STATE OF RHODE ISLAND
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

In Re: Blue Cross & Blue Shield of Rhode Island	)	
Rates Filed for 2026 Individual Market Plans	)	OHIC-RH-2025-1

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

Blue Cross & Blue Shield of Rhode Island ("Blue Cross") submits this Post-Hearing Memorandum in support of its rates requested in the individual market for plan year 2026. Blue Cross seeks approval for an overall 28.6% increase in the weighted average premium, which accounts for two agreed-to modifications from its initial filing on May 16, 2025: (1) updating the 2024 claim runout base period through May 2025 (which results in a 0.3% decrease)[1] and (2) removing an adverse impact built into the pharmacy cost trend for anticipated 340b legislation (which results in a 0.6% decrease).[2] This also accounts for a 0.6% increase due to the required contribution to the $30M assessment provided for in the recently-passed legislation at R.I. Gen. Laws 42-7.4-3(c).[3] As set forth in further detail below, Blue Cross has met its burden of demonstrating that this requested rate increase is consistent with both the proper conduct of its

[1] Blue Cross agrees to update its claim runout period for base year 2024 through May 2025, as suggested by OHIC's actuary, Ryan Schutlz, in OHIC Ex. 1 at 5. Blue Cross believes this approach is reasonable to the extent that the update would apply to each carrier in this market, and would apply going forward regardless of whether the update to the claim runout period results in a rate increase or rate decrease. Tr. I at 95-96.

[2] Blue Cross agrees to remove the assumption included in its pharmacy cost trend related to increased costs associated with anticipated 340b legislation. Blue Cross agrees to do so because it understands the legislation as passed (which occurred after the Rate Filing) now excludes the adverse impacts Blue Cross had anticipated and rated for in the Rate Filing. Tr. I at 81-82.

[3] *See* Stipulation of the Parties Regarding (1) CPI-U 12-Month Percentage Change Through June 2025, (2) The Final Risk Adjustment Transfer Payment, (3) Medical Inflation Definition, and (4) State Budget $30M Assessment ("Stipulation"), at Par. 4.

business and the interests of the public. As a result, the rate increase requested by Blue Cross should be approved.

FACTS AND TRAVEL

Blue Cross submitted its filing for individual health insurance products to the Office of the Health Insurance Commissioner ("OHIC") via the System for Electronic Rate and Form Filing Access (SERFF) on May 16, 2025 (the "Rate Filing"). Tr. I at 35; Blue Cross Exs. 1, 2, 3.[4] The Rate Filing requested a 28.9% percent increase in the weighted average premium and was approved by Blue Cross's Board of Directors. Tr. I at 38.

Due to the anticipated expiration of enhanced premium tax credits for the 2026 rate year, OHIC's instructions required Blue Cross to submit two rate filings for 2026 – one filing assuming that the enhanced premium tax credits expire (the primary filing), and a second filing assuming they continue. Tr. I at 36-37. The filing incorporating the assumption that the enhanced premium tax credits expire is the rate filing discussed herein, and was the focus of the testimony during the public hearing. Tr I. at 38; 149.

The expiration of enhanced premium tax credits accounts for 9.7% of Blue Cross's requested rate increase, resulting from an adjustment to the morbidity of Blue Cross's expected membership in 2026. Tr. I at 180. There is no dispute among the parties as to Blue Cross's methodology in arriving at that assumption and calculation included in the Rate Filing, which

[4] Citations to "Blue Cross Ex.", "OAG Ex." and "OHIC Ex." refer to the exhibits offered by the respective parties. Citations to "Tr. I" refer to pages in the transcript of the Public Hearing for June 30, 2025. Citations to "Tr. II" refer to pages in the transcript of the Public Hearing for July 1, 2025.

assumes that, as a result of the enhanced premium tax credits ending, healthier members will disenroll, thereby increasing the morbidity of Blue Cross's individual market membership.[5]

The Health Insurance Commissioner ("Commissioner") presided over the public hearing required by R.I. Gen Laws § 27-19-6 and § 27-20-6 and retained Raymond Marcaccio to act as his legal advisor. The public hearing was held on June 30, 2025 and July 1, 2025 ("Public Hearing"). *See generally* Tr. I and Tr. II.

Blue Cross, the Rhode Island Office of the Attorney General ("OAG") and OHIC submitted witness lists and proposed exhibits on June 20, 2025. OHIC submitted a report of its consulting actuary, Ryan Schultz. *See* OHIC Ex. 1.[6] The OAG submitted a report of its consulting economist, Christopher Whaley. *See* OAG Ex. A.[7] The OAG did not hire a consulting actuary to review the Rate Filing and offers no opinion regarding whether Blue Cross's Rate Filing is actuarially justified. Tr. II at 387-88.

At the Public Hearing, the parties stipulated that (1) Brian Mackintosh (chief actuary for Blue Cross), and Mr. Schultz were each experts in the field of actuarial science and could testify as such; (2) Dr. Whaley was an expert in health economics and could testify as such, (3) the Commissioner, assisted by his legal advisor Raymond Marcaccio, had jurisdiction to hear this matter; and (4) published notice of the Public Hearing was provided in accordance with the statutory requirements set forth in R.I. Gen Laws § 27-19-6(b) and § 27-20-6(b). Tr. I at 6-8; *see*

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[5] *See* OHIC Ex. 1 at 20, stating that Mr. Schultz reviewed Blue Cross's morbidity adjustment related to the expiration of enhanced premium tax credits finding it "not unreasonable" and "within the range of morbidity change assumptions I have observed being used for 2026 by other carriers in the industry."

[6] OHIC Ex. 1 is a reference to the report of OHIC's actuary Ryan Schultz provided to the parties on June 25, 2025. A prior version of that report was provided to the parties on June 20, 2025. The report provided on June 25, 2025 was substituted as the final version of the report.

