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-RH-2024-1

OHIC Post-Hearing Memorandum

Introduction

The Office of the Health Insurance Commissioner ("Office" or "OHIC") hereby files its Post-Hearing Memorandum ("Memorandum") in the above captioned matter in support of OHIC's recommendations for modifications to the rates requested by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for their CY 2025 Individual Market plans. The Memorandum will discuss the law applicable to this proceeding, identify the issues in dispute and analyze the evidence and the law relevant to the disputed issues.

On May 13, 2024, Blue Cross filed its health insurance rate request in the Individual Market for calendar year 2023 ("Rate Request" or "Rate Filing") requesting a weighted average premium increase of 14.3% for its 2025 plans in the Individual Market.[1] For the reasons set forth below, the Office submits to the Health Insurance Commissioner for the State of Rhode Island (the "Commissioner") that Blue Cross has failed to prove that its Rate Request is consistent with the proper conduct of its business and with the interest of the public. Instead, the evidence supports a finding that a lower weighted average premium increase is more consistent with the

[1] Blue Cross did submit updated filing documents on May 31, 2024, and June 17, 2024, to modify some information to the Components of Premium Tab V but there was no change to the rates or rate change.

proper conduct of Blue Cross' business and the best interest of the public. If OHIC's recommendations are adopted OHIC estimates this will result in an approximate 1.8% reduction from the Rate Filing's proposed 14.3% weighted average premium increase to a weighted average premium increase of approximately 12.5%.[2, 3] The Office notes that, because it does not have access to Blue Cross' pricing models, the ultimate percentage rate increase resulting from the adoption of one or more of the Office's recommendations may vary slightly from the estimates contained herein. Moreover, while not making a recommendation in favor of or against, OHIC is providing the Commissioner with information relevant to Blue Cross' requested (a) increase in administrative PMPM and (b) 2% contribution to reserves because OHIC submits that the evidence can support the Commissioner's modification of these portions of the Rate Request if the Commissioner in his discretion determines the modification to be appropriate. Table 3 below contains a summary of the approximate rate impacts of the Office's various recommendations for alternative assumptions and the two topics the Office is presenting information on for the Commissioner's discretion.

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[2] At the Hearing, Blue Cross represented that some of OHIC's recommendations of alternative assumptions would result in slightly larger reductions to its proposed 14.3% rate increase when run through Blue Cross' rate development tool. See e.g. Mackintosh TR I at 56-57. This fact is not surprising given that OHIC does not have access to Blue Cross' rate development tool and must instead provide the Commissioner with its educated approximation of the impact each of its recommendations will have on the rate request.

[3] In the context of this administrative hearing matter, the weighted average rate increase (also alternatively referred to as the weighted average premium increase) the parties refer to and that the Rate Filing reflects, refers to the Calibrated Plan Adjusted Index Rate (CPAIR) average increase. The CPAIR reflects the average base rate across all plans prior to the adjustments for age. The weighted average is calculated using the most recent membership enrollment by plan offering. Ultimately, each individual market enrollee's rate is equal to the CPAIR for the plan offering they are enrolled in multiplied by the enrollee's age factor or age adjustment factor (the age factors are federally prescribed). OHIC Exhibit 1 at 6.

Travel

Blue Cross filed its Rate Request on May 13, 2024 ("Rate Request" or "Rate Filing"). Blue Cross Exhibits 1 and 2.[4] The Rate Request requested a weighted average CPAIR rate[5] of $424.45, which represents a weighted average premium increase of 14.3% for 2025 plans in the Individual Market.[6] Blue Cross Exhibit 1; Blue Cross Exhibit 2 at Rate Template Tab V.

The primary drivers of the 14.3 % weighted average premium increase set forth in the Rate Filing were identified by Blue Cross as: the "continuing increase in the total cost of health care in Rhode Island"; significant inflation's impact on the cost of medical services and provider unit costs; specialty drug treatments; increases in utilization; and administrative costs. Blue Cross Exhibit 1 at 10, Consumer Disclosure-Individual Market; see also Mackintosh TR I at 36;[7]; OHIC Exhibit 1 at 7-8. OHIC identified the major drivers of Blue Cross's proposed rate change on Table 4 of OHIC Exhibit 1, inclusive of a 4.2% base period restatement, a 4% Medical Utilization and Severity Trend and a 2.5% Medical Cost Trend. See also Smagula TR I at 270-271.

The Office has established standards and procedures relating to ex parte communications to ensure compliance with the requirements of Arnold v. Lebel, 941 A2d 813 (R.I. 2007) and

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[4] See also OHIC Exhibits 2 through 5. Blue Cross's updated May 31, 2024, and June 17, 2024, filings referenced in footnote 1 can be found at OHIC Exhibits 32 and 37.

[5] A "weighted average CPAIR rate increase" is also commonly referred to as an "overall average-rate increase" or "a weighted average premium increase."

[6] For Calendar Year 2024, the weighted average CPAIR PMPM was $371.38. Blue Cross Exhibit 2, Rate Template Tab V.

[7] Citations to "TR I at __" refer to pages in the transcript of the Public Hearing for July 2, 2024. Citations to "TR II at __" refer to pages in the transcript of the Public Hearing for July 3, 2024. Citations to "Mackintosh TR I," for example, refer to pages in the transcript of the Public Hearing for July 2, 2024, wherein Mr. Mackintosh is testifying.

with the requirements of R.I. Gen. Laws § 42-35-9(g). On or about May 21, 2024, the Office circulated a memorandum among OHIC staff and other relevant parties setting forth these standards and procedures.

The Commissioner assumed jurisdiction over the Rate Request, in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

The proceedings have been conducted as an administrative hearing in accordance with the Rhode Island Administrative Procedures Act. R.I. Gen. Laws Title 42, Chapter 35.

The Commissioner scheduled the public hearing, as required by R.I. Gen. Laws §§27-19-6 and 27-20-6, for July 2 and July 3, 2024 (the "Public Hearing"). Appearances were entered on behalf of Blue Cross by Jamie Bachant, Esq. and on behalf of the R.I. Office of the Attorney General ("OAG" or "AG") by Jordan Broadbent, Esq., Special Assistant Attorney General and Dorothea R. Lindquist, Esq., Special Assistant Attorney General. TR I at 7. The undersigned counsel entered her appearance on behalf of the Office. TR I at 7. The parties stipulated on the record at the Public Hearing that the Commissioner, assisted by his legal advisor Raymond A. Marcaccio, Esq., has jurisdiction to hear this matter of the Rate Request. TR I at 12.

Public notice of the Rate Request and the Public Hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6. Blue Cross Exhibit 3; TR I at 10-11.

The Parties filed their respective Pre-Hearing Submissions on June 21, 2024. The Pre-Hearing Submissions of the Office and the OAG included actuarial reports (sometimes also

referred to as the pre-filed testimony or Actuarial Analysis) of their respective actuarial experts, OHIC Exhibit 1 (inclusive of OHIC Exhibits 1A and 1B) and AG Report.[8]

OHIC's Actuarial Analysis, prepared by Jennifer Smagula, FSA, MAAA, identified five aspects of the Rate Filing where the Office recommended, in their professional actuarial opinion, equally or more reasonable alternative assumptions, methods or strategies in developing Blue Cross' rates.[9]

These five areas of dispute were as follows: (1) whether Blue Cross should be required to update their CY 2023 base period experience with claims runout through May 2024, not just through February 2024; (2) Blue Cross' pharmacy rebate trend assumption; (3) Blue Cross's medical utilization and severity trend assumption; (4) Blue Cross' methodology for predicting the relevant CPI-U (less food and energy) 12-month percent change figure to be employed as its 2025 hospital inpatient and outpatient unit cost trends; and (5) Blue Cross' methodology with respect to risk adjustment. OHIC Exhibit 1.

In addition to these five areas of dispute, Ms. Smagula's report also provided information for the Commissioner's consideration on the questions of the Contribution to Reserves factor and

[8] The AG Report is a reference to the document with filename "(4) LE BCBSRI 2025 Ind Filing Final 6-21-24", provided to the parties and Commissioner electronically on June 21, 2024 as part of the AG's pre-hearing filings. While the AG Report was not separately numbered as an exhibit in this matter, OHIC submits that it was effectively entered into evidence in full at the public hearing. For the purposes of OHIC's Post-Hearing filing, this document will be referenced as the "AG Report." It should be noted that, because it was provided to the parties as "pre hearing non-exhibit 4", it was at times mistakenly referred to at the Public Hearing as AG Exhibit 4 (see e.g., Stentz TR I at 224, 229 and Smagula TR I at 308).

[9] At the Public Hearing, after hearing testimony on the topic, Ms. Smagula and OHIC adopted an additional recommendation, a sixth OHIC recommendation, that was presented by the AG's actuarial expert on an alternative methodology for estimating Blue Cross' High-Cost Risk Pool (HCRP) Recoveries for 2025. Smagula TR I at 253-254, 257, 312, and 344-346; see also AG Report at 10.

the Administrative Charge PMPM increase from 2024 to 2025 included the Rate Filing's development. OHIC Exhibit 1 at 23-25.

Following a series of pre-hearing conference calls with the Commissioner and the Commissioner's outside legal advisor, Raymond A. Marcaccio, Esq., an administrative hearing was held on the Rate Request before the Commissioner on July 2 and July 3, 2024. At this Public Hearing Blue Cross presented actuary Brian Mackintosh, FSA, MAAA, for testimony (Mackintosh TR I at 33-163), the OAG presented actuary Brian Stentz, FSA, MAAA, for testimony (Stentz TR I at 164-246), and the Office presented actuary Jenn Smagula, FSA, MAAA for testimony (Smagula TR I at 247-352). Brian Mackintosh, Brian Stentz, and Jenn Smagula, the three actuarial experts who testified at the administrative hearing, are all experts in the field of actuarial science, as stipulated to by the Parties on the record at the Public Hearing. TR I at 11. No other witnesses testified at the Public Hearing. All Parties had the opportunity to question all three witnesses at the Public Hearing. Testimony of these witnesses concluded on the afternoon of July 2, 2024. TR I at 352.

At the Public Hearing, the parties' proposed exhibits were admitted into the record as full exhibits (specifically, Blue Cross Exhibits 1 through 3; AG Exhibits 1 through 32; and OHIC Exhibits 1 through 120). TR I at 7-8, 289-292; 353-355.

Of these, OHIC Exhibits 77-114 and AG Exhibits 12-22 and 31-32 were identified as containing confidential information and it was determined prior to the Public Hearing pursuant to the *Stipulated Order Regarding Confidential Exhibits* issued by the Commissioner on July 1, 2024, that these exhibits contain confidential and proprietary business information of Blue Cross not for public disclosure in accordance with R.I. Gen. Laws §38-2-2(4)(B) and therefore would

be designated as confidential exhibits, sealed, and excluded from the public record. TR I at 8-9 and 251-258.

