment transfer amount). As Mr. Mackintosh testified, to assess how much weight (risk) to assign to a member shifting to a platinum plan, it is necessary to know from where that member is originating and from what tier plan – each such scenario will impact the risk adjustment transfer differently, including whether the member originates from the other carrier in the market or from outside the current plan distribution. *Id.* Ms. Smagula does not account for those situations in her methodology, rendering her methodology flawed and unreliable. *Id*. at 95, 341-43 (conceding that "I don't feel like I have any information to do that analysis").

Additionally, Ms. Smagula's approach to isolating the metal tier variable as the proxy for risk wholly ignores the ways in which other variables of the complex risk adjustment transfer formula drive the ultimate receivable, such as the plan level risk scores ("PLRS") that rely on the specific diagnosis of the member in a given calendar year coupled with the member's age. Tr. I at 76, 79-80. Ms. Smagula's methodology assumes that there will be no change from the distribution of 2023 PLRS to the year 2025. *Id.* at 339. But, that assumption is not reasonable. Neither Ms. Smagula nor Blue Cross have the data to predict how members will change by plan in 2025 relative to base year 2023, nor is it known how such member's health status (ie the conditions and diagnoses for those members) will change in 2025, which is ultimately what drives the risk adjuster weights. *Id.* at 90-91.

Indeed, a member's chosen metal tier level is not – and cannot be – a proxy for a member's PLRS. As Mr. Mackintosh testified, platinum level plans are correlated with higher risk because (1) the formula assigns higher weights to higher metals, and (2) members who have more chronic conditions, and therefore higher risk scores, tend to choose higher metal plans.

Importantly, however, it is *correlation*, and not a causation. *Id.* at 88-89. Thus, while it is true that a member with a certain PLRS in a platinum plan accounts for greater risk than if that exact same member were in a lower level plan, it is also true that a member with a lower PLRS in a platinum plan would account for *less* risk than a member with a higher PLRS in a lower metal tiered plan. *Id.* at 90. Ms. Smagula has not accounted for this scenario in her analysis – she wholly ignores it. *Id*. at 340.

Moreover, implicit in Ms. Smagula's methodology is that Blue Cross will be insuring a more risky population in 2025. Tr. I at 94. Yet, she does not make any adjustment to her methodology related to the other side of that coin: an increase in the costs that Blue Cross would incur. *Id*. at 343. As Mr. Mackintosh testified, platinum plans tend to have much higher allowed claims than members who choose other metal plans. *Id.* at 88-89. As a result, increased platinum membership would likewise increase the overall expected block of claim costs, requiring a higher index rate and therefore a higher rate increase than what was included in the Rate Filing. *Id.* at 94. Ms. Smagula acknowledged as much during her testimony, but stated that she did not actually quantify this impact in her rate review, which further renders her analysis as flawed. *Id.* at 343.

Finally, Ms. Smagula's methodology to predict the 2025 risk adjustment transfer amount by looking solely at the March 2024 platinum membership should be rejected for the additional reason that, historically, platinum distribution in isolation has *not* impacted the risk adjustment transfer payments. As Mr. Mackintosh attests, in 2018 and 2019 Blue Cross had no platinum membership, so there was no change in platinum membership distribution. Affidavit of Brian Mackintosh at par. 2 Yet, the risk adjustment transfer decreased by 59% PMPM from 2018 to 2019. *Id.* at par. 4. In each of the most recent four years (2020 through 2023), Blue Cross's

platinum membership has grown between 2.1 to 2.4%, which is a consistent level of growth. *Id.* at par. 5. However, over that same time period, the risk adjustment transfer payment PMPM experienced an annual change of: -29%, +325%, +20%, and +8%. *Id.* at par. 6. Particularly given that the market share between Blue Cross and the other carrier in the individual market has been consistent over this time period, this wildly diverse set of changes shows that there are far more complex variables at play in the risk adjustment transfer receivable than the metal distribution alone. *Id.* at par. 8.

For the above-stated reasons, Blue Cross has satisfied its burden to show that the risk adjustment transfer projection used in the Rate Filing, amended to use the final payment amount for 2023 and trended forward to 2025 using the statewide premium assumption, is appropriate and should be used in projecting the 2025 rates, which results in a 0.3% increase to the rate request. To the extent that Blue Cross is further required to apply Ms. Smagula's alternative methodology related to platinum shift, Blue Cross estimates this would result in a 0.2% decrease to the rate request.