[7] OAG Ex. A is a reference to the "Consumer and Economic Report: Blue Cross Blue Shield of Rhode Island," provided to the parties on June 20, 2025.

also Blue Cross Ex. 4 (attesting that the notice of Public Hearing was published in the Providence Journal on June 18, 2025).

Mr. Mackintosh, Mr. Schultz, and Dr. Whaley each testified at the Public Hearing in their expert capacities. Tr. I and Tr. II. Public comment was taken from 6:00 p.m. to 7:00 p.m. on June 30, 2025 and from 9:00 a.m. to 9:30 a.m. on July 1, 2025. Tr. I at 324-26; Tr. II at 333-34. No members of the public provided oral comment. *Id.* Written public comments were required to be submitted to OHIC on or before July 24, 2025, and OHIC provided those written comments to the parties on July 25, 2025. The following exhibits of the parties were entered into evidence in full: Blue Cross Exs. 1-5,[8] OAG Exs. 1-8 and 10-29, and OHIC Exs. 1-124, 126-127, 129, and 131-135.[9] Certain of those exhibits (OHIC Exs. 10, 46, and 81-121) were marked as confidential and sealed from the public record in accordance with R.I. Gen Laws §38-2-2(4)(B), as ordered by the Commissioner on June 27, 2025. *See* Stipulated Order Regarding Confidential Exhibits (stating that the parties agree that those exhibits contain confidential and proprietary information of Blue Cross, and that Blue Cross has sufficiently proffered that those exhibits satisfy the requirements set forth in R.I. Gen Laws § 38-2-2(4)(B), and thereby ordering that the exhibits must be sealed and excluded from the public record).

During Day 1 of the Public Hearing, the Centers for Medicare & Medicaid Services (CMS) issued the final Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2024 Benefit Year, indicating that Blue Cross is entitled to a risk

[8] *See* Tr. I at 69, for admission of Blue Cross Ex. 5 into evidence in full.
[9] OHIC withdrew its exhibits 125, 128, and 130, which had been marked for identification only. Those exhibits are not entered into evidence. Tr. I at 196-97; Tr. II at 335. The OAG marked its exhibit 9 for identification only, and the record does not reflect that the exhibit was entered into evidence. Tr. I at 7.

adjustment transfer payment for calendar year 2024 in the individual market in the amount of $16,801,611. Tr. II at 545.[10]

Following the Public Hearing, on July 15, 2025, the U.S. Bureau of Labor Statistics released its Consumer Price Index figures inclusive of the June 2025 data. The Consumer Price Index for all Urban Consumers (less food and energy) ("CPI-U") 12-month percent change through June 2025 is 2.9%. *See* Stipulation at par. 1.

Blue Cross submits this Post-Hearing Memorandum in support of the assumptions and methodologies used to develop the rate increase it requested in the Rate Filing, with the above-referenced modifications: (1) updating the claim runout period through May 2025 for base year 2024, (2) removing the assumption it had included in its pharmacy cost trend related to anticipated 340b legislation, and (3) including the impact of the newly-passed assessment in R.I. Gen. Laws 42-7.4-3(c), which together result in a 0.3 % decrease to the as-filed 28.9% rate request increase in the May 16, 2025 Rate Filing, for a total requested rate increase of 28.6%.

ARGUMENT

Blue Cross must establish by a preponderance of the evidence that the rates proposed for the individual market are "consistent with the proper conduct of its business and with the interest of the public." R.I. Gen Laws §§27-19-(6)(d)(1) & 27-20-6(d)(1); *Miele v. Bd. of Med. Licensure & Discip*., 1991 WL 789899, C.A. 90-1390, at *2 (Oct. 9, 1991). As a non-profit hospital and medical services corporation, Blue Cross is obligated to both "[e]mploy pricing strategies that

[10] On July 23, 2025, that report was revised to reflect a change to the risk adjustment payment in the small group market, not the individual market. *See* Stipulation of the Parties Regarding (1) CPI-U 12-Month Percentage Change Through June 2025, (2) The Final Risk Adjustment Transfer Payment, (3) Medical Inflation Definition, and (4) State Budget $30M Assessment ("Stipulation"), at Par. 2.

enhance the affordability of health care coverage" and also "[p]rotect the financial condition" of the company. R.I. Gen Laws § 27-19.2-10. Indeed, protecting the financial solvency of Blue Cross is part of OHIC's mandate as well. R.I. Gen Laws § 42-14.5-2(1). To satisfy the preponderance of the evidence standard, Blue Cross must present "evidence which is of greater weight than its opposition. It is evidence which, on the whole, shows that the fact to be proved is more probable than not." *Miele*, 1991 WL 789899, at *2.

The parties are in agreement as to most of the calculations and assumptions in the Rate Filing. *See* OHIC Ex. 1; Tr. II at 388.[11] There is no dispute that the Rate Filing submitted by Blue Cross used standard and appropriate actuarial methods and practices, was consistent with the instructions provided by OHIC, and that Blue Cross responded to all of the questions during the course of the rate review in a timely and professional manner. Tr. I at 214, 217; OHIC Ex. 1 at 27.

The Public Hearing focused on the handful of areas where there are differing methodologies or assumptions. Importantly, though, there is no dispute that Blue Cross's methodologies and assumptions are reasonable on their own. In this regard, it is merely a matter of debate as to which alternatives are more reasonable to use. Mr. Schultz's report suggested seven alternative assumptions to consider in reviewing the Rate Filing. OHIC Ex. 1. As referenced above and during the Public Hearing, Blue Cross has agreed to incorporate two of those alternative assumptions, both of which result in a decrease to the overall requested rate increase in the Rate Filing. Tr. I at 81-82, 95-96. Of the five remaining alternatives suggested by Mr. Schultz, Mr. Schultz testified that while Blue Cross's methodologies in the Rate Filing are

[11] Dr. Whaley is not an expert in actuarial science and therefore did not, and cannot, opine on whether Blue Cross's Rate Filing is actuarially appropriate. Indeed, he does not challenge Blue Cross's Rate Filing in that regard. Tr. II at 388.

all reasonable, four of his alternatives are more reasonable, while one of those five alternatives is "equally as reasonable" to the methodology proffered by Blue Cross (although, he testified that this last methodology may be "slightly" more reasonable). Tr. I at 278-79.