Notice and an opportunity for in-person public comment regarding the Rate Request was made available on the record at the Public Hearing on July 2 and July 3, 2024. Blue Cross Exhibit 3; TR I at 255-257 and TR II at 3-5. No individuals provided in-person public comment on either July 2 or July 3, 2024. TR I at 255-257 and TR II at 3-5. Notice and an opportunity for written public comment regarding the Rate Request was made available to the public, with notice that written public comment would be received by the Office by email, mail, and hand-delivery through 5 pm on July 19, 2024. Blue Cross Exhibit 3. Written public comment received by the Office through 5 pm on July 19, 2024, relating to the Rate Request is attached hereto as Appendix A.[10]

Subsequent to the hearing, a stipulation entitled *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* was filed on July 31, 2024 (July 31, 2024 Stipulation) and entered into evidence in full in the administrative record of the above-captioned matter. The July 31, 2024 Stipulation is attached hereto as Appendix B. The July 31, 2024 Stipulation provided that the Centers for Medicare & Medicaid Services (CMS) final *Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2023 Benefit Year*, released on July 22, 2024, indicated Blue Cross is entitled to a risk adjustment transfer payment of $12,252,585.48 for calendar year 2023 in the individual market. The July 31, 2024 Stipulation also provided that the U.S. Bureau of Labor Statistics

[10] Where appropriate, the Office redacted personal information.

released its Consumer Price Index for all Urban Consumers (CPI-U) figures inclusive of June 2024 data on July 11, 2024, and that the CPI-U (less food and energy) 12-month percent change through June 2024 was an increase of 3.3%. Appendix B.

The Office now submits this post-hearing memorandum, and accompanying proposed findings of fact and conclusions of law, in support of its recommendation that Blue Cross' Rate Request be modified downwards as set forth herein.

Jurisdiction

The Commissioner has jurisdiction over the Rate Request pursuant to R.I. Gen. Laws §§ 42-14.5-3(e), 42-14-5(d), 27-19-6 and 27-20-6.

The Commissioner assumed jurisdiction over the Rate Request, in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6 and the parties stipulated that the Commissioner, assisted by his legal advisor Raymond A. Marcaccio, Esq., has jurisdiction to hear this matter of the Rate Request. TR I at 12.

Notice of the Public Hearing and an opportunity for public comment regarding the Rate Request was provided to the public, in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6, together with notice that written public comment would be received by the Office by email, mail and hand-delivery through 5 pm on July 19, 2024. Blue Cross Exhibit 3. TR I at 10-11.

The Rate Request proceeding has been conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq*.

Generally Applicable Law

The Rate Request is governed by Rhode Island laws and regulations relating to health insurance rates.

Blue Cross & Blue Shield of Rhode Island is an entity organized as a Nonprofit Hospital Service Corporation and Nonprofit Medical Service Corporation subject to Chapters 19 and 20 of Title 27 of the Rhode Island General Laws.

Rhode Island law requires the Commissioner "hold a public hearing in any instance where the applicant covers ten thousand (10,000) or more enrolled individuals in the individual market, and the rates proposed in the filing for the annual rate increase for products offered in the individual market produce an overall average-rate increase of ten percent (10%) or more." R.I. Gen. Laws §§ 27-19-6(f) and 27-20-6(f).

As set forth in Tab I of the Rate Filing, as of March 31, 2024, Blue Cross has had an enrollment of 17, 614 members in its Individual Market plans. Blue Cross Exhibit 1.

The Blue Cross' proposed Rate Request for a 14.3% weighted average premium increase constituted a proposed "overall average-rate increase of ten percent (10%) or more" pursuant to R.I. Gen. Laws §§ 27-19-6(f) and 27-20-6(f).

Rhode Island Law provides that at any hearing held pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6, "the applicant shall be required to establish that the rates proposed to be charged 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) and 27-20-6(d)(1). Consequently, Blue Cross must establish that its proposed rates 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) and 27-20-6(d)(1).

Pursuant to R.I. Gen. Laws §§ 27-19-6(i) and 27-20-6(i), the holding and conducting of any public hearing in connection with the proposed rates of a nonprofit Hospital Service Corporation or a Nonprofit Medical Service Corporation, "shall be held in accordance with the provisions of chapter 35 of title 42," i.e., the Rhode Island Administrative Procedures Act.

In 2004 the Rhode Island General Assembly elaborated on the meaning of "proper conduct of [the applicant's] business" with respect to Blue Cross with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq*. The Legislature declared that Blue Cross' mission includes providing "affordable and accessible health insurance to insureds," R.I. Gen. Laws § 27-19.2-3(1), and "affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals," R.I. Gen. Laws § 27-19.2-3(5). The Blue Cross Board of Directors was specifically charged with ensuring that the corporation effectively carries out its charitable mission. R.I. Gen. Laws § 27-19.2-4(a). Under this 2004 legislation, Blue Cross must also "employ pricing strategies that enhance the affordability of health care coverage . . .." R.I. Gen. Laws § 27-19.2-10(3). These legislative directives make clear that the "proper conduct of the applicant's business" is no longer left solely to management's discretion. Blue Cross has a legal obligation to provide "affordable" and "accessible" health insurance.

During the same 2004 legislative session, the General Assembly created the Office of the Health Insurance Commissioner, and directed the Commissioner to discharge the powers and duties of the Office for the following purposes: (1) to guard the solvency of health insurers; (2) to protect the interests of consumers; (3) to encourage fair treatment of health care providers; (4) to encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and (5) to view the health care system as a comprehensive entity, directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. R.I. Gen. Laws § 42-14.5-2.

The Commissioner is authorized to approve, disapprove, or modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6. The authority to modify rates

includes the authority to modify any of the components or factors used to develop rates, if warranted by the evidence (or lack of evidence) in the record. The law does not constrain the Commissioner to review the Rate Request only from the perspective of mathematical and actuarial accuracy. Hospital Service Corporation of Rhode Island v. West, 308 A2d 489, 495 (RI 1973). Rather, the Legislature has directed the Commissioner to review rates based on considerations of affordability, health system improvement, and the interests of the public, provided there is a factual and analytical record to support the Commissioner's decisions and judgment. R.I. Gen. Laws §§ 42-14.5-1.1 and 42-14.5-2.

Blue Cross bears the burden of proving, by a preponderance of the evidence, that its Rate Request is consistent with the proper conduct of its business and with the interest of the public. Blue Cross & Blue Shield of R.I. v. McConaghy, PC No. 04-6806, 2005 WL 1633707 (R.I. Super. 2005); R.I.G.L. §§27-19-(6)(d)(1) & 27-20-6(d)(1). Consequently, to the extent the Commissioner determines, based on a review of all the evidence before him, that an alternative methodology or assumption is equally reasonable to a methodology or assumption proposed by Blue Cross, the Commissioner may adopt either methodology or assumption.

Issues in Dispute

The Office ultimately identified six aspects of the Rate Filing where equally or more reasonable alternative assumptions, methods or strategies should be or could be employed in the development of Blue Cross' rates, specifically: (1) that Blue Cross should be required to update their CY 2023 base period experience with claims runout through May 2024, rather than through February 2024; (2) that Blue Cross should adopt an annualized pharmacy rebate trend assumption of 16% in place of Blue Cross' selected 10.6% trend prediction; (3) that Blue Cross should adopt a medical utilization and severity trend assumption of 2.4% rather than 2.8%; (4)

that Blue Cross should utilize a predicted August 2023 to August 2024 CPI-U (less food and energy) 12-month percent change figure of 3%, and therefore employ 4% as its 2025 hospital inpatient and outpatient unit cost trends; (5) that Blue Cross should assume a risk adjustment transfer of $72.03 PMPM rather than $70.78 PMPM; and (6) that Blue Cross should utilize the nationwide 22.5% annualized trend in the development of its High-Cost Risk Pool (HCRP) Recoveries for 2025. See OHIC Exhibit 1; AG Report at 10; Smagula TR I at 253-254, 256-257, 311-312.

In addition to the above six alternative recommendations, OHIC also provided information on Blue Cross' financial metrics for the Commissioner's consideration on the question of an appropriate Contribution to Reserves factor as well as information and analysis on the topic of Blue Cross' Administrative Charge PMPM increase from 2024 to 2025 included the Rate Filing's development. OHIC Exhibit 1 at 23-25; Smagula TR I at 257-258 and 302-310.

The OAG, at the Public Hearing and to some extent in the AG Report: (1) generally supported OHIC's recommendation that Blue Cross should be required to update their CY 2023 base period experience (Stentz TR I at 196-197); (2) appeared to indicate it did not have enough information to take a position for or against OHIC's recommended alternate pharmacy rebate trend assumption (Stentz TR I at 221-223); (3) did not take a clear stance on the reasonableness of OHIC's recommended alternative assumption for the medical utilization and severity trend assumptions (Stentz TR I at 198-199); (4) made an argument similar to OHIC's in favor of adopting an alternative hospital unit cost trend assumption for 2025, but was in favor of utilizing the upcoming July 2024 available CPI-U figure rather than taking the admittedly equally reasonable approach of looking at downward inflationary data points to predict where it will be

in September of 2024 (Stentz TR I at 204-205)[11]; (5) proposed two of the three OHIC recommended methodology differences on the topic of Blue Cross' assumed risk adjustment transfer figure and did not appear to take a position on the reasonableness of OHIC's third proposed methodology difference (Stentz TR I at 206-208)[12]; (6) made a recommendation that the projected reinsurance receivable be revised to reflect the impact of any changes to the relevant trend assumptions that the Commissioner may order (AG Report at 12)[13]; and (7) proposed that Blue Cross utilize alternative methodologies to calculate its HCRP charge and its HCRP recoveries, the latter methodology being adopted by OHIC (Stentz TR I at 181-189).

<u>Blue Cross' CY 2023 Base Period Experience Should Be Updated With Claims Runout Through May 2024</u>.

In developing its proposed Rate Request for 2025 rates, Blue Cross utilized its CY 2023 claims experience, including claims paid through February 2024 and an estimate of the

[11] Stentz TR I at 205 responded to a question of whether he was recommending OHIC's methodology of projecting as to whether the CPI-U will have decreased or increased as of October 2024 by stating:

> I think it's reasonable. I don't know that it's unreasonable. I mean, I don't know that I would do it. I just -- Because of some history. Do I say it's wrong? By no means. I'm not -- That's just my opinion. If you think you have confidence that it's going down, and you have reasons that it's justifiable -- It could be argued, and I would listen to the argument. It's just my personal opinion, this is what I would use in rate.

[12] Regarding OHIC's third methodology recommendation on risk adjustment, Mr. Stentz on cross-examination stated "I actually have no problem if you have a reason to believe that risk adjustment and you're going to get sicker, healthier, there's reasons to believe that, make [OHIC's] risk adjustment. But I'm okay using [Blue Cross's risk adjustment]." Stentz TR I at 207.

[13] Although not specifically addressed at the Public Hearing, OHIC concurs with the OAG's recommendation that Blue Cross should revise its projected reinsurance receivable to reflect the impact of any changes to the relevant trend assumptions that the Commissioner may order. Given that the OAG and OHIC are recommending fairly small changes to trend, it is not anticipated that the impact to reinsurance will be significant. AG Report at 12. Nonetheless, it would be more accurate to require this revision.

completion of the 2023 claims incurred in 2023 but that had not yet been paid out. OHIC Exhibit 1 at 5; Smagula TR I at 258-59. Blue Cross' incurred claims PMPM figure for CY 2023 that it included in the Rate Filing was $604.91 PMPM. Smagula TR I at 259.