V. BLUE CROSS AGREES TO USE THE 3.3% REPORTED CPI-U AS OF JULY 2024 IN PROJECTING THE COST TREND FOR 2025, WHICH RESULTS IN A 0.3% DECREASE TO THE RATE REQUEST

There is no dispute among the actuaries regarding the soundness of the methodology employed by Blue Cross to develop its cost trends in the Rate Filing, including the cost trend related to projected payments to hospital facilities for 2025. OHIC Ex. 1 at 17-18; AG Report at 6-7. Tr. I at 171-72. The question among the actuaries is what specific CPI-U figure to include with respect to that cost trend for hospital facilities – it is a simply a matter of substituting a certain CPI-U figure, and does not involve changing the methodology employed to project the hospital cost trend in the Rate Filing. Of course, the actual CPI-U that will set the maximum rate

increase for 2025 will not be known and reported until September of 2024, so it is not known at this time.[14] In the Rate Filing, Blue Cross projected the anticipated payments to its contracted hospitals for 2025 utilizing the CPI-U published as of the time it developed the Rate Filing (3.9%), which it then increased by 1 percent, per the applicable OHIC regulation. Tr. I at 59. At the time of the Public Hearing, the CPI-U was reported at 3.4%, and on July 11, 2024, the CPI-U was reported at 3.3%. *See* Stipulation at par. 2.

Consistent with the view of Mr. Stentz, who testified at the Public Hearing that the most recently known CPI-U reported in July 2024 should be used (Tr. I at 204), Blue Cross does not disagree that the CPI-U of 3.3% as published on July 11, 2024 is reasonable to include in projecting 2025 rates. Tr. I at 59 (testifying that it is reasonable to include the most recently available CPI-U figure in the Rate Filing).

Blue Cross does not agree with an approach that would otherwise project CPI-U to be *lower than* 3.3% as of October 1, 2024, such that a lower CPI-U should be required to be included in projecting rates. *Id*. at 60 (testifying that actuaries are not economists and that "actuarial judgment for predicting a very volatile economic number is limited").

OHIC Ex. 65 supports Blue Cross's position to not project a lower CPI-U than 3.3%. That exhibit includes the respective CPI-U for each month from May of 2004 to May of 2024. *See* OHIC Ex. 65; and Tr. I at 333. The two most recently published CPI-U numbers are 3.4 %

[14] The OHIC Affordability Regulation governs the maximum rate increase that an insurer can offer a hospital for each given year. *See* 230-RICR-20-30- 4.10(D)6(e) (stating that review and prior approval of OHIC is required if "[t]he average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-U") percentage increase (determined by the Commissioner by October 1 each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus one percent (1%).") Thus, the actual CPI-U published as of October 1, 2024 increased by 1 percent will be the maximum rate increase that Blue Cross can pay its contracted hospitals in 2025. AG Report at 6-7; OHIC Ex. 1 at 18; Tr. I at 172.

(published for May) and 3.3 % (published for June). OHIC Ex. 65; Stipulation at par 2 (for the June figure). The CPI-U included in the Rate Filing was 3.9%, which was the CPI-U reported in January. Tr. I. at 59; *see also* OHIC Ex. 65. As OHIC Ex. 65 shows, in 11 out of the 20 year span reflected, the CPI-U was lower for June than it had been for January (as is the case here). Out of those 11 years, the CPI-U in September (the figure that will govern the rate cap for 2025 hospital increases) as compared to the CPI-U for June was actually higher or the same in 7 of those 11 years (it was higher in 5 of those 11 years, and the same in 2 of those 11 years).[15] It is therefore not reasonable to require Blue Cross to substitute a lower CPI-U in the Rate Filing than what has been reported to date. Predicting that the CPI-U in September will be lower than the CPI-U reported to date is not based on any evidence in the record, and is contra-indicated by the volatility of the monthly reported CPI-U for the past 20 years.

Further, OHIC Ex. 63 does not support projecting that the CPI-U will be lower in September, either, and should not be relied on for that purpose. The exhibit – an internet article published by Morningstar on May 15, 2024 – opines that *inflation* is projected to "return to normal levels." *See* OHIC Ex. 63 at p. 2. There is no indication in the article that the reported CPI-U as of September 2024 will be lower than 3.3%. The mere generalized statement in this article about how general inflation may trend in the second half of 2024 does not support requiring Blue Cross to include a CPI-U figure that is lower than 3.3% in projecting its 2025 cost trend.