As set forth in further detail below, each of those five alternatives to the Rate Filing should be rejected in favor of the more reasonable methodology that Blue Cross used. First, Blue Cross's utilization trend for 2026 should be adopted and should not be revised to project a lower utilization trend. *See* Section I, *infra*. Second, Blue Cross's methodology in projecting the risk adjustment receivable should be adopted and not be revised. *See* Section II, *infra*. Third, Blue Cross's methodology in developing its facility cost trends, which projects that the applicable CPI-U as of October 1, 2025 will be 0.5% greater than the CPI-U available at time of the Rate Filing due to inflation, should be adopted and not revised. *See* Section III, *infra.* Fourth, Blue Cross's methodology in projecting the reinsurance receivable should be adopted and not revised. *See* Section IV, *infra*. Fifth, Blue Cross's projection that tariffs will impact pharmacy costs in 2026 by 3% should be adopted and not be revised to assume a lower impact. *See* Section V, *infra*

The Public Hearing also included testimony as to some of the areas where the parties do not disagree: (1) the inclusion of a 3% contribution to reserves; (2) the inclusion of the 9.3% administrative charge included in the Rate Filing,[12] (3) the morbidity adjustment due to the expiration of enhanced premium tax credits, and (4) the rate impacts associated with

[12] Mr. Schultz included in his report for the Commissioner's consideration the rate impact associated with capping the administrative charge based on the most recent 3 months of reported CPI-U. Mr. Schultz testified that he does not recommend that this be adopted (and Blue Cross agrees). Tr. I at 282. He calculated the rate impact to be less than a 0.05% impact. OHIC Ex. A at 28. As Mr. Mackintosh testified, Blue Cross took the significant action of a reduction in workforce earlier in 2025 as one of several measures to lower administrative costs, including "streamlining of operational tasks to try to minimize expenses." Tr. I at 191.

requirements for primary care provider (PCP) spend in 2025 and 2026 pursuant to OHIC's affordability regulation: 230 RICR-20-30-4. Neither Mr. Schultz nor Dr. Whaley challenge Blue Cross as to these methodologies or assumptions and do not recommend any changes or modifications to the Rate Filing with respect to these aspects of the Rate Filing. OHIC Ex. 1 at 17-18; 19-20; 24-26; Tr. I at 282-83; OAG Ex. A; Tr. II.[13] As set forth more fully below, any consideration to reduce the requested rate increase related to these four duly supported and unchallenged assumptions should be rejected. *See* Section VI (discussing Blue Cross's contribution to reserves and the assumptions related to the morbidity adjustment); and Section VII (discussing the PCP spend).

Finally, the Public Hearing also addressed the economic report of the OAG's economist, Dr. Whaley, which provides that the overall rate increase requested in the Rate Filing will result in an increase in costs to consumers. OAG Ex. A. Dr. Whaley opines that cost increases could lead consumers to decide not to purchase health insurance, which he says would put a strain on the Rhode Island delivery system and potentially lead to uncompensated care. *Id*. at 12-13. However, Dr. Whaley's report fails to acknowledge or account for the fallout associated with inadequate rates that would cost consumers less in the short term but would have disastrous long term impacts to consumers and providers – an insolvent Blue Cross unable to pay the claims of its members as they become due, and unable to pay the providers who delivered that care.[14] Significantly, his report does not challenge whether Blue Cross's rates are actuarially justified or

[13] The OAG offered no testimony challenging any of these components of Blue Cross's Rate Filing. Tr. II.

[14] At the Public Hearing, and in his report, Dr. Whaley applauded the rate review process as having helped Rhode Island achieve some of the lowest premiums in the country. Tr. II at 368, 390, 394, 419-20; OAG Ex. A at 6-7, 9-10. The OAG has consistently hired an actuary to review Blue Cross's rate filings in prior years during each rate review process, but did not do so this year.

within the proper conduct of Blue Cross's business, and he does not offer an actuarial opinion related to the assumptions included in the Rate Filing. Tr. II at 387-388 (testifying that he has "not examined the rate increase from an actuary perspective" and that he is "not commenting on the actuarial impact of the requested rate"). To the extent that his report can be viewed to challenge Blue Cross's methodologies in the Rate Filing and to advocate for reducing the rate increase, those challenges should be rejected.

I. BLUE CROSS'S PROPOSED UTILIZATION TRENDS ARE REASONABLE AND APPROPRIATE AND SHOULD BE USED IN CALCULATING THE RATES.

Blue Cross has demonstrated that the utilization trends included in the Rate Filing are reasonable and appropriate and should not be reduced to lower the rates. Although Mr. Schultz has proffered an alternative methodology to consider in the development of the utilization trend, he agrees that Blue Cross's methodology is reasonable, testifying that his methodology is "equally reasonable" to Blue Cross's methodology, if not "slightly more reasonable." Tr. I at 287. Because Blue Cross's methodology accounts for more recent claims experience, however, it is the better approach for evaluating trend in the current environment.