While reviewing the Rate Filing, Ms. Smagula requested Blue Cross provide an updated CY 2023 base period estimate using claims paid through May 2024. OHIC Exhibit 1 at 5; Smagula TR I at 259-260.The updated CY 2023 base period estimate using claims paid through May 2024 produced by Blue Cross indicated a $602.27 PMPM. OHIC Exhibit 35; Smagula TR I at 260.

Ms. Smagula testified that this updated CY 2023 base period estimate with data reflecting claims paid through May 2024, as opposed to paid just through February 2024, should constitute a more accurate reflection of Blue Cross' actual 2023 claims experience. Smagula TR I at 261. She further testified that in her professional actuarial opinion it would be more reasonable for Blue Cross to update their base period claims experience for CY 2023 with claims runout through May 2024 rather than to stick with their current base period experience with runout only though February of 2024. Smagula TR I at 261-262. Mr. Mackintosh "agree[d] that it reflects our latest and greatest estimate of calendar year '23 claims." Mackintosh TR I at 63. Mr. Stentz stated that he agreed with OHIC's recommendation to update the 2023 claims experience with runout through May 2024. Stentz TR I at 227-28.

Neither Mr. Mackintosh nor Mr. Stentz suggested it would be equally or more reasonable for Blue Cross to stick with its original CY 2023 base period estimate with claims paid only through February of 2024. Nonetheless, they both expressed the view that a requirement to update CY 2023 base period estimate with more recent claims paid data through May 2024, should (1) be applied consistently across all carriers with the same updated through date and (2)

be consistently required of (or allowed for) carriers during rate review regardless of the directionality of the update's impact to rates. Mackintosh TR I at 63; Stentz TR I at 228. Ms. Smagula' s testimony indicated that a base period update with more recent claims is something that had been required of other carriers in the Rhode Island market in the past, and that the impact of such requirements had at time reduced rates and at times increased rates to the best of her knowledge. Smagula TR I at 319-20. She further testified that she did not necessarily agree that an updated base period estimate requirement during rate review consistently applied across all carriers every year is something she would recommend given the number of variables that could be involved but agreed that the consistency concerns identified by Blue Cross is something that the Commissioner should consider. Smagula TR 1 at 320-321.

It is OHIC's position that, regardless of the possible merits of concerns regarding consistency across carriers and across rate review years, in the specific context of the Blue Cross' Rate Request for 2025 rates in this hearing, Blue Cross should be required to adopt the undisputed more reasonable approach of using the more accurate CY 2023 base period estimate with claims data paid through May 2024 as the basis upon which to develop its rate request.[14] The recommendation to update the CY 2023 base period estimate with claims data paid through

[14] To the extent Blue Cross advocates in its post-hearing papers that the Commissioner must also require an adjustment to Blue Cross' trend analysis using the more recent available claims data, OHIC would oppose any such recommendation. As pointed out by Ms. Smagula, "updating the base period experience is a more straightforward exercise versus a trend. I mean, the trend data can be updated, but making the final assumption still involves a lot of judgment and reviewing of data." Smagula TR I at 322-323. At this point in time there is neither sufficient time nor an available forum pursuant to which the outcome of any such update to trend data run through a certain methodology could be properly subjected to expert actuarial analysis, judgement, and recommendations by the OAG and OHIC.

May 2024 as the basis upon which Blue Cross develops its rate request is consistent with the proper conduct of Blue Cross' business and is in the public interest.

OHIC estimates that the impact of requiring Blue Cross to update its CY 2023 base period estimate with claims paid through May 2024 would be an approximate 0.4% reduction to Blue Cross' 14.3% rate increase request. OHIC Exhibit 1 at 5; Smagula TR I at 261. Blue Cross estimates that the impact of requiring Blue Cross to update its CY 2023 base period estimate with claims paid through May 2024 would be a 0.5% reduction its 14.3% rate increase request. Mackintosh TR I at 64.

Blue Cross Should Adopt An Annualized Pharmacy Rebate Trend Assumption Of 16% In Place Of Blue Cross' Selected 10.6% Trend Prediction.

To estimate pharmacy rebates for CY 2025, because their contract with their PBM for 2025 rebates was not yet finalized, Blue Cross "used estimated 2024 rebates projected forward annually with a 10.6% trend." OHIC Exhibit 39 at para 5. The 10.6% trend figure that Blue Cross applied is their gross pharmacy trend assumption. Smagula TR I at 265. According to Mr. Mackintosh, "[Blue Cross] projected 2025 rebates, assuming that our rebates increase at the same rate as our overall pharmacy costs, the 10.6 percent trend" so "[Blue Cross] used the 10.6 percent trend consistent with our utilization trend assumption." Mackintosh TR I at 64-65.

Ms. Smagula testified that, based on her many years of professional experience as an actuary specializing in health insurance work "I have seen that rebate PMPMs trend at a higher rate than gross pharmacy cost." Smagula TR I at 265-66. Consequently, to test the reasonableness of Blue Cross' 10.6% trend figure, she requested and analyzed the Blue Cross

Pharmacy Rebate PMPMs for the five calendar years of 2019 through 2023. See OHIC Confidential Exhibit 89. Based on her analysis, Ms. Smagula found that, on average, Blue Cross' pharmacy rebate trends over the 2019-2023 period "have trended higher than overall pharmacy trend year after year." Smagula TR I at 323-24. She testified that "when I looked at the data from 2019 to 2023, on an annualized basis the pharmacy rebate PMPM trended at 23 percent per year on average. But . . . the jump from 2019 to 2020 seemed like a bit of an anomaly, so I also looked at the increase from 2020 to 2023, which on average was 16 percent." Smagula TR I at 266. Ms. Smagula also looked at pharmacy rebate PMPM as a percent of total pharmacy spend as a check for the reasonableness of her 16% trend figure, testifying "historically that number has gone up and down a little bit. But it is, in 2023, it was roughly. . . 28 percent. . . [and] based on my projections the 2025 rebate PMPM as a percent of total would be roughly 29.3 percent. And in my opinion, that's a reasonable projection." Smagula TR I at 267. Ms. Smagula stated the reasonableness of her recommended projection was further supported by "information that shows rebates on a percent of total pharmacy spend is generally increasing over time, especially with the increased use of specialty drugs, which tend to have higher rebates, so it is reasonable to assume that on a percentage total pharmacy spend that rebates can increase." Smagula TR I at 267.

Ms. Smagula concluded her testimony on direct on this topic by affirming that a 16% pharmacy rebate trend assumption to project Blue Cross' 2025 pharmacy rebates is a more reasonable trend assumption that the 10.6% pharmacy trend that Blue Cross chose to utilize as its pharmacy rebate trend. She "estimated that this would have a 0.4 percent reduction on rates." Smagula TR I 267-68.

Blue Cross appeared to defend its selected 10.6% trend figure over OHIC's recommended 16% figure because: (1) when pharmacy trend is high Blue Cross expects a similarly high pharmacy rebate offset (Mackintosh TR I at 65); (2) OHIC's analysis that led to its 16% recommendation, while not unreasonable to undertake, produced a rebate to gross pharmacy spend ratio of 29.3% that was outside of the 25-28% range previously observed by Blue Cross for calendar years 2020, 2021, 2022 and 2023; and (3) Blue Cross' proposed 10.6% figure produced a rebate to gross pharmacy spend ratio of approximately 28% which was on the high end but still within Blue Cross' "relatively narrow historical range." Mackintosh TR I at 65-68.

Blue Cross' defense of its selected 10.6% pharmacy rebate trend over OHIC's recommended 16% figure, while not devoid of logic was nonetheless lacking in logic. First, while Blue Cross offered testimony that its pharmacy rebates tended to increase when its gross pharmacy spend increased, it failed to point to any empirical analysis that pharmacy rebate trends, generally or in the specific case of Blue Cross, hewed so closely to gross pharmacy spend trend lines that utilizing the gross pharmacy spend trend line was the most reasonable assumption to predict 2025 pharmacy rebates.

Second, Blue Cross appeared to take the position that using the 10.6% trend figure is further justified because, when they looked at their ratios of pharmacy rebates to pharmacy gross spend for '20, '21. '22, and '23 and found that the ratios varied from 25% to 28% and their 10.6 % figure produced a 28% ratio. However, Blue Cross failed to present any evidence as to why it was reasonable to assume future ratios would fall within these 25 to 28% figures. Interestingly, Blue Cross also failed to present evidence of how these four annual ratio figures would be plotted on a graph over the course of four years. When the Commissioner inquired of Mr. Mackintosh about what the trend or pattern was in these ratios over time, Mr. Mackintosh

provided a relatively vague response that "Its varying. I don't remember the precise value. But I do remember, it was not like a monotonically increasing like a ratchet only upwards. It did show some variation." TR at 155. This response allowed for the possibility that the ratios were generally trending upwards over time. Indeed, Ms. Smagula testified that in 2023 the ratio was roughly 28 percent. Smagula TR I at 267.

Based on data provided by Blue Cross, OHIC has calculated, and presented in Table 1 below, that rebates as a percentage of gross pharmacy costs since 2020 are as follows[15]:

Calendar Year	Pharmacy Rebates as Percentage of Gross Pharmacy Costs
2020	24%
2021	26%
2022	25%
2023	28%

Table 1 – Pharmacy Rebates as a Percentage of Gross Pharmacy Costs Since 2020

This evidence in Table 1 shows that the ratios have generally been trending upwards from 24% in 2020 to 28% in 2023. Consequently, an approximate 29.3% pharmacy rebate as percentage of gross pharmacy spend, as estimated by Mr. Mackintosh (Mackintosh TR I at 67-68), two years later in 2025 appears reasonable and consistent with this trend.

[15] OHIC Confidential Exhibit 89 set forth the Pharmacy Rebate PMPMs by calendar year. OHIC Exhibit 20 set forth the individual market allowed claims PMPM by month. OHIC first calculated an allowed claims PMPM for each calendar year by taking a weighted average of the allowed pharmacy PMPMs weighted by member months. The percentages set forth herein were then calculated by taking the Pharmacy Rebate PMPM divided by the allowed pharmacy PMPM for each year.

Third, Blue Cross essentially acknowledged (and at a minimum did not dispute) that, since 2019, pharmacy rebate PMPMs have trended higher than total pharmacy costs, stating "It's, it's possible. I don't have the math in front of me. It could. It could be a fair statement." Mackintosh TR I at 141-142.

Fourth, Blue Cross acknowledged that, as illustrated by OHIC Confidential Exhibit 89, it was an accurate statement that pharmacy rebate PMPMs have increased at an average rate of 23% per year between 2019 and 2023, responding "Yes, I see the 23 percent increase that you alluded to." Mackintosh TR I at 142-143.

Finally, Blue Cross presented no evidence to counter Ms. Smagula's testimony that rebates as a percent of total pharmacy spend have generally been increasing over time, especially with the increased use of specialty drugs, which tend to have higher rebates. Smagula TR I at 267.