[15] Looking specifically at the reported figures on OHIC Ex. 65, the years 2005, 2007, 2008, 2010, 2012, 2013, 2017, 2020, 2022, 2023 all show that the CPI-U reported in June was lower than the CPI-U reported in January (as is the case here for 2024). However, of those 11 years, the CPI-U reported for September was (1) higher than the CPI-U reported in June in the following 5 years: 2008, 2013, 2019, 2020, and 2022 and (2) the same as the CPI-U reported in June in the following 2 years: 2005, and 2017.

At the hearing, Mr. Stentz agreed that using the CPI-U as reported in July (the June CPI-U) would be reasonable to include in the Rate Filing, but projecting what the CPI-U figure may be months down the road is not reasonable and requires economic expertise beyond the scope of the Rate Filing and the respective actuaries' expertise. Tr. I at 204. Blue Cross agrees with Mr. Stentz. Although Blue Cross included a 3.9% CPI-U in the Rate Filing, Blue Cross believes it is reasonable to substitute the most recently published CPI-U (3.3%) into its pricing model for 2025 rates.

Ms. Smagula further acknowledges that if the CPI-U reported in September is in fact higher than 3.3%, the rate request would consist of understated price trends. Tr. I at 337.[16] In that regard, to the extent that the CPI-U published in September 2024 turns out to be higher than what Blue Cross is allowed to include in its projected premium rates, Blue Cross is at greater risk of inadequate rates. *Id.* at 60.

As set forth above, the relevant CPI-U for purposes of the allowed hospital rate increases for 2025 is not known at this time. Blue Cross has satisfied its burden to show that the 3.3% CPI-U, which Blue Cross proposes to use instead of the 3.9% it had included in the Rate Filing, is reasonable and appropriate, which results in 0.3% decrease the requested rate.

VI. BLUE CROSS'S METHODOLOGY FOR PROJECTING THE HIGH COST RISK POOL RECOVERY AND CHARGES FOR 2025 IS REASONABLE AND SHOULD BE USED IN CALCULATING RATES

As Mr. Mackintosh testified, the high cost risk pool (HCRP) is a component of the risk adjustment program associated with high-cost claimants. Tr. I at 97. The program partially

[16] Ms. Smagula also stated that if the CPI-U comes in lower, then there would be extra conservatism in the Rate Filing. Tr. I at 337.

reimburses insurers at 60% for enrollees with claim costs above $1M. *Id.* The program charges insurers a set percentage of premium by market. *Id.*

Turning first to the development of the projection for the HCRP recovery for 2025, the Rate Filing explicitly provides for a $0.29 PMPM anticipated recovery for 2025, which is based on the 6-year average of Blue Cross's recoveries. Tr. I at 97-98. Importantly, this $0.29 PMPM HCRP receivable is not the full picture – elsewhere in the Rate Filing is an additional assumption for a HCRP receivable related to gene therapy drugs, which is built into the development of the net gene therapy cost. Tr. I at 118-19; *See* AG Confidential Ex. 19, reflecting that in the Rate Filing Blue Cross included an assumption that it would receive an additional $0.56 PMPM HCRP receivable related to gene therapy drugs.[17] Accordingly, when combined with the HCRP amounts related to the development of the net gene therapy cost, the total HCRP receivable in the Rate Filing is $0.86 PMPM ($0.29 + $0.56).[18]

Blue Cross disagrees with Mr. Stentz's recommendation to include an assumption that the HCRP receivable would be $1.20 PMPM, as that recommendation assumes that Blue Cross's HCRP recovery somehow will be significantly higher than it has been in the past 6 years – and in many years the HCRP receivable has been $0. *See* AG Confidential Ex. 20 (which shows the

[17] That exhibit provides detail on specific items impacting the net cost of gene therapy drugs. Specifically, the exhibit shows the assumed overall fully insured average HCRP amounts expected to offset a portion of the gross cost of gene therapy drugs that can be calculated for each market. In the "individual" tab of that exhibit, this is done by taking the sumproduct of row 8 (HCRP recovery by drug) and row 16 (number of potential utilizers), which is $3,390,000. That figure is then converted to a PMPM by dividing by the membership in cell B14, then dividing by 12, which is a result of $16.55 PMPM. That figure is then reduced by 90% consistent with the overall utilization assumption adjustment made for gene therapy utilization, which is a result of $1.66 PMPM. That same formula can be followed for small group, which is $0.99PM. As large group is not subject to the HCRP, the result is $0. The overall average of fully insured PMPM for the HCRP for gene therapy drugs is therefore $0.56PMPM (taking $1.66 for IND, $0.99 for SG, $0 for LG).