Mr. Mackintosh testified that in developing the utilization trends for the Rate Filing, Blue Cross used its standard regression methodology. Tr. I at 51. In doing so, Blue Cross looked at the claims experience for its entire fully insured population across the individual market, small group, and large group markets, and developed each utilization trend separately for inpatient, outpatient, professional and pharmacy. *Id*. at 58. The analysis included the three most recent years of claims data, which shows how trends have developed in terms of use and severity. *Id.*

As Mr. Mackintosh testified, Blue Cross used the prior three years of data (years 2022 through 2024) converted to rolling 12-month data points, and considered several "lines of best

fit" regressions. *Id*. at 51-53. These methods evaluated r-squared values from 13 regression lines using the most recent 13-rolling 12-month data points (2 years of data) adding one additional data point at a time, up to 25-rolling 12-month data points (3 years of data). *Id*. at 57. In this regard, for each service category (inpatient, outpatient, professional and pharmacy) Blue Cross compared three regression lines: (1) the trend line indicated by the most recent 13-rolling 12-month data points, (2) the trend line indicated by the most recent 25-rolling 12-month data points, and (3) the trend line indicated by the time period (between 13 and 25 data points, inclusive) that reflects the highest r-squared value (ranging from 0-1), which is a measure of how well a trendline fits data (with a value of 1 indicating the trendline is a perfect fit to the underlying data). *Id.* at 52-53. The Society of Actuaries has "ranked best in class predictive models" as having an r-squared values "anywhere between 0.3 and 0.5, or 0.6." *Id.* at 53. The r-squared values of Blue Cross's trends are all well above those thresholds. *Id.* at 53

Here, the r-squared values for the best fit and 13-point regression lines were each "well above 0.9, indicating excellent r-squared," for outpatient, pharmacy, and professional categories. *Id*. And, with respect to the inpatient category, the r-squared values were "in the 0.7 range, which was quite high for inpatient relative to past years." *Id*. In examining the trend lines, Mr. Mackintosh testified there was no statistically significant difference in the r-squared values between the 13-point regressions and the "best fit" regressions in any service category. *Id*. at 56. Given that the r-squared values as to those two regression lines were essentially a "statistical tie" and "photo finish,"[15] Blue Cross used actuarial judgment to select the 13-point regression trends

[15] The difference in r-squared value between the regression lines for each of the categories were as follows: inpatient was 0.04, outpatient 0.01, professional 0.00 (an actual tie), and pharmacy 0.01. OHIC Ex. 20 (showing the regression lines and the corresponding r-squared values).

as the assumed utilization trend for each service category because it reflects the most recent available data in the 3-year lookback. Tr. I at 55-56.[16]

Indeed, as Mr. Mackintosh testified, the recency of data is an important consideration in evaluating trend, since more current data is more likely to reflect current and near-future utilization of Blue Cross's membership than older data would. *Id*. at 56, 57. Therefore, as Mr. Mackintosh testified, the approach of choosing the 13-point regression line is the better approach because it accounts for the more recent experience. *Id*. at 53.

Blue Cross should not be required to modify its utilization trend assumptions to choose a different trend line. Blue Cross disagrees that the best fit regression line, as opposed to the 13-point regression line it used, should be the required trend pick for the Rate Filing, which results in an overall decrease to Blue Cross's requested rates. OHIC Ex. 1 at 11.[17]

Mr. Schultz acknowledged that the results of the best fit regression trends and the 13-point regression trends were "similar to each other," (and in one category actually a tie), but he selected the trend that resulted in lower projected utilization without offering an explanation for *why* this was the more reasonable projection. *Id.* at 222-24. He acknowledged that "it can be valuable to look at more recent data," to the extent that those trends are "reflective of where near-future trends are going be." *Id*. at 224. Agreeing that that Blue Cross's utilization trend used in the Rate Filing was reasonable, he nonetheless selected a different trend, preferring an

[16] The trends for each category included in the Rate Filing are: inpatient (3.5%), outpatient (5.9%), professional (7.4%) and pharmacy (9.6%). Blue Cross Ex. 1 at p. 2.

[17] This results in a reduction of inpatient utilization trend from 3.5% to 2.2%, an increase in outpatient utilization trend from 5.9% to 6.1%, a reduction in the professional (and "other" medical) utilization trend from 7.4% to 7.0%, and a reduction of the pharmacy utilization trend from 9.6% to 8.7%. OHIC Ex. 1 at 11.

approach that would lower the rate increase without offering a basis for why he believes that may be "slightly more reasonable." *Id.* at 278-79, 289 (emphasis added).

For the above stated reasons, Blue Cross has shown by a preponderance of the evidence that its methodology in developing the utilization trends included in the Rate Filing is reasonable and appropriate. There is no reason, therefore, to depart from Blue Cross's utilization trend calculations included in the Rate Filing in favor of a different trend. Were Blue Cross required to use the best fit regression lines for the utilization trends for each of the categories, Blue Cross has estimated that this would result in a 1.6% decrease to its requested rate. Tr. I at 62.

II. BLUE CROSS'S METHODOLOGY IN PROJECTING THE 2026 RISK ADJUSTMENT TRANSFER PAYMENT IS REASONABLE AND APPROPRIATE AND SHOULD BE USED IN CALCULATING THE REQUESTED RATES.

There is no disagreement among the parties that an appropriate methodology for projecting the 2026 risk adjustment transfer payment includes substituting the risk adjustment transfer payment Blue Cross is entitled to receive for the 2024 base year (as reported by CMS), and then trending that amount to 2026 using an assumed statewide premium trend assumption. OHIC Ex. 1 at 21-22; Tr I. at 260.[18]

On June 30, 2025, CMS published the final 2024 risk adjustment report, which provides that Blue Cross is entitled to a risk adjustment transfer payment for 2024 in the amount of $16,801,611.[19] Tr. II at 545; Stipulation at par 2. Consistent with its representations at the

[18] At the time of the Rate Filing, this figure was not yet published. As a result, Blue Cross used the 2024 interim risk adjustment transfer payment amount for 2024, but intended to substitute the final payment amount when it was available. Blue Cross Ex. 1; Tr. I at 103.

[19] The final 2024 payment is *lower* than the interim 2024 amount Blue Cross had included in the Rate Filing, which means that the Rate Filing is inadequate related to the calculation of risk adjustment transfer payment, such that the as-filed rates would need to increase by 0.6%. Tr. I at 105.