Blue Cross has failed to carry its burden of proof, by a preponderance of the evidence, to support its position that the 10.6% pharmacy rebate trend figure it utilized to project 2025 pharmacy rebates is a more reasonable trend figure than the 16% pharmacy rebate trend figure recommended by OHIC. Blue Cross has therefore failed to establish that its proposed 10.6% pharmacy rebate trend figure that it utilized to project 2025 pharmacy rebates is consistent with the proper conduct of Blue Cross' business and is in the public interest.

Ms. Smagula's recommended 16% pharmacy rebate trend assumption to project Blue Cross' 2025 pharmacy rebates is a more reasonable trend assumption than the 10.6% pharmacy trend that Blue Cross chose to utilize as its pharmacy rebate trend. This 16% recommended alternative assumption is supported by the evidence in the record, consistent with the proper conduct of Blue Cross' business, and in the public interest. If the Commissioner accepts this

recommendation, OHIC "estimate[s] that this would have a 0.4 percent reduction on rates." Smagula TR I 267-68. Blue Cross testified that adoption of this recommendation would have a 0.5% reduction on rates. Mackintosh TR I at 70.

Blue Cross Should Adopt A Medical Utilization And Severity Trend Assumption Of 2.4% Rather Than 2.8%.

Blue Cross develops its utilization trend projection factors by performing regression analyses combining their last three years of claims experience data across their Individual, Small Group, and Large Group markets.[16] Mackintosh TR I at 37-39. To develop its utilization trends and severity trends, Blue Cross used 2021 through 2023 experience years. Mackintosh TR I at 36. In OHIC Exhibit 14, Blue Cross provided its results with regression charts by service category: inpatient hospital, outpatient hospital, professional, and pharmacy. Consistent with its standard practice, Blue Cross applied its "best fit" regression methodology to each of these four service categories. Mackintosh TR I at 39. However, Blue Cross ultimately made adjustments to the "best fit" trend line in the three medical categories (inpatient, outpatient and professional) because "we saw an unusual pattern in the three-year experience data. What we saw was a very large uptick in trend, in 2023 in particular." Mackintosh TR I at 39-40.

In OHIC Exhibit 13 Blue Cross explained that regarding the medical utilization and severity trends:

> Most of the best fit regression lines (with the highest r-squared values) used the most recent 2 years of data and indicated historically high utilization and severity trends. By contrast, the regression lines using all 3 years of data resulted in a lower r-squared fit because the 2023

[16] While the regression analysis employed by Blue Cross is an actuarially accepted method for the development of health insurance utilization trends it is not the only actuarially accepted method. Indeed, Standard 8 of the Actuarial Standards of Practice recommends developing trend projections using multiple methods. See OHIC Exhibit 1 at 12; Smagula TR I at 276.

> utilization and severity experience was substantially higher than 2022 and 2021. We decided to deviate from the best fit trend recommendations and use the trend that incorporated a more longitudinal view of utilization trends based on 3 years or 25 data points for all trend picks, especially knowing that post-Covid trend has been more volatile, among other considerations. As a result, our rate filing includes an overall utilization trend that is 1.8% lower overall than the trend based on the best fit recommendation.
>
> For Inpatient, we used actuarial judgement to arrive at a 0% trend. There was a clear inflection point at the end of 2022 resulting in a poor fit for the 3 year trend line, but a high trend for the best fit based on the most recent 2 years of data.

OHIC Exhibit 13 at 1.

Consistent with the explanation set forth in OHIC Exhibit 1, Mr. Mackintosh further explained that:

> Our regression best fit methodology that I described gave a lot of weight to that 2023 higher trend number. Also, when we look at the regressions, we look at a statistics called R-squared which indicates how well do those regression lines fit the data. A very high R-squared means that it correlates quite accurately. A very low R-squared means it doesn't correlate very well at all. In looking at that V shape that I described, a very low R-squared. It was not, the high trend was not necessarily indicative of a good fit for that overall three-year period, even though it fit very well the latter half of 2023. . . . to expect that the high trends we saw in 2023 would continue for two more years straight seemed, even though the model says it is the best fit, seemed unlikely, unsustainable.

Mackintosh TR I at 40-41.

In essence, Blue Cross testified that because its standard "best fit" methodology yielded relatively low R-squared trend-line fits, it was deemed not accurately predictive of 2025 medical utilization. Consequently, Blue Cross: (a) in the case of inpatient utilization where the methodology yielded a V-shaped downward trend followed by an upwards trend, applied its actuarial judgement in selecting a 0% trend; and (b) in the case of outpatient and professional utilization where the "best fit" methodology relied on more recent data and yielded a trend assumption that was significantly higher than historical trends, applied actuarial judgement to select a more longitudinal trend line observable over three years and 25 data points, which had

the effect of giving less weight to the arguably aberrant 2023 utilization and severity experience. See Smagula TR I at 273-275; Mackintosh TR I 3-41.

The Actuarial Standards of Practice #8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*, Section 3.13 provide that a reviewing actuary should review assumptions for reasonableness. Consistent with these standards and given the observed volatility in the medical utilization data, Ms. Smagula conducted her own independent trend analysis to test the reasonableness of Blue Cross' medical utilization and severity experience trend assumption, asking for some additional information from Blue Cross and employing some alternative methodologies. Smagula TR I at 276 and 325. OHIC Exhibit 1 at 12-17.

First, Ms. Smagula requested additional data covering claims experience from January 2019 through January of 2024. Next, she adjusted for COVID-19 vaccine and testing expenses and age and de-priced the claims data, consistent with the adjustments made by Blue Cross in their trend analysis, so that she could examine trends. Smagula TR I at 277; OHIC Exhibit 1 at 12. Ms. Smagula also conducted her independent analysis on aggregated medical claims data, as opposed to segregating out the claims data into inpatient, outpatient, and professional categories as was Blue Cross's practice. Smagula TR 1 at 326. She explained her reasoning for doing so as follows:

> In my experience in looking at filings submitted by carriers, and all of this is publicly available as well, it's not required [for] carriers [to] have a different assumption by service category. There are lots of instances where carriers will look at their data – the medical in total and come up with one overall assumption and they'll enter that same number into each of the service categories. And I would just offer, in my experience and opinion, in a lot of ways it can be just as reasonable, if not more reasonable, to look at the medical service categories in total, given the volatility that can happen by different service categories and also the general shift that has happened over time between inpatient and outpatient, if you're looking at those

> things isolated, that could skew your end results versus if you're looking at it across the whole medical category, you know, any type of shift that's happening is all part of that one number.

Smagula TR I at 326-27.

Ms. Smagula described the numerous steps to her independent analysis in her actuarial report and during her testimony. Smagula TR I at 277-283; OHIC Exhibit 1 at 12-17.

As a result of her analysis Ms. Smagula observed that the medical utilization claims data was very “volatile” and that there was “a lot of unexplained fluctuation and volatility in that data” (Smagula TR I at 328), with unadjusted medical claims trends increasing significantly from the older time periods to the more recent time periods, specifically from 1.4% for the rolling 12-month period ending December of 2022 to 10.3% for the rolling 12-month period ending January 2024 and adjusted medical claims trends increasing from -1.4% for the rolling 12-month period ending December of 2022 to 7.2% for the rolling 12-month period ending January 2024. Smagula TR I at 277-279, 329; OHIC Exhibit 1 at 12-15.

Ms. Smagula testified in her professional opinion that she believed this volatility was likely attributable to: (a) residual and/or not fully understood direct and indirect impacts of the COVID-19 pandemic, such as pent-up demand and the impacts of deferred care; and (b) high-cost claimants. Smagula TR I at 279; OHIC Exhibit 1 at 15-16.

After requesting and analyzing data related to high-cost claimants, see Smagula TR I at 279-280; OHIC Exhibit 1 at 16, OHIC Confidential Exhibit 106, Ms. Smagula concluded that there was a significant impact in to the 2023 claims experience from high-cost claims as compared to 2022 and that 2023 was also more impacted by high-cost claims as compared to 2020 and 2021. See Smagula TR I at 280; OHIC Exhibit 1 at 16. Ms. Smagula further calculated that, if members’ claims were to be capped at $500,000 per member per year, this would have

the effect of reducing "overall allowed medical claims PMPM by 0.4% in 2022 and by 1.3% in 2023." OHIC Exhibit 1 at 16.

"The impact of high cost claimants on large trends can greatly impact trend analysis" and Ms. Smagula represented both that the high-cost claims she observed were "not limited to impatient claims" and that it is reasonable to adjust for high-cost claims. See OHIC Exhibit 1 at 16. Blue Cross represented that "Generally speaking, we do not adjust for high-cost claims in our trend picks." See OHIC Exhibit 1 at 16.

Ms. Smagula testified that, given the data available to her, she observed that the impact of high-cost claimants in 2019 was more similar to the impact in 2023 than the other years she had looked at, and that the 2019 claims experience also had the benefit of not having been impacted by COVID-19. Smagula TR I at 280; see also OHIC Exhibit 1 at 16. Therefore, to best eliminate the volatility of COVID-19 impact on trend and 2023's significant impact of high-cost claimants, Ms. Smagula adopted a long-term trend view and compared rolling 6 and 12-month data points from January 2019-January 2020 against the same data points, as available, from January 2023-January 2024, and then annualized the results. See Smagula TR I at 280-281; OHIC Exhibit 1 at 16-17. In her testimony explaining Table 10 of her actuarial report, Ms. Smagula provided the illustrative example that the January 2024 data point of 2.5% in the rolling 12 month column represents a comparison of the PMPM for the 12 months ending as of January 2024 compared to the PMPM four years earlier for the 12 months ending as of January 2020, and then taking that trend figure to the one-fourth power to annualize it over 4 years. See Smagula TR I at 281.

Table 10 from OHIC Exhibit 1 at 17, set forth below, illustrates the more stable results of Ms. Smagula's longer-term analysis that produced her recommended 2.4% medical utilization and severity trend and is presented here:

Table 10: Medical Adjusted Allowed Claims Trend Assumptions (Fully Insured) 4 Year Annualized		
Period Ending	**Rolling 6 Month**	**Rolling 12 Month**
Jun-23	2.1%	
Jul-23	2.1%	
Aug-23	2.2%	
Sep-23	2.0%	
Oct-23	2.4%	
Nov-23	3.0%	
Dec-23	2.7%	2.4%
Jan-24	2.9%	2.5%
Average of Data Points	**2.4%**	**2.4%**

Ms. Smagula, in her professional opinion, testifying regarding the alternative analysis she performed in order to better address and control for the recent volatility in 2023 claims experience as well as the impact of high-cost claimants and COVID-19 in the context of Blue Cross' proposed medical utilization and severity trend, explained:

> when I looked at this data, to me, it seems like [it] had a much more stable trend pattern that I know is most likely not as much impacted by high-cost claimants because of the fact that those high-cost claimants were more similar in the two time periods I was focused on, and then I felt more confident that any kind of noise that might have been happening with COVID into 2021 and 2022 …was more eliminated from this view. And for those reasons...kind of looking at this in total and taking some averages of the various data points is what lead me to offer this alternative assumption, rather than the overall 2.8 percent, 2.4 percent.