[18] There is a small rounding effect that produces the $0.86 PMPM.

HCRP receivable for each of those 6 years). Mr. Stentz notes that, although not the case of Blue Cross's experience, nationwide payments have increased by an annualized 22.5% due to the impact of leveraging claims exceeding $1M – which is not the trend that Blue Cross has seen in its own experience. AG Report at 10. Nevertheless, Mr. Stentz applies that higher trend to the historical recovery amounts that Blue Cross has received and thereby projects a higher payment for 2025. *Id.* This methodology should be rejected. There is no evidence that Blue Cross's claim experience is not credible such that a nationwide view should be injected into the analysis of how Blue Cross's payout would fare. In all other respects, Blue Cross's claim and market experience is used in projecting 2025 rates; there is no appropriate reason why this aspect of the Rate Filing should be treated differently. Tr. I at 101, 212. To the extent that Blue Cross is required to increase the total HCRP recovery assumption from $0.86 to $1.20, or $0.34 PMPM, Blue Cross estimates that this would result in a rate decrease of 0.05%.[19]

Turning next to projecting the HCRP charges, Blue Cross took the average year to year increase in the charge as a percentage of premium for 2018-2023, and applied two years of that increase to the 2023 charge as a percentage of premium. Tr. I at 98-99. Ms. Smagula agrees with Blue Cross's methodology in the Rate Filing projecting those charges and does not suggest an alternative approach. OHIC Ex. 1; Tr. I at 257, 345 (testifying as to her adoption of the methodology related to the development of the HCRP recoveries as proffered by Mr. Stentz, but not agreeing to modify Blue Cross's methodology as to projecting the HCRP charges).

[19] At the Public Hearing, Blue Cross testified that it estimated the rate impact to be about 0.2%; however, this estimation did not account for the fact that the HCRP recovery assumption of $0.29 PMPM was exclusive of the separate HCRP assumption for gene therapy, which was separately included in the Rate Filing.

Contrastingly, Mr. Stenz suggests that the 2025 charges will somehow be lower. His methodology is flawed and should be rejected. He recommends a linear regression to estimate the costs, which he says accounts for historical changes, but he decided not to use 2023 as the base year in projecting for 2025. Tr. I at 101. He testified that "conceptually he liked the idea" of what Blue Cross had done to project the charges, but that to him 2023 "seemed like a higher charge" so he decided to treat it is an outlier year and discount it when projecting to the 2025 charge. Tr. I at 179-80, 212. Blue Cross and Ms. Smagula disagree with this flawed methodology and do not consider it reasonable, as it ignores the 2023 base year. To the extent that Blue Cross is required to use the alternative methodology of Mr. Stentz in estimating that the HCRP charges will be lower than it had estimated in the Rate Filing, this would result in a rate decrease of 0.1%.

For the above-stated reasons, Blue Cross has demonstrated that its development of the projection for HCRP recoveries and charges is reasonable and should be used in calculating the rates.

VII. BLUE CROSS'S ADMINISTRATIVE CHARGE INCLUDED IN THE RATE FILING IS REASONABLE AND APPROPRIATE AND SHOULD NOT BE ARTIFICIALLY LIMITED

None of the actuaries dispute the administrative charge included in the Rate Filing of 11.7% or challenge the methodology employed by Blue Cross related to this charge. Tr. I at 223, 314. The administrative charge reflects the component of the Rate Filing that is not tied to medical and pharmacy costs and benefits, but instead includes administrative expenses – the costs associated with administering the Blue Cross policies. *Id*. at 106. The key drivers of the administrative charge included in the Rate Filing are excess of loss gene therapy coverage and long-term strategy investments. *Id.* at 107; *see also* OHIC Ex. 12 at 1-12.

In her report, Ms. Smagula makes the following statement: "For the Commissioner's consideration, if the administrative change PMPM was only allowed to increase from 2024 to 2025 based on the average of the most recent three months of CPI-U: Less Food and Energy [CPI-U], I have estimated that this change would decrease rates by approximately 0.5%." OHIC Ex. 1 at 23.