Public Hearing, and the recommendation of Mr. Schultz, Blue Cross agrees to substitute that final payment amount into its pricing model for the interim payment it had used for 2024, and trend that to 2026. Tr. I at 102-103. Additionally, as reflected in the Rate Filing, it is Blue Cross's position that merely using the 2024 payment amount is not enough to adequately project the risk adjustment transfer payment for 2026. In this regard, as it had done in the Rate Filing, the 2024 payment must be blended with the 2023 payment (weighting 75% to 2023 and 25% to 2024), and then that blended figure should be trended to 2026. *Id.* at 103. As Mr. Mackintosh testified, this methodology more accurately projects the risk adjustment transfer payment for 2026. *Id.* at 103.

Indeed, in projecting the risk adjustment transfer payment for 2026, it is important to account for both how 2024 and 2023 enrollment are needed to characterize the 2026 risk pool. As Mr. Mackintosh testified, the 2024 base year was significantly impacted by Medicaid redeterminations and the new members that entered the marketplace during that time, who also had access to the enhanced premium tax credits. Tr. I at 42, 101, 171. As a result, Blue Cross's risk pool in 2024 is *not* representative of the risk of Blue Cross's 2026 population, which will see healthy members leave the market due to the expiration of those enhanced premium tax credits. *Id.* Indeed, after the enhanced premium tax credits end, many of those members who previously entered the market as a result of the Medicaid redeterminations in 2024 will be the same members exiting the market. *Id*. As a result, the 2026 risk adjustment transfer payment is expected to more closely align with the 2023 payment. *Id*. at 101, 171 (testifying that Blue Cross expects to see a 2026 risk pool "more similar to 2023 than to 2024"). Nonetheless, Blue Cross did not disregard 2024 entirely – it weighted 25% to 2024 given that 2024 is the base year and

"more recent for the rest of the population"[20] and the 2024 risk payment is reflective of the most recent changes to the CMS risk model. *Id.* at 171.

Blue Cross disagrees with Mr. Schutlz's logic in seemingly concluding the contrary with respect to projecting the risk adjustment transfer payment. In his report, Mr. Schultz states that because Blue Cross is "assuming its morbidity will move in tandem with the statewide average morbidity between 2024 and 2026," this means that "the 2024 risk adjustment results will best reflect the expected risk relativity in 2026." OHIC Ex. 1 at p. 22. Mr. Schultz wrongly focuses on morbidity in place of the more relevant enrollee risk characteristics which drive the risk adjustment transfer payment amount. Indeed, as Mr. Mackintosh testified, the morbidity adjustment relates to *claim costs* and how those claim costs will change in 2026 due to anticipated population changes. Tr. I at 106. By contrast, the risk adjustment formula does *not* take claim costs into account. *Id.* at 107, 108, 109, 176. Instead, the risk adjustment formula factors are based on specific member population characteristics including age, diagnoses, metal level, benefit level, and statewide average premium. *Id.* at 178. Simply put, the *number or cost* of claims incurred by Blue Cross are *not* factored into the applicable risk adjustment formula calculation. *Id*. By way of example, Mr. Mackintosh testified that a member with a diagnosis captured by the risk adjustment formula (i.e. diabetes) will receive a risk score related to that diagnosis. *Id.* at 110. The risk adjustment formula captures that specific member's diagnosis one time, regardless of the number of claims or the amount of spend that member has in a given year related to that diagnosis. *Id.* Given that the number of claims and the amount of claim costs is *not* a factor in the risk adjustment formula, it is therefore not appropriate to use claim costs as

[20] The transcript reflects testimony that "2023" is more recent, but this appears to be a typographical error. Tr. I at 171.

a proxy for projecting Blue Cross's risk score for 2026, as Mr. Schultz has done. *Id*. at 110, 176-79.

For the above-stated reasons, Blue Cross has satisfied its burden to show that the risk adjustment transfer projection methodology used in the Rate Filing, amended to substitute the final payment amount for 2024 for the interim 2024 payment used in the Rate Filing, blended with the final 2023 risk adjustment transfer payment, trended forward to 2026 using the statewide premium assumption, is appropriate and should be used in projecting the 2026 rates. Given that the 2024 final payment is lower than what was estimated in the Rate Filing, this results in a 0.6% increase to the requested rates. Were Blue Cross required to use the alternative methodology proffered by Mr. Schultz, Blue Cross estimates that this would result in a 1.6% decrease to the as-filed rate. Tr. I at 111.

III. BLUE CROSS APPROPRIATELY PROJECTED CPI-U IN DEVELOPING ITS COST TREND FOR 2026 HOSPITAL FACILITY RATES, WHICH SHOULD BE USED IN CALCULATING THE REQUESTED RATES.

There is no dispute among the experts regarding the soundness of the methodology employed by Blue Cross to develop its cost trend related to projected payments to hospital facilities for 2026. OHIC Ex. 1 at 15; Tr. I; Tr. II.[21] The question at issue relates *only* to what specific CPI-U figure to include with respect to that particular cost trend. The applicable CPI-U that will set the maximum rate increase for 2026 will not be known and reported until September of 2025, so Blue Cross had to estimate the future inflation measure.[22]

[21] In neither his report nor in his testimony does Dr. Whaley dispute how Blue Cross has developed its cost trend related to payments to hospitals. OAG Ex. A; Tr. II.

[22] The OHIC Affordability Regulation governs the maximum rate increase that an insurer can offer a hospital for each given year. *See* 230-RICR-20-30- 4.10(D)6(e) (stating that review and prior approval of OHIC is required if "[t]he average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-U") percentage increase (determined by the Commissioner by October 1 each year,

In the Rate Filing, Blue Cross projected the anticipated payments to its contracted hospitals for 2026 utilizing the CPI-U published as of the time it developed the Rate Filing (2.8%), which it then increased by 1 percent, per the applicable OHIC regulation, to arrive at 3.8%. Tr. I at 59. To account for anticipated inflation, Blue Cross increased the then-known CPI-U of 2.8% by 0.5%. Tr. I at 63-64. Accordingly, the CPI-U used for purposes of the Rate Filing was 4.3% for year 2026 (3.8% + 0.5% (inflation)). *Id*. at 63-64.