Smagula TR 1 at 281-282. See also OHIC Exhibit 1 at 16-17.

Finally, on this topic of medical utilization and severity trend, Ms. Smagula testified that, even after hearing the testimony of the other actuaries, it was her professional actuarial opinion based on her actuarial experience and expertise that 2.4% is an equally reasonable trend assumption as compared to Blue Cross' proposed 2.8%. Smagula TR 1 at 282.

Blue Cross failed to establish in its Rate Filing or in testimony at the Public Hearing that its' proposed 2.8% medical utilization and severity trend figure and the underlying methodology that it used to arrive at this figure was more reasonable than the analysis and 2.4% trend figure recommended by OHIC.[17]

Utilizing a 2.4% medical utilization and severity trend in place of Blue Cross' proposed 2.8% trend is estimated by OHIC to reduce Blue Cross' 14.3% rate request by approximately 0.5%. Smagula TR I at 282-283; OHIC Exhibit 1 at 16-17. Blue Cross provided testimony that utilizing a 2.4% medical utilization and severity trend in place of a 2.8% trend will reduce Blue Cross' 14.3% rate request by approximately 0.7%. Mackintosh TR I at 56-57.

Blue Cross Should Utilize A Predicted August 2023 To August 2024 CPI-U (Less Food And Energy) 12-Month Percent Change Figure Of 3%, And Therefore Employ 4% As Its 2025 Hospital Inpatient And Outpatient Unit Cost Trends.

OHIC's Affordable Health Insurance – Affordability Standards regulation, 230-RICR-2030-4.10 -- sets forth certain requirements for insurance companies' hospital contracts. One such requirement is that review and prior approval by OHIC shall be required of a contract if: "(1) The average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reported by the Commissioner by October 1 each year, in accordance with the method

[17] For example, Blue Cross argued that, while aggregating trends is a useful check, it believed it was better to look at granular yet credible categories consistent with its standard methodology. Mackintosh TR I at 50. However, Blue Cross failed to establish or even explain why its approach was "better".

set forth in § 4.10(D)(6)(i) of this Part)[18]. Such percentage increase shall be plus one percent (1%) . . ." 230-RICR-20-30-4.10(D)(6)(e).

Blue Cross develops its price trend projection factors for Hospital Inpatient and Hospital Outpatient services by using a combination of known contractual changes through 2025 and estimated contractual changes for facilities that have not yet been negotiated. OHIC Exhibit 1 at 17; Mackintosh TR I at 58-59; AG Report at 6-7. For facility contracts that have yet to be negotiated, Blue Cross used the most recent published CPI-U 12-month increase figure – 3.9% through January 2024 (plus 1%) -- that was available at the time it was preparing its Rate Filing. See Mackintosh TR I at 58-59; Stentz TR I at 170; Smagula TR I at 286-287.

At the Public Hearing Blue Cross acknowledged that the most recently available CPI-U number representing the 12-month percent increase through May 2024 is different and has decreased to 3.4%. Mackintosh TR I at 58-59. The OAG recommended, and Blue Cross agreed, that Blue Cross should replace the 3.9% figure with the more recent 3.4% figure in developing their hospital price trend. Stentz TR I at 170; Mackintosh TR I at 59. Mr. Stentz testified that the impact of this recommendation on Blue Cross' Rate Request would be to reduce it by 0.2%. Stentz TR I at 173. The OAG further recommended that, if the information is available, then Blue Cross should replace the 3.9% figure with whatever figure is published in mid-July representing the 12-month percent increase through June 2024. Stentz TR I at 204-05, 227.

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[18] 230-RICR-20-30-4.10(D)(6)(i) provides in relevant part that "[t]he US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase to be reported according to the Standard Method by the Commissioner shall be equal to the 12- month percent change in the CPI-Urban published by the United States Bureau of Labor Statistics in September of each year. The September report will reference the 12-month percent change from August of the prior year to August of the report year."

Mr. Mackintosh testified he believed that using this 3.4% figure in place of Blue Cross' original 3.9% figure was reflective of an "aggressive assumption" on the part of Blue Cross because it was "a relatively low number compared to recent . . . so that is a relatively volatile assumption . . ." Mackintosh TR I at 120. For at least three reasons, it is not logical for Blue Cross to assert that replacing the 3.9% figure with the more recent 3.4% figure is reflective of an "aggressive assumption." First, Blue Cross's standard methodology for determining its hospital price trend appears to be that of using the most recently available 12-month percent increase in CPI-U, so utilizing the 3.4% figure does not appear to vary from that methodology in any aggressive manner. Second, as OHIC Exhibit 65, which charts the last 20 years of 12-month percent increases in CPI-U, illustrates, this CPI-U figure has been steadily declining since September of 2022 when it was 6.6%. And third, Blue Cross failed to point to any evidence to suggest interest rates are expected to be volatile and/or rise in the near term.[19]

More recently, as reflected in the July 31, 2024 Stipulation, the June 2024 CPI-Urban annual percentage increase figure released by the U.S. Bureau of Labor of Labor Statistics reflected that the 12-month percent change through June 2024 had decreased further to 3.3%. Appendix B. Set forth below, in Table 2, is OHIC Exhibit 65 updated to include this newly released June 2024 CPI-U 3.3% figure.

[19] Indeed, Mr. Stentz testified that 3.4% should be the maximum CPI-U figure to employ in the development of hospital price trend. Stentz TR I at 202.

Table 2: CPI for All Urban Consumers
(CPI-U) 12-Month Percent Change

Not Seasonally Adjusted
Item: All items less food and energy
Years: Past 20 (May 2004 to June 2024)

Month	January	February	March	April	May	June	July	August	September	October	November	December
2004					1.7%	1.9%	1.8%	1.7%	2.0%	2.0%	2.2%	2.2%
2005	2.3%	2.4%	2.3%	2.2%	2.2%	2.0%	2.1%	2.1%	2.0%	2.1%	2.1%	2.2%
2006	2.1%	2.1%	2.1%	2.3%	2.4%	2.6%	2.7%	2.8%	2.9%	2.7%	2.6%	2.6%
2007	2.7%	2.7%	2.5%	2.3%	2.2%	2.2%	2.2%	2.1%	2.1%	2.2%	2.3%	2.4%
2008	2.5%	2.3%	2.4%	2.3%	2.3%	2.4%	2.5%	2.5%	2.5%	2.2%	2.0%	1.8%
2009	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.5%	1.4%	1.5%	1.7%	1.7%	1.8%
2010	1.6%	1.3%	1.1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.8%	0.6%	0.8%	0.8%
2011	1.0%	1.1%	1.2%	1.3%	1.5%	1.6%	1.8%	2.0%	2.0%	2.1%	2.2%	2.2%
2012	2.3%	2.2%	2.3%	2.3%	2.3%	2.2%	2.1%	1.9%	2.0%	2.0%	1.9%	1.9%
2013	1.9%	2.0%	1.9%	1.7%	1.7%	1.6%	1.7%	1.8%	1.7%	1.7%	1.7%	1.7%
2014	1.6%	1.6%	1.7%	1.8%	2.0%	1.9%	1.9%	1.7%	1.7%	1.8%	1.7%	1.6%
2015	1.6%	1.7%	1.8%	1.8%	1.7%	1.8%	1.8%	1.8%	1.9%	1.9%	2.0%	2.1%
2016	2.2%	2.3%	2.2%	2.1%	2.2%	2.2%	2.2%	2.3%	2.2%	2.1%	2.1%	2.2%
2017	2.3%	2.2%	2.0%	1.9%	1.7%	1.7%	1.7%	1.7%	1.7%	1.8%	1.7%	1.8%
2018	1.8%	1.8%	2.1%	2.1%	2.2%	2.3%	2.4%	2.2%	2.2%	2.1%	2.2%	2.2%
2019	2.2%	2.1%	2.0%	2.1%	2.0%	2.1%	2.2%	2.4%	2.4%	2.3%	2.3%	2.3%
2020	2.3%	2.4%	2.1%	1.4%	1.2%	1.2%	1.6%	1.7%	1.7%	1.6%	1.6%	1.6%
2021	1.4%	1.3%	1.6%	3.0%	3.8%	4.5%	4.3%	4.0%	4.0%	4.6%	4.9%	5.5%
2022	6.0%	6.4%	6.5%	6.2%	6.0%	5.9%	5.9%	6.3%	6.6%	6.3%	6.0%	5.7%
2023	5.6%	5.5%	5.6%	5.5%	5.3%	4.8%	4.7%	4.3%	4.1%	4.0%	4.0%	3.9%
2024	3.9%	3.8%	3.8%	3.6%	3.4%	3.3%						

Table 2: CPI-U 12-Month Percent Change Through June 2024

Ms. Smagula, testified to the trends she has observed in the CPI-U 12-month percentage change figures over the past several years as illustrated by OHIC Exhibit 65, stating "you can go back in time from [the January 2024 3.9% figure utilized in the Rate Filing] and just see that…since roughly sometime in early or mid 2022 the CPI has generally been decreasing over time." Smagula TR I at 287. She further testified that "[b]ased on the research that I did, it seems like all economists are generally predicting that CPI is going to continue to decline at this point, and it would seem… again, based on what's happened even just this year, that . . . there is this steady decline that is happening." Smagula TR I at 287. A May 15, 2024, report from Morningstar offers corroboration of Ms. Smagula's testimony, stating that "In 2024, we project inflation to return to normal levels, in line with the Federal Reserve's 2% target" and to then "average 1.9% from 2024 to 2028." OHIC Exhibit 63 at 1-2; see also Smagula TR I at 287-289.

Based on the evidence introduced at the Public Hearing and through the July 31, 2024 Stipulation regarding the consistent and steady downward trend in the CPI-U 12-month percentage increase figures over the past several months as well as the past few years, together with the consistent economic predictions that inflation will continue to trend downwards in 2024, Ms. Smagula recommended that Blue Cross should adopt an alternative assumption that the CPI-U 12-month percentage increase figure through August 2024 will be 3.0% (as opposed to 3.9% or 3.4% or 3.3%) for use in developing their hospital price trend for 2025. Specifically, Ms. Smagula provided her professional actuarial opinion that a 3.0% CPI-U figure (plus 1%) is a more reasonable 2025 maximum hospital unit cost increase assumption to be used in place of the 3.9% or 3.4% figure Blue Cross proposed because "based on the data that I've reviewed and the path of where CPI-U is going, it is reasonable to assume that it could continue to drop further. So it's at 3.4 now. Another couple of months, based on the historical pattern, to get down to 3.0." Smagula TR I at 294. Ms. Smagula further testified that, while the June CPI-U number that will be coming out in mid July "would be another important data point to look at," rather than being dispositive of the CPI-U figure that should be utilized, it "would be an important number to take [into] consideration in deciding ultimately where that assumption should land." Smagula TR I at 294, 335-37.