That consideration should be rejected. First, although she included the modification for consideration, she does not actually recommend that the administrative charge be modified in any way. Tr. I at 314. She further acknowledges that administrative expenses actually incurred by Blue Cross are "not necessarily tied to CPI[U]." Tr. I at 317. Thus, requiring Blue Cross to limit the administrative charge in proportion to the CPI-U erroneously assumes Blue Cross's administrative expenses and costs change in proportion to CPI-U, which they do not. *Id.* at 108-09. This artificial limitation also fails to account for the real ways in which the structure changes due to investments, cost reduction initiatives, and changes in overhead allocation based on Blue Cross's membership outlook, factor into the administrative charge. *Id.*

As the actuaries all agree, Blue Cross has satisfied its burden to show that the administrative charge included in the Rate Filing is reasonable and appropriate and should be included in calculating the rates without being artificially reduced. To the extent that Blue Cross is required to limit the administrative charge based on the average of the most recent three months of CPI-U, Blue Cross has estimated that this would result in a rate decrease of approximately 0.6%. Tr. I at 109; OHIC Ex. 1 at 26.

VIII. THE REQUESTED 2% CONTRIBUTION TO RESERVES IS REASONABLE AND APPROPRIATE AND SHOULD NOT BE REDUCED

Neither Mr. Stentz nor Ms. Smagula challenge Blue Cross's inclusion of a 2% contribution to reserves in the Rate Filing. Tr. I at 221; 314. Indeed, in evaluating the Rate

Filing, the actuaries understand and agree that in establishing its rates Blue Cross is charged with enhancing the affordability of healthcare coverage while protecting its financial condition so that it can pay its claims when they are due. *Id.* at 221, 347. Mr. Stentz testified that the 2% contribution to reserves is "what he sees as reasonable" and he "would not say it is unreasonable." *Id*. at 221. In his report, he further states that the contribution to reserves including in the Rate Filing is consistent with industry standards. AG report at 12. Ms. Smagula likewise testified that she does not challenge Blue Cross's 2% contribution to reserves because it is one way to protect Blue Cross's financial condition and it allows for a margin of error with respect to the assumptions included in the Rate Filing. *Id*. at 346-47.

As Mr. Mackintosh testified, it is not sustainable for Blue Cross to keep its reserves at the same dollar amount from year to year. Tr. I at 111, 113. As the overall cost and utilization of healthcare increases, Blue Cross must ensure that its corresponding reserves also increase in dollar value, as well. *Id*. at 110-11. Otherwise, if the reserves stay constant, rather than increasing in accordance with how cost and utilization are increasing, the same set of dollars covers less claims. *Id.* at 110-13. Currently, Blue Cross's reserve level is sufficient to pay provider medical and dental claims for fewer than 90 days. *Id*. at 112.[20]

Further supporting the need for the 2% contribution to reserves included in the Rate Filing is the fact that because the individual market is small and high risk, the margin of error can be large. As the actuaries all agree, to adequately project rates, assumptions and projections must be made and balanced. Tr. I at 219; 346-47. Including a more aggressive assumption results in more financial risk to Blue Cross. *Id.* at 219. In this regard, as Mr. Mackintosh

[20] Mr. Mackintosh further testified that reserves as a percentage of revenue as of Q1 2024 is 21.1%. Tr. I at 113. As Ms. Smagula testified, this is below the range identified in the Lewin Report (OHIC Ex. 66) related to appropriate surplus. Tr. I at 308.

testified, the alternative assumptions suggested by Ms. Smagula and Mr. Stentz are aggressive, on top of the aggressive assumptions that Blue Cross has already included in the Rate Filing. *Id*. at 114-15.

As Mr. Mackintosh testified, examples of the more aggressive assumptions Blue Cross has included in the Rate Filing include: (1) the gene therapy adjustment and (2) the overall utilization trend pick, each of which adds risk to the Rate Filing. *Id.* at 115. The contribution to reserves is needed to appropriately balance against these aggressive assumptions that add risk to the Rate Filing, so that Blue Cross's rates are not at risk of being inadequate.