Blue Cross disagrees with the assumption of Mr. Schultz and Dr. Whaley that the applicable CPI-U will not have increased from the date of the Rate Filing. Each testified that, in their view, the CPI-U will remain stagnant at 2.8% (the CPI-U published as of the date of the Rate Filing) for purposes of projecting the CPI-U as of October 1, 2025. OHIC Ex. 1 at 17; Tr. I at 239.[23] These predictions have already proven incorrect. Indeed, the CPI-U has increased from 2.8% to 2.9%[24] and there is no evidence that the CPI-U is projected to decrease. Requiring Blue Cross to include a projected CPI-U that is lower than the current CPI-U would be unreasonable in light of this uptick, and adds increased risk to the Rate Filing that the rates would be inadequate. As acknowledged by Mr. Schultz during the Public Hearing, "it would be fair" to take additional more recently published CPI-U figures "into consideration" when projecting the applicable CPI-U to use for purposes of the Rate Filing. Tr. I at 241.

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based on the most recently published United States Department of Labor data). Such percentage increase shall be plus one percent (1%).") Thus, the actual CPI-U published as of October 1, 2025 increased by 1 percent will be the maximum rate increase that Blue Cross can pay its contracted hospitals in 2026. OHIC Ex. 1 at 15-16; Tr. I at 62.

[23] When asked at the Public Hearing about his predictions related to CPI-U, as a healthcare economist, Dr. Whaley seemed to not know the most recently reported CPI-U as of the date of the Rate Filing, testifying he thought it was "around 4 percent" then indicated "3 percent" then that it was "2 percent," calling into question his testimony in this regard. Tr. II at 494-95.

[24] *See* Stipulation at par. 1.

Mr. Schultz has acknowledged that if Blue Cross were required to include a CPI-U of 2.8% in these cost trends, and the CPI-U reported as of October 1, 2025 is in fact higher than 2.8%, the rate request would consist of understated price trends. Tr. I at 297-98. In that regard, to the extent that the CPI-U published as of October 1, 2025 is higher than what Blue Cross is allowed to include in its projected premium rates, Blue Cross is put at greater risk of having inadequate rates. *Id.* at 60; 297-98.

As set forth above, the relevant CPI-U for purposes of the allowed hospital rate increases for 2026 is not known at this time. Blue Cross has satisfied its burden to show that the 3.3% it projected to be published as of October 1, 2025 is reasonable and appropriate, particularly in light of the uncertainty around inflation (as forecasted in Blue Cross Ex. 5), and the fact that the CPI-U already has increased for the month of June (as reported on July 15, 2025). At minimum, it should not be the case that Blue Cross be required to use the CPI-U as of the date of the Rate Filing (2.8%), given that June CPI-U already has increased to 2.9%.

IV. BLUE CROSS'S METHODOLOGY IN PROJECTING THE REINSURANCE REIMBURSEMENT FOR 2026 IS REASONABLE AND SHOULD BE USED IN CALCULATING THE REQUESTED RATES.

Blue Cross's methodology in projecting the reinsurance reimbursement for 2026 in the Rate Filing is reasonable and should be adopted. The Rhode Island Reinsurance Program reimburses carriers for members whose total claims reach $30,000 in a given calendar year, with a cap of $60,000. *See* OHIC Ex. 33. To estimate the reinsurance payment it expects to receive for the 2026 calendar year, Blue Cross took its Individual Market claims by member for base year 2024 (applying a completion factor), applied the trend assumptions to get to the expected 2026 cost by member, and then applied the respective State Reinsurance parameters for 2026.

Tr. I at 113. In so doing, Blue Cross estimated that the receivable would be a PMPM of $45.38 for 2026. Blue Cross Ex. 1 at p. 3.

Blue Cross disagrees with Mr. Schultz's alternative methodology in incorporating additional factors to project a greater 2026 reinsurance payment to Blue Cross. *See* OHIC Ex. 1 at 24. Specifically, Mr. Schultz applies a morbidity factor to develop the projected reinsurance payment, which is a fundamental misreading of the impact of the expired tax credits on the market. The morbidity factor applied elsewhere in Blue Cross's Rate Filing (4.8%) assumes that more healthy members will leave Blue Cross when enhanced premium tax credits expire for the 2026 plan year. Said differently, the morbidity factor reflects the impact of *lower-cost members leaving* Blue Cross – not that more high-cost members (e.g. members with greater than $30,000 in claims expenses in a given year) are expected to join. Indeed, the lower cost members expected to leave Blue Cross are not the members that experience claims above the $30,000 threshold for reinsurance to apply. Tr. I at 115. Thus, applying the morbidity adjustment to project the reinsurance payment for 2026 (as Mr. Schultz has done) misunderstands that reinsurance is not impacted by the low-cost claims of those members expected to exit Blue Cross in 2026. *See id*. By contrast, Blue Cross appropriately applied the reinsurance parameters on a per member per year claim basis, without applying overall population/morbidity assumptions to this methodology, given that only claims greater than $30,000 count towards reinsurance. *Id*.

For these reasons, Blue Cross's methodology in projecting the 2026 reinsurance payment should be adopted as reasonable and appropriate and should not be rejected in favor of Mr. Schutlz's alternative methodology. Were Blue Cross required to apply this alternative methodology, Blue Cross estimates that this would result in a 0.3% decrease to the overall requested rate. Tr. I at 117.

V. BLUE CROSS APPROPRIATELY ESTIMATED THAT TARIFFS ARE LIKELY TO IMPACT 2062 PHARMACY COSTS IN PROJECTING PHARMACY COST TREND IN THE REQUESTED RATES.