Mr. Stentz agreed that, regarding the CPI-U figure "I mean, there's every reason to believe it is going down . . . And since January, it has not been gone up any, it's gone down . . ." Stentz TR I at 173; see also AG Report at 12 ("CPI-U has been decreasing in recent months"). Mr. Stentz further testified that in his professional actuarial opinion that OHIC's recommendation projecting that the CPI-U will decrease as of October of 2024, while different from what he was recommending, was nonetheless also reasonable. Stentz TR I at 204-05.

Finally, the reasonableness of OHIC's recommendation on this point is further supported by the fact that CPI-Urban annual percentage increase figure released by the U.S. Bureau of Labor of Labor Statistics in July evidenced that the 12-month percent change through June 2024 had decreased further to 3.3. July 31, 2024, Stipulation at Appendix B.

Blue Cross has failed to carry its burden of proof, by a preponderance of the evidence, to support its position that the 3.4% 12-month change through May 2024 figure, plus 1%, reflects a more reasonable prediction of what the September 2024 CPI-Urban plus 1% figure will be for the purpose of developing Blue Cross's price trend factors for Hospital Inpatient and Hospital Outpatient services for 2025. Blue Cross has therefore failed to establish that predicting a 3.4% CPI-U figure for the purpose of developing its price trend factors for Hospital Inpatient and Hospital Outpatient services for 2025 is consistent with the proper conduct of Blue Cross' business and is in the public interest.

The OAG's actuary's recommendation at the Public Hearing was that the Commissioner should use the most recently released CPI-Urban 12-month percentage increase figure that is available to him as of the time he renders his decision. Stentz TR I at 204-05, 227. As set forth in the July 31, 2024, Stipulation at Appendix B, that figure is 3.3%. Consequently, the Office anticipates the OAG will recommend utilizing a 4.3% projected rate cap for developing price trends for Hospital Inpatient and Hospital Outpatient (4.3% after adding the +1%).

OHIC submits, based on all the credible evidence introduced on this matter, that it is more reasonable for Blue Cross to utilize the assumption that the CPI-U 12-month percentage increase figure through August 2024 will be 3.0% (as opposed to 3.9% or 3.4% or 3.3%) in developing their hospital price trend for 2025. This alternative assumption is supported by the evidence in the record and consistent with the proper conduct of Blue Cross' business, and in the

public interest. If the Commissioner accepts this recommendation, the relevant maximum rate cap for developing price trends for Hospital Inpatient and Hospital Outpatient would be 4.0% after adding the +1%. OHIC estimates that this would reduce rates by approximately 0.2%. OHIC Exhibit 1 at 18, 26; Smagula TR I at 293.

Blue Cross Should Assume A Risk Adjustment Transfer Of $72.03 PMPM Rather Than $70.78 PMPM.

The Risk Adjustment program is a program implemented under the Affordable Care Act and administered by CMS. The program is designed to benefit consumers by measuring the relative risk of all enrollees with each carrier and redistribute funds among carriers to level the playing field among carriers with different risk profiles in their insured enrollees. See Mackintosh TR I at 71-72; see also AG Report at 7. Blue Cross "has consistently received transfer payments from the federal Risk Adjustment program because [Blue Cross] has an unhealthy population relative to the Rhode Island Individual market." AG Report at 7. A component of the Risk Adjustment program is the high-cost risk pool, also administered by CMS. For members with claims over one million dollars the high-cost risk pool will reimburse a portion of the excess of claims over one million dollars. Consumers will benefit if carriers are required to compete for cost and quality, not on attracting healthier or less expensive members.

Blue Cross has indicated that its normal practice in developing its individual market rate requests is to estimate risk adjustment dollars for the base experience period. In the present Rate Filing for rates to be charged for calendar year 2025, "[Blue Cross'] assumption is developed by taking the PMPM results from the 2022 Final TPIR Report and the 2023 Interim TPIR Report, trending those PMPM results forward to 2025 by the statewide premium trend, and averaging the

resulting 2025 estimates. Statewide premiums trend was assumed to be 6.1% from 2022 to 2023 (based on actual approved rate increases), 5.9% from 2023 to 2024 (based on actual approved rate increases), and 9.0% from 2024 to 2025 (based on BCBSRI's estimate). OHIC Exhibit 1 at 20.

OHIC is recommending a revised methodology for projecting Blue Cross' 2025 risk adjustment figure, which methodology differs from the methodology employed by Blue Cross in three facets. OHIC's first two recommended differences in methodology mirror those being recommended by the OAG. See AG Report 7-8. At the Public Hearing, Blue Cross indicated it agreed with the recommendation that it adopt these first two different methodology recommendations for estimating its 2025 PMPM risk transfer amount. Mackintosh TR 1 at 75-77. These differences in methodologies are attributable to the fact that the OAG and OHIC had access to more and more recent information from the Rhode Island Individual Market relevant to risk adjustment than did Blue Cross.

The first recommended methodology difference is using updated 2023 risk adjustment results which were supplied to OHIC and the OAG by each carrier in the individual market via the May 2024 RATEE files sent to them by CMS. The RATEE files are produced by CMS and can be used to estimate final risk adjustment payments and receivables. Using the May 2024 RATEE files from all carriers in the market to estimate final 2023 risk adjustment payments and receivables in the Rhode Island individual market represents more updated information compared to the interim 2023 risk adjustment file used by BCBSRI in their risk adjustment estimate. The update leads to a decrease of approximately $4 PMPM in the estimated 2023 risk adjustment receivable from $63.17 PMPM generated by the Interim 2023 TPIR Report to $59.06

PMPM[20] generated by the May 2024 RATEE files. OHIC Exhibit 1 at 20; see also Mackintosh TR I at 75-77. As set forth in the July 31, 2024, Stipulation (see Appendix B), the final risk adjustment transfer payment figures for calendar year 2023 in the Rhode Island individual market issued by the CMS on July 22, 2024 were consistent with the figures developed by OHIC and the OAG utilizing the RATEE files. Consequently, these final figures released by CMS have not altered OHIC's recommendations, as set forth in OHIC Exhibit 1 and through the testimony of Ms. Smagula, regarding the Risk Adjustment in the Rate Filing.

The second difference is that BCBSRI blended 2022 results with 2023 results to develop their estimate. OHIC and the OAG recommended using the 2023 base year only, in part because more recent results will be more reflective of recent enrollment trends, market dynamics, coding practices and risk adjustments model changes. OHIC Exhibit 1 at 20. After applying trend, the 2022 results on a PMPM basis were similar to the estimated final 2023 results, therefore there was minimal impact from this change. As a result of these first two differences, the 2025 projected risk adjustment receivable PMPM changes from $70.78 PMPM in BCBSRI's estimate to $68.18 PMPM in OHIC's estimate.[21] OHIC Exhibit 1 at 20.

The third difference is that OHIC is recommending that Blue Cross make an adjustment to its projected 2025 risk adjustment receivable to account for a shift in enrollment within the Blue Cross market toward platinum plans from CY 2023 to March 2024. OHIC Exhibit 1 at 21; Smagula TR I at 297-300. Ms. Smagula observed "an approximately 0.9% shift from gold plans to platinum plans." OHIC Exhibit 1 at 21; see also Smagula TR I at 298. To adjust for the impact of this shift,

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[20] The OAG estimated a $59.83 PMPM figure. AG Report at 8.

[21] The OAG estimated a 2025 risk adjustment receivable of $69.06 PMPM and estimated this would increase Blue Cross' premiums by approximately 0.3%. AG Report at 8.

she "used the plan liability risk scores (PLRS) by metal level as observed in the 2023 experience and applied the [Blue Cross] March 2024 enrollment distribution to develop the projected 2025 BCBSRI average PLRS. Then I adjusted the statewide average PLRS accordingly using the March 2024 enrollment distribution by carrier. As a result of all three of these differences, the 2025 projected risk adjustment receivable PMPM changes from $70.78 PMPM in [Blue Cross'] estimate to a projected amount of $72.03 PMPM in [OHIC's] estimate."[22] OHIC Exhibit 1 at 21; see also Smagula TR I at 298-299.

Mr. Mackintosh described the risk adjustment formula during his testimony, highlighting the complexity of the risk adjustment formula and stated that "[metal] level is just one variable and an extremely complicated risk adjustment formula and to – and lots of other variables impact. I think it would lend a false level of precision to assume that just adjusting, isolating for this one change and holding all else equal would be a realistic view of 2025." Mackintosh TR I at 79. Still, Mr. Mackintosh acknowledged that, within the risk adjustment formula, the same member will receive a higher PLRS in a Platinum plan compared to a plan at another metal level. See generally Mackintosh TR I at 91. Given that Blue Cross's enrollment has been fairly stable for the past couple years, it is reasonable to assume that there is shifting in metal levels occurring within Blue Cross's population rather than an influx of new members to Platinum plans or from members leaving who have metal levels other than Platinum. Since the shifts in Platinum enrollment are known and it is known that PLRS increases for Platinum plans, it is reasonable to account for the shift to Platinum plans when projecting risk adjustment transfers. See Smagula TR I at 342-343.

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[22] These calculations are illustrated on Table 13 of Ms. Smagula's Actuarial Report. OHIC Exhibit 1 at 21.

Based on the evidence introduced on this matter, reasonable inferences that can be drawn from that evidence, and Blue Cross' burden of proof, Blue Cross has failed to establish that it is more reasonable for Blue Cross to adopt only the first two of OHIC's three recommendations regarding the calculation of the Risk Adjustment receivable for 2025.

All three parts of OHIC's proposed alternative assumptions on the topic of calculating the Risk Adjustment receivable for 2025 are supported by the evidence in the record and consistent with the proper conduct of Blue Cross' business, and in the public interest.

If the Commissioner adopts all three of OHIC's recommendations regarding the calculation of the Risk Adjustment receivable for 2025 this would result in a reduction to the average rate of approximately 0.2%.

Blue Cross Should Utilize The Nationwide 22.5% Annualized Trend In The Development Of Its HCRP Recoveries For 2025.

The High-Cost Risk Pool (HCRP) Program was introduced in 2018 as a part of the ACA's risk adjustment program to help stabilize it. The program partially reimburses insurers that have high-cost claimants that exceed a million-dollar threshold, reimbursing those insurers 60% for every dollar above that million-dollar threshold. Stentz TR I at 176-177.

The OAG's Actuarial Report presented an argument and analysis recommending the adoption of a different methodology to predict Blue Cross' high-cost risk pool charges (HCRP) and receivable in 2025. After reviewing and considering the AGO's analysis and hearing testimony on this topic at the Public Hearing, OHIC adopted the AGO's recommendation to adopt a different methodology to predict Blue Cross' high-cost risk pool receivable in 2025. Smagula TR I at 254-255, 344.

Blue Cross explained at the Public Hearing that it developed its HCRP receivables by reviewing its past HCRP recoveries for the years 2018 through 2023. Mr. Mackintosh testified that they utilized "a relatively long lookback period because we saw, frankly, very low amounts of recoveries in the past couple of years. Of those six years, we actually had zero recoveries in three of those years, and relatively minimal recoveries in two other years, and only one year was there – and it happened in 2018, which is why we kind of went back a little further, is, in our view, averaging the most recent three years, kind of consistent with how we develop trends, was perhaps an artificially low number. . . We averaged the full six years and then trended – excuse me – we averaged a full six years." Mackintosh TR I at 98; see also OHIC Confidential Exhibit 99 (setting forth Blue Cross's HCRP recoveries since 2018). Blue Cross noted that "our experience for the past six year shows recoveries dramatically lower than what on a nationwide basis have been." Mackintosh TR I at 102. Mr. Mackintosh further opined that "giving credence to, you know, not just one year of the base year, but for the past six years that we've witnessed here in Rhode Island, is more credible than looking at nationwide statistics." Mackintosh TR I at 103.