Turning first to the aggressive assumption for gene therapy included in the Rate Filing, as Mr. Mackintosh testified, the net cost to Blue Cross for each gene therapy drug is generally $1M on average, but could be up to $3M. Tr. I at 115, 116. In developing the gene therapy factor for the Rate Filing, Blue Cross began with a report from its Pharmacy Benefits Manager (PBM), which identified, by market segment, the number of members found to be potential candidates for each gene therapy drug. *Id*. at 116-17. Blue Cross used actuarial judgment to then *reduce* the final utilization assumption by 90% relative to that candidate list for the individual market, acknowledging that there are complex clinical and member decisions involved in whether to pursue a gene therapy treatment. *Id.* at 117-18.

However, as Mr. Mackintosh testified, there is a potential for significantly higher costs and utilization for these drugs. Tr. I at 118. Indeed, Blue Cross conducted additional independent analyses that indicates a wide upper range of potential uptake, which show that there is material risk that gene therapy utilization could be well above the average expected utilization assumption including in the Rate Filing. *Id*. at 118-19. Given Blue Cross's membership size and premium rates, every $1M is nearly 1% in revenue. *Id*. at 115. This means

that each additional gene therapy claim outside of what was anticipated for purposes of the Rate Filing renders the Rate Filing 1% deficient due to that single claim.[21] *Id.* Moreover, as explained above related to the HCRP, Blue Cross's gene therapy factor accounts for reinsurance, HCRP recoveries, and excess of loss coverage. Tr. I at 118-20.

Turning to another example of an aggressive assumption included in the Rate Filing, Mr. Mackintosh further testified regarding the overall utilization trend pick – a trend pick that was 1.8% lower than the best fit regression trend and resulted in a 4.7% decrease to the overall requested rate increase. Tr. I at 115. The Rate Filing assumes that the trends observed in 2023 will not continue at those same elevated levels – but, if Blue Cross is wrong in that regard, the Rate Filing is inadequate.

The contribution to reserves in the Rate Filing is also lower than the typical contribution to reserves Blue Cross has sought historically. Tr. I at 120. To keep the rate lower this year, and in an effort to minimize the year over year rate impact of returning to Blue Cross's pre-pandemic levels of contribution to reserves, Blue Cross only included a request for a contribution to reserves in the amount of 2%.

In assessing the reasonableness of the contribution to reserves, it is important that the alternative methodologies and assumptions proffered by Mr. Stentz and Ms. Smagula to further decrease the rate be evaluated in the context of the full Rate Filing, where a 2% contribution to reserves likely cannot absorb an additional risk load. Indeed, reserves are critically important to a health insurer, and Blue Cross is not exception. Insurers need to be able to pay claims when

[21] As Mr. Mackintosh testified, Blue Cross does not anticipate receiving any rebates or discounts related to these drugs, nor any offset related to other treatments for 2025. Tr. I at 118-19. Mr. Stentz does not challenge this projection. Tr. I at 217-18. Ms. Smagula's report does not include any challenge to Blue Cross's gene therapy projection. OHIC Ex. 1.

they are due, and adequate reserves allow an insurer to withstand unforeseen and volatile events in the future, which cannot be predicted with certainty ("[r]eserves are funds set aside so that we are able to pay claims . . . our policy holders count on us to pay their claims, hold stop, and we need to ensure that we have the funds to do so"). Tr. I at 110. Mr. Stentz agrees, acknowledging that adequate reserve levels are themselves a protection for the consumer. AG Report at 11 ("surplus is set aside to protect consumers from unexpected adverse financial conditions"). To the extent that Blue Cross is instructed to incorporate the more aggressive assumptions proffered by the other actuaries into its rates, the corresponding rate impact could be insufficient to cover Blue Cross's claim expenses. Currently, Blue Cross is projecting losses in this market for 2024, and was allowed only a 1% contribution to reserves for its 2024 rates. Tr. I at 121. On the heels of losses in 2024, Blue Cross could be facing similarly inadequate rates in 2025. In this regard, any additional requirement that Blue Cross also reduce its contribution to reserves could impact Blue Cross's ability to absorb losses and pay the claims of its members.

Accordingly, Blue Cross has demonstrated that the requested contribution to reserves of 2% is reasonable and appropriate and should not be reduced.

CONCLUSION

For the reasons stated above, Blue Cross has satisfied its burden to show that the requested rates for 2025 are consistent with the proper conduct of its business and in the interests of the public. Blue Cross therefore respectfully requests that the Commissioner approve its requested rates for 2025.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of August, 2024, a copy of the foregoing Post-Hearing Memorandum was sent via electronic mail to:

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