In developing its pharmacy cost trend used in the Rate Filing, Blue Cross used actuarial judgment, in consultation with its pharmacy department and in review of external studies, to include a 3% adjustment to pharmacy cost trends attributed to tariffs. Tr. I at 86-87; Blue Cross Ex. 1 at p. 8.[25]

In arriving at that adjustment used in the Rate Filing, Blue Cross reviewed a report from Mercer, a national health analytics consulting firm, issued in April 2025, which discussed the impact of tariffs on healthcare costs. Tr. I. at 88-89; OHIC Ex. 22. As Mr. Mackintosh testified, that report cited to a "survey earlier in 2025 of 200 healthcare industry experts on their expectations around the potential inflation impacts to various sectors of the healthcare industry." *Id*. at 89; OHIC Ex. 22 at p. 2. The report found that "nearly 70 percent of those 200 respondents predicted *at least a 10 percent spike in pharmaceutical costs*, driven largely by U.S. dependence on Chinese imports for active pharmaceutical ingredients." *Id*. at 89; OHIC Ex. 22 at p. 2 (emphasis added). This survey suggests significant cost trend far exceeding what was built into the Rate Filing, which could render the rates inadequate.

Blue Cross disagrees with Mr. Schultz's suggestion that the tariff impact related to pharmaceuticals should be removed from the Rate Filing. Indeed, when asked about the rationale and basis for the statement in his report that the pharmaceutical industry "will have the ability to adapt by sourcing material from different suppliers or optimizing production

[25] Other than with respect to projecting the CPI-U which ties directly to hospital reimbursement for 2026, Blue Cross did not account for any other tariff-related impact in the Rate Filing. Tr. I at 87-88.

processes," he acknowledged that was "just me speculating …" Tr. I at 301. Mr. Schultz has acknowledged uncertainty related to the tariff impact, but in the same moment, resolves that uncertainty in favor of finding no impact, stating that "it's not unreasonable to assume that tariffs will have no material impact on future pharmacy costs." OHIC Ex. 1 at 19. On the other hand, while Dr. Whaley also agrees that there is uncertainty related to tariffs, he could not (and did not) quantify how Blue Cross should or should not treat that uncertainty any differently than it did in the Rate Filing. Tr. II at 415. Accordingly, the uncertainty related to tariffs should not be dismissed out of hand. Blue Cross's reasoned approach of assuming a 3% impact (far less than the 10% impact suggested by the Mercer survey) is more appropriate than Mr. Schultz's unsupported assumption that there will not be any impact at all. In this regard, Mr. Mackintosh testified that "even just the atmosphere of uncertainty around prices and potential tariff actions can, in fact, cause disruptions in the supply of the market and production that, in turn, could lead to increased prices." Tr. I at 92.

As Mr. Mackintosh further testified, to the extent that the tariffs associated with pharmaceuticals are greater than the 3% cost impact built into the Rate Filing, "that's going to directly impact our results and our ability to sustainably issue insurance." Tr. I at 89. If Blue Cross were nonetheless required to remove this adjustment related to the tariff impact on its projected pharmacy costs, Blue Cross estimates that this would result in a 1.3% decrease to the overall requested rate. *Id.* at 93.

VI. THE REQUESTED 3% CONTRIBUTION TO RESERVES IS REASONABLE AND APPROPRIATE AND SHOULD BE USED IN CALCULATING THE REQUESTED RATES.

Blue Cross's contribution to reserves in the Rate Filing is *particularly critical* for 2026, on the heels of significant losses in 2024 and with a forecast projecting additional losses for

2025.[26] Of note, there is no challenge to Blue Cross's inclusion of a 3% contribution to reserves in the Rate Filing. Tr. I at 221; 282, 314.[27] As was clear during the course of the Public Hearing, the parties each understand and agree that in establishing its rates Blue Cross is charged with enhancing the affordability of healthcare coverage while protecting its financial condition so that it can pay claims when they are due. The contribution to reserves is the primary way to protect Blue Cross's financial condition, and it allows for a margin of error with respect to the assumptions included in the Rate Filing. *Id*. at 285, 312.

As Mr. Mackintosh testified, reserves are a measure of risk-based capital (RBC) and SAPOR, which is reserves as a percent of revenue. *Id.* at 119-20. As of December 31, 2024, Blue Cross reported an RBC of 474%. *Id.* at 120. As of quarter 1 of 2025, the year-end forecast is slightly lower, at 472%. *Id.* at 121. With respect to SAPOR, Blue Cross reported that as of year-end 2024, it measured at 15%. *Id*. As of the first quarter of 2025, this also was lower, at 14%. *Id*. These figures are far below the range identified in the Lewin Report (OHIC Ex. 42) related to the amount of surplus necessary for Blue Cross to sustain. *Id*. at 121, 123. Blue Cross's RBC and SAPOR are at their *lowest values* in 10 years. *Id*. Moreover, at year-end 2024, Blue Cross had a net underwriting loss of $113 million. *Id*. at 124. To put that in context, the sum total of the prior nine years of operating losses and gains (2015-2023) was a $52 million gain. *Id.* at 125. Thus, one year of significantly higher claims costs than were collected in

[26] Historically, Blue Cross has sought a contribution to reserves between 2% to 4%. Tr. I at 140. During the COVID-19 pandemic, Blue Cross was approved for significantly lower contributions to reserves (one year at 1% and another year at 0%). *Id.* at 140. In 2025, in order to minimize the year-over-year rate impact of getting back to necessary contribution to reserves, Blue Cross filed for the lower 2% contribution in 2025, which was reduced to 1%. *Id.* at 139, 140. For 2026, it is critically necessary to fund the reserve pool, and, given the significant losses in 2024, there is not the benefit of time to gradually ramp back up to 3%. *Id.* at 140-41.

[27] Dr. Whaley did not challenge the contribution to reserves in his report or during his testimony. OAG Ex. A and Tr. II.

premium erased more than double the reserves of the prior nine years combined. *Id*. As Mr. Mackintosh testified, "despite the best intentions of the assumptions of the rate filings, the one guarantee is we will be wrong. And we will not nail it to the penny. And we try to minimize that error. But as we saw just in the most recent year, it can be quite extreme." *Id.* at 126.