The OAG questioned the reasonableness of Blue Cross's methodology on this point, noting that "calculating the simple average PMPM recovery . . . from 2018 through 2023. . . does not account for trends nor the varying member months by year." AG Report at 10. Perhaps more importantly, Mr. Stentz testified that Blue Cross' methodology – taking a straight average of their recoveries over a six-year time frame and predicting their recoveries in 2025 would equal that average -- was "not credible." Stentz TR I at 181-182. The OAG made the following arguments. First, that Blue Cross' methodology failed to account for any increase in cost trends. Stentz TR I at 183. Since the bulk of their recoveries over the six-year period occurred six years

earlier in 2018, it is unreasonable to use a methodology that does not account for any price trends from 2018 to 2025. Second, when you factor in leveraging and the nature of the HCRP that is targeted at claims over a million dollars, "this type of program . . . trends faster than just normal trend." Stentz TR 1 at 183-184. Third, while acknowledging that Blue Cross' experience over the past six years has been lower than the national average, Mr. Stenz emphasized that "their data is not credible either," "for Rhode Island, it's not credible . . . it's just because of how rare these claims are, just it takes time to be credible." Stentz TR I at 184-185, 215-217.

OHIC's professional actuarial opinion was consistent with that of Mr. Stentz on HCRP recoveries, with Ms. Smagula testifying "I think it is reasonable to assume that the high cost risk pool is going to increase at a higher rate due to the leveraging impact and looking at other data sources, including national metrics to estimate that amount," Smagula TR I at 254, "given the fact that . . . these are claims over a million dollars . . . – they're not very frequent, so even across the state of Rhode Island, it's not a credible source, so I do think it is reasonable to also consider what's happening on a national basis, in addition to the impact of leverage that we've discussed, it's also reasonable to assume that they're going to increase at a higher rate, and that's what's been shown in the data." Smagula TR I at 344-345.

The alternate methodology recommended by the OAG and OHIC as being more reasonable to predict HCRP recoveries for 2025 than the methodology utilized by Blue Cross in the Rate Filing, is to utilize the nationwide HCRP annualized recovery trend of 22.5% and apply it to Blue Cross' historical recoveries from 2018 to 2023 and then weight the results by year using Blue Cross member months. AG Report at 10; Stentz TR I at 185-186. As Mr. Stentz explained, given that the Rhode Island data was not credible, it is more reasonable to use the nationalized data on HCRP recoveries to predict Blue Cross' HCRP recovery for 2025. Stentz

TR I at 186. Mr. Stentz also described that Lewis & Ellis tested the reasonableness of utilizing the nationalized data by performing numerous alternative approaches to calculating Blue Cross' HCRP recoveries for 2025 and that through this testing they were able to conclude that the results of their proposed methodology were reasonable. Stentz TR I at 185-187.

OHIC submits, based on all the credible evidence introduced on this topic, that it is more reasonable for Blue Cross to predict its HCRP recoveries for 2025 by adopting the OAG's proposed alternative methodology of utilizing the nationwide HCRP annualized recovery trend of 22.5%, applying it to Blue Cross' historical recoveries from 2018 to 2023, and then weight the results by year using Blue Cross member months. This alternative assumption is supported by the evidence in the record and consistent with the proper conduct of Blue Cross' business, and in the public interest. If the Commissioner accepts this recommendation, Blue Cross' HCRP estimated recoveries figure for 2025 will be increased from $0.29 PMPM to $1.20 PMPM (AG Report at 13) and OHIC estimates this change will reduce Blue Cross' 2025 premiums by approximately 0.1%.[23]

<u>Blue Cross' Requested Administrative Charge</u>

Ms. Smagula observed from her review of the Rate Filing that Blue Cross' administrative charges increased from 2024 to 2025 by 8.3% on a PMPM basis from $79.17 PMPM in 2024 to

[23] Mr. Stentz estimated this change would reduce Blue Cross' 2025 premiums by approximately 0.2%. AG Report at 10, 13; Stentz TR I at 188, 189. At the Public Hearing, Ms. Smagula adopted Mr. Stentz's 2% estimate. Smagula TR I at 257. However, after opportunity for further analysis, OHIC has estimated that this change would reduce Blue Cross' 2025 premiums by approximately 0.1%. The 0.1% variable between the OAG and OHIC's estimates is consistent with Mr. Mackintosh's testimony that Blue Cross' estimates of the impact of the OAG's recommendations on the HCRP claims and recoveries on the Rate Request was close to that of the OAG but varied by approximately 0.1%. Mackintosh TR I at 105.

$85.73 PMPM in 2025. She illustrated these figures in Table 15 of her Actuarial Report. OHIC Exhibit 1 at 23; see also Smagula TR 257-258, 303. Ms. Smagula represented, for the Commissioner's consideration, that if Blue Cross' administrative charge PMPM was only allowed to increase from 2024 to 2025 at the maximum of the average of the most recent three months of CPI-U: Less Food and Energy, then this change to the Rate Filing change would decrease rates by approximately 0.5%. OHIC Exhibit 1 at 23; Smagula TR I at 257-258, 306. Blue Cross offered testimony that in its estimation the impact of this recommendation on rates would have a "slightly larger" "maybe 0.1 percent" higher impact on rates. Mackintosh TR I at 109. At the time of the hearing this most-recent three-month average was 3.6%. Presently, it is 3.4%. See Appendix B.

Ms. Smagula testified that the Commissioner has, in the past, including in the last year, required some carriers in the individual and small group markets to limit their administrative charge PMPM increase from one year to the next to the average of the most recent three months of CPI-U, less food and energy. Smagula TR I at 303-304.

Blue Cross offered testimony that key drivers of its administrative costs increasing on a PMPM basis from 2024 to 2025 included: (a) "an estimate – a projection of lower membership in 2025 relative to what we had assumed last year in 2024 filing." attributable to its decreasing membership"; (b) "an assumption of participating in a gene therapy related excess of lost program"; and (c) long-term investments and other solutions. Mackintosh TR I at 107-108. On the topic of its projected lower membership in 2025, Blue Cross represented that its "anticipated membership is decreasing by roughly 6%" and that this reduction in enrollment "is the major driver of the PMPM increase." OHIC Exhibit 20. However, upon further questioning, Blue Cross acknowledged that this approximate 6% reduction in membership was not documented anywhere

in the Rate Filing and that its "actual membership . . . in the past few years, has been relatively stable" in terms of overall enrolment. Mackintosh TR I at 150-151. Instead, Blue Cross explained that the 6% reduction in membership figure that it referenced to explain the increase in its administrative PMPM did not reflect an actual reduction in its membership but rather reflected that Blue Cross' membership was "6 percent below our hypothetical assumption [for 2024], not any 6 percent change in actual numbers." Mackintosh TR I at 150-151. In sum, Blue Cross' explanation of why it was reasonable for its administrative PMPM charges to increase at a rate well in excess of the average of the most recent three months of CPI-U, less food and energy, annual increases was not entirely convincing.

The evidence supports that Blue Cross' administrative charge increase from 2024 to 2025 of 8.3% on a PMPM basis is not necessarily unreasonable. However, while OHIC is not making a recommendation on this topic, based on the evidence in the record OHIC submits that it would also be reasonable and within the Commissioner's discretion in the context of issuing a decision on the Rate Request to limit Blue Cross' administrative charge increase from 2024 to 2025 to 3.6% or 3.4% on a PMPM basis if he determines that doing so would be consistent with the proper conduct of Blue Cross' business and in the public interest.

Blue Cross' Requested 2% Contribution to Reserves

The Commissioner has a statutory responsibility to balance his obligation to promote the affordability of health insurance with his obligation to ensure the financial solvency of health insurance carriers. R.I.G.L. §42-14.5-2; R.I.G.L. §27-19.2-10. This balancing obligation is particularly at the center of the question that arises each year during the rate review process of whether and how much of a contribution to reserves should be allowed to be incorporated as part

of a carrier's proposed rates. "Reserves are funds set aside so that [Blue Cross is] able to pay claims . . . no matter how volatile they get. [Blue Cross] policy holders count on [Blue Cross] to pay their claims . . . and so we need to ensure that we have the funds to do so," Mackintosh TR I at 110, "in the vast majority of [possible] scenarios." Mackintosh TR I at 112.

Blue Cross is seeking a two percent (2%) contribution to reserves in its Rate Filing. In support of this request, Blue Cross has argued that "a contribution to reserves in the amount of 2 percent [in the individual market] . . . is necessary to maintain its financial solvency, especially after its contribution to reserves has been reduced in recent years." Blue Cross Opening Statement TR I at 20; see also Table 5 at AG Report at 12.

A review of the record reveals that the evidence and/or arguments put forth by Blue Cross in support of its request can be summarized as follows:

(a) Neither Ms. Smagula nor Mr. Stentz, in their professional actuarial opinions, are recommending to the Commissioner that Blue Cross's requested percent contribution to reserves be reduced or denied. Stentz TR I at 221 (a 2% contribution to reserves "is within what I see as reasonable, and I would not say it's unreasonable," "I don't have a recommendation [regarding the contribution to reserves]"); Smagula TR I at 314.

(b) Blue Cross must increase its reserves each year as claim cost and utilization increase, to keep pace with continually increasing cost and utilization of care. Reserves are necessary to ensure Blue Cross can cover those costs in the vast majority of possible scenarios. Mackintosh TR I at 111-112.

(c) Denying Blue Cross' requested contribution to reserves year after year is not sustainable, particularly in the Individual Market where Blue Cross has observed historic levels of volatility. Mackintosh TR I at 112-113.

(d) The contribution to reserves factor in the Rate Filing is, in part, a hedge against the risk of approving a rate increase based on aggressive assumptions, because the contribution to reserves allows for a reasonable margin of error. Mackintosh TR I at 114; Stentz TR I at 219-220.

(e) Blue Cross is projecting that its premium rates for 2024 in the direct pay market will not cover the direct pay claims experience in 2024. Mackintosh TR I at 120-121.

(f) The only means that Blue Cross has to add to its reserves over time is through a contribution to reserves assumption built into our Rate Filings. Mackintosh TR I at 110-111; Stentz TR I at 221.

Evidence presented by the OAG and OHIC on the topic of Blue Cross' requested 2% contribution to reserves included:

(a) That Blue Cross' recent Risk Based Capital (RBC) levels are in line with industry averages for the ACA marketplace. AG Report at 12; Smagula TR I at 309.

(b) That the reduction to Blue Cross' requested contributions to reserves in prior individual market rate reviews does not appear to have materially impacted Blue Cross' RBC position relative to its historical position. AG Report at 12; Smagula TR I at 309.

(c) Blue Cross has an RBC ratio of 656.2% and a Surplus as a Percent of Revenue (SAPOR) of 21.5% as of 2023. OHIC Exhibit 1 at 25 (including Table 16 which provides these figures for 2021 through 2023); Smagula TR I at 307.

(d) Blue Cross' current SAPOR percentage of 21.5% is just slightly below the low end of the appropriate SAPOR percentage range set forth in the Lewin Report published in 2006. Smagula TR I at 308; OHIC Exhibit 66.

(e) If the Commissioner were to approve an alternative contribution to reserves of 1%, this would lower Blue Cross' 14.3% Rate Request by approximately 1.2%. Smagula TR I at 310.

(f) If the Commissioner were to approve a zero percent (0%) contribution to reserves this would lower Blue Cross' 14.3% Rate Request by approximately 2.3%. Smagula TR I at 310.

The evidence supports that a 2% contribution to reserves is not unreasonable. However, it is difficult to access from the evidence presented whether a 2% contribution to reserves in the Individual Market for 2025 is necessary to ensure Blue Cross' financial stability and the proper conduct of Blue Cross' business. Moreover, the Commissioner must weigh the proper conduct of Blue Cross' business against the affordability concerns of Rhode Island health insurance consumers, all while recognizing that a fiscally stable Blue Cross with adequate reserves is also in the public interest. OHIC received written public comment from approximately 3 individuals relating to the Blue Cross Rate Request.[24] See Appendix A. These individuals expressed the significant fiscal challenges they, and others, are encountering in their attempts to maintain health insurance coverage, especially in the face of the annual rate increases.

OHIC submits that, based on the evidence in the record, it is within the Commissioner's discretion in the context of issuing a decision on the Rate Request to find that an alternative contribution to reserves figure is consistent with the proper conduct of Blue Cross' business, and in the public interest.

[24] It was unclear from the content of one of the written comments whether the comments related to Blue Cross' Individual Market Rate Filing or a different Blue Cross rate filing.

OAG's Post-Hearing Recommendation To Deny Blue Cross Any Rate Increase In The Individual Market.

In the Attorney General's pre-hearing letter dated and submitted on June 21, 2024, the Attorney General represented that its actuaries – Lewis & Ellis – concluded that it is actuarially appropriate to reduce Blue Cross' 14.3% Rate Request by approximately 0.1% "to reflect the appropriate, evidence-based amounts that will support appropriate insurer investments in providers and hospital." At the hearing, the Attorney General had the opportunity to present documentary evidence and testimony, which evidence would then be subject to cross-examination as well as comment by the other parties in accordance with Rhode Island's Administrative Procedures Act. See e.g. R.I. Gen. Law § 42-35-9(c) which provides that in a contested administrative hearing "opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved." The evidence submitted by the Attorney General at the hearing was consistent with the filed Actuarial Report of Lewis and Ellis. The Attorney General did not put on any witnesses other than Mr. Stentz and declined to cross-examine the witnesses presented by Blue Cross or OHIC.

However, in a document entitled "Post-Hearing Memorandum of the Attorney General", submitted on the day post-hearing papers were due, the Attorney General suddenly seeks to have the Commissioner render a decision based entirely on a slew of new evidence that it did not even attempt to introduce into evidence at the Public Hearing and which could therefore not be subject to any cross-examination or testimony by the other parties.

The Attorney General in its post-hearing memorandum is arguing for the first time in this matter and based entirely on this new "evidence" that is not in the record that the Commissioner

should deny Blue Cross any rate increase at all. However, R.I. Gen. Law § 42-35-9(g) states that "findings of fact shall be based exclusively on the evidence and matters official noticed."

Procedurally, the Attorney General for the State of Rhode Island should be able to appreciate that in the context of an Administrative Hearing the parties to the hearing should have notice of each other's arguments and evidence and that the Commissioner is obligated to render a decision based on the evidence in the record.

Protecting the interests of consumers and considering and promoting affordability are always at the forefront of the Commissioner's actions and decisions. Moreover, the Office applauds the OAG's commitment to and advocacy on behalf of consumers. However, the OAG's recommendation that it is legally appropriate for the Commissioner to deny Blue Cross any rate increase at all based on asserted facts that are not in evidence is not reflective of Rhode Island law and is in direct conflict both with the Commissioner's statutory duty to guard the solvency of insurance companies and the rate review standard of evaluating proposed rates to ensure they are consistent with both the proper conduct of an insurer's business and with the interest of the public.

The Attorney General asserts that the Commissioner should deny Blue Cross any rate increase even if the Commissioner finds that a rate increase of some amount is actuarially justified to ensure premiums collected for 2023 will be adequate to cover member claims in 2023. Moreover, he does so for the first time after the Public Hearing on the matter has concluded.

Accordingly, the Office recommends the Commissioner deny the Attorney General's request that Blue Cross be ordered to charge an actuarially insufficient rate for its 2025 plans because this request is contrary to the proper conduct of Blue Cross' business as well as contrary

to the public interest. OHIC also recommends that the Commissioner reject the Attorney General's Post Hearing submissions as being procedurally inappropriate.

Summary of Recommendations

Alternative Assumption #1: It is a more reasonable actuarial assumption for Blue Cross to update their CY 2023 base period experience with claims runout through May 2024 rather than only through February 2024. Adopting this recommendation this would result in an estimated approximate 0.4% reduction to rates.

Alternative Assumption #2: It is a more reasonable actuarial assumption for Blue Cross to assume that their pharmacy rebates will increase at an annualized trend of 16%, consistent with historical experience, rather than 10.6%. Adopting this recommendation would result in an estimated approximate 0.4% reduction to rates.

Alternative Assumption #3: It is an equally reasonable actuarial assumption for Blue Cross to assume a medical utilization and severity trend of 2.4% rather than 2.8%. Adopting this recommendation would decrease rates by approximately 0.5%.

Alternative Assumption #4: It is an equally reasonable actuarial assumption for Blue Cross to assume a 2025 hospital inpatient and outpatient unit cost trend of 4.0% rather than 4.6%. Adopting this recommendation would decrease rates by approximately 0.2%.

Alternative Assumption #5: It is an equally reasonable actuarial assumption for Blue Cross to assume a risk adjustment transfer of $72.03 PMPM rather than $70.78 PMPM. Adopting this recommendation would decrease rates by approximately 0.2%.

Alternative Assumption #6: It is a more reasonable actuarial assumption for Blue Cross to assume its HCRP estimated recovery figure for 2025 will be increased from $0.29 PMPM to $1.20 PMPM. Adopting this recommendation would decrease rates by approximately 0.1%.

Additional Recommendation: Blue Cross should revise its projected reinsurance receivable to reflect the impact of any changes to the relevant trend assumptions that the Commissioner may order. AG Report at 12; Stentz TR I at 232. Given that the OAG and OHIC are recommending fairly small changes to trend, if the Commissioner adopts this recommendation, it is not anticipated that the impact to reinsurance will be significant or that the impact will materially affect Blue Cross' proposed rate increase. AG Report at 12-13; Stentz TR I at 232.

Furthermore, while OHIC is not making a recommendation in favor of or against Blue Cross' requested administrative charge and its requested contribution to reserves, based on all the evidence presented, it remains within the Commissioner's discretion to modify either or both requests and any such modification would be consistent with the proper conduct of Blue Cross' business and in the public interest.

For the Commissioner's consideration, if the administrative charge PMPM was only allowed to increase from 2024 to 2025 based on the average of most recent three months of CPI-U: Less Food and Energy, this change would decrease rates by approximately 0.5%.

For the Commissioner's consideration, a 1.0% contribution to reserve charge would decrease rates 1.2% and a 0% contribution to reserve charge would decrease rates by 2.3%.

Table 3 below shows the approximate impact to Blue Cross' filed Rate Request based on changing certain assumptions.[25] Please note that the changes in Table 3 below are not additive.

Table 3: Summary of Alternative Assumption for Consideration	
Description of Alternative Assumption	**Estimated Reduction to 2025 Rates**
1. Revise CY 2023 Base Period Experience	0.4%
2. Revise 2025 Pharmacy Rebate Projection	0.4%
3. Revise Medical Utilization and Severity Trend Assumption from 2.8% to 2.4%	0.5%
4. Revise 2025 Hospital Unit Cost Trend	0.2%
5. Revise 2025 Projected Risk Adjustment Transfer Amount	0.2%
6. Revise 2025 High Cost Risk Pool Receivable Figure	0.1%
Total of All Recommended Alternative Assumptions (1 through 6 above)	**1.8%**
7. Consider Limiting Administrative Charge PMPM Increase to Recent CPI-U Increase	0.5%
8. Consider Limiting the Contribution to Reserves to 0% or 1%	2.3% or 1.2%

Table 3 - Estimated Impact to Average Rate Change for Alternative Assumptions

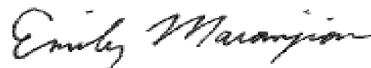
[25] Because OHIC does not have access to Blue Cross' Rate Development Template these approximate reductions to the 14.3 percent Rate Request are necessarily educated estimates. As noted in more detail above, Blue Cross presented testimony at the Public Hearing that it estimated that OHIC's recommended revisions to the: (a) 2023 Base Period Experience would reduce rates by 0.5% rather than 0.4%; (b) 2025 Pharmacy Rebate Projection would reduce rates by 0.5% rather than 0.4%; and (c) Medical Utilization and Severity Trend Assumption would reduce rates by 0.7% rather than 0.5%.

Conclusion

If the Commissioner accepts the recommendations of the Office as set forth above, Blue Cross should be directed to file a modified Rate Request consistent with the assumptions and conclusions herein.

Respectfully submitted,
Office of the Health Insurance Commissioner

By its attorney:



Emily Maranjian, Executive Counsel #5922
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Building 69-1
Cranston, RI 02920
401-462-9636
Emily.maranjian@ohic.ri.gov

CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of August 202, a copy of this OHIC's Proposed Findings of Fact and Conclusions of Law was sent by electronic mail to the following:

Cory B. King
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, Rhode Island 02920
cory.king@ohic.ri.gov

Raymond A. Marcaccio, Esq.
Legal Advisor to the Commissioner
55 Dorrance Street, Suite 400
Providence, Rhode Island 02903
ram@om-rilaw.com

Jasmin Amaral, OHIC Docket Clerk
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1

Cranston, Rhode Island 02920
Jasmin.Amaral@ohic.ri.gov

Jamie Bachant, Esq.
Associate General Counsel
Blue Cross Blue Shield of Rhode Island
500 Exchange Street
Providence, Rhode Island 02903
Jamie.Bachant@bcbsri.org

Jordan Broadbent, Esq.
Special Assistant Attorney General
Insurance Advocate
Office of the Attorney General
150 South Main Street
Providence, Rhode Island 02903
JBroadbent@riag.ri.gov

Jared Page
Insurance Advocacy Unit
Office of the Attorney General
150 South Main Street
Providence, Rhode Island 02903
JPage@riag.ri.gov

Emily Maranjian

APPENDIX A

(See attached for public comment submissions)

APPENDIX B

(See attached for July 31, 2024 Stipulation)