Currently, Blue Cross's reserve level could pay provider medical and dental claims for fewer than 60 days. *Id*. at 120. It is not sustainable for Blue Cross to keep its reserves at the same dollar amount from year to year. *Id*. at 119. As the overall cost and utilization of healthcare increases, Blue Cross must ensure that its corresponding reserves also increase in dollar value, as well. *Id*. If the reserves stay constant, rather than increasing in accordance with how cost and utilization are increasing, they will ultimately cover fewer claims. *Id*.

Further supporting the need for the 3% contribution to reserves included in the Rate Filing is the fact that because the individual market is small and high risk, the margin of error in assumptions can be large. As Mr. Schultz agrees, to adequately project rates, assumptions and projections must be made and balanced. Tr. I at 126-27. Including a more aggressive assumption results in more financial risk to Blue Cross and its ability to cover claims costs. *Id.* at 127. In this regard, the alternative assumptions suggested by Mr. Schultz are aggressive, on top of the aggressive assumptions that Blue Cross has already included in the Rate Filing, compounding the risk of inadequate rates. *Id*.

As it stands today, Mr. Mackintosh testified that the 3% contribution to reserves included in this Rate Filing may still render the Rate Filing inadequate with respect to claim costs in 2026. *Id.* Mr. Mackintosh provided examples of some of the more aggressive assumptions Blue Cross included in the Rate Filing, including risks that Blue Cross could have: (1) underestimated the morbidity adjustment; (2) underestimated the gene therapy adjustment, (3) underestimated the

inpatient admission costs, and (4) underestimated the impact of tariffs, each of which adds risk to the Rate Filing. *Id.* at 128. The contribution to reserves is needed to appropriately balance against these aggressive assumptions in order to mitigate the risk that Blue Cross's rates are inadequate. Each of these are discussed further below.

i. Morbidity Assumption Could be Underestimated

The morbidity assumption included in the Rate Filing relates to the expiration of enhanced premium tax credits, where the expectation is that healthier members are more likely to disenroll. *Id*. at 45. Mr. Mackintosh testified that Blue Cross's internal modeling related to the anticipated morbidity of its 2026 population yielded a higher morbidity factor than was included in the Rate Filing, which could render the as-filed rates inadequate. *Id*. at 48-49. As Mr. Schultz acknowledged, that internal modeling showing a higher morbidity factor "adds some risk to the rates." *Id.* at 314.

In developing the morbidity assumption included in the Rate Filing, Blue Cross relied on a report by Wakely. *See* OHIC Exs. 32 and 33 (Ex. 33 is the Wakely report itself). The morbidity factor of 4.8% included in the Rate Filing was sourced directly from that report, which incorporates the assumption that healthier members are more likely to disenroll following the expiration of enhanced premium tax credits. *See id*. In this regard, Mr. Mackintosh testified that when enhanced premium tax credits were introduced, the market enrollment grew as newly eligible members had access to subsidized health insurance. Tr. I at 45-46. These newly enrolled members were generally healthier than existing members. With those enhanced tax credits expiring, Blue Cross expects generally to see that pattern reverse: now that members are no longer subsidized (or are subsidized to a lesser degree), some members will discontinue their coverage. Those members are likely to be healthier than average, leaving the 2026 population to

be sicker on average than the overall population would have been had those tax credits continued into 2026. *Id*.

In assessing the morbidity factor in the Wakely report, Blue Cross conducted its own analysis related to the enrollment loss assumptions for 2026. *Id.* at 47-48. As of January 2025, Blue Cross had approximately 6,200 enrollees who received some amount of premium tax credits. OHIC Ex. 32. Blue Cross anticipated that approximately 15–25% of these members would be at risk of disenrollment in the absence of enhanced premium tax credits, corresponding to a range of 900 to 1,500 members.[28] For modeling purposes, Blue Cross used the midpoint of 1,200 members to reflect a reasonable expectation of disenrollment and modeled the disenrollment of 1,200 of the bottom 90th percentile lowest-cost members receiving the enhanced premium tax credits. *Id*. This internal modeling yielded a morbidity increase of approximately 5.2% to 7.0%, which is higher than the 4.8% morbidity assumption in the Rate Filing.[29] Tr. I at 48. As a result, and as Mr. Schutlz agreed, the morbidity factor that Blue Cross assumed in the Rate Filing related to the expiration of the enhanced premium tax credits, may underestimate the risk associated with the expected population change, thereby rendering the rates as filed inadequate. *Id*. at 48-49.

During the Public Hearing, the Commissioner inquired whether the morbidity assumption incorporated in the Rate Filing accounted for the provision within the Rhode Island tax code that applies a penalty to individuals who do not maintain health coverage. Tr. I at 181. Both Mr. Mackintosh and Mr. Schultz testified that they did not know off-hand whether the analysis conducted by Wakely accounted for that consideration. *Id.* at 181, 322. An additional review of

[28] That figure is based off of the State's affordability study, which estimated a 17% reduction in membership for 2026 if the enhanced premium tax credits were eliminated. OAG Ex. 5 at 9.
[29] *See* OHIC Ex. 43 for the internal modeling that was conducted.

the Wakely report reveals that this factor must have been incorporated, however. In the report's scenario assuming that the enhanced premium tax credits continue, there is an assumption of State funding available in the amount of $5,029,349. By contrast, in the scenario where these tax credits expire, the State funding amount *increases* to $5,672,501. Given that the State funding is comprised of the tax penalty for not having coverage, it is reasonable to conclude that the analysis accounted for member enrollment decisions being impacted by the tax penalty. *See* OHIC Ex. 33.

ii. Gene Therapy Assumption Could be Underestimated

Additionally, there is a risk that the as-filed rates are inadequate due to potential gene therapy claims that exceed the adjustment applied in the Rate Filing. As Mr. Mackintosh testified, gene therapy is an emerging "extremely high dollar" treatment, with the pipeline of drugs expanding every year, as well as the population of candidates expanding, as well. Tr. I at 134. The "cheapest gene therapy on the market is just under $1 million, and it can range to several million dollars for just one claim." *Id.* at 135-36.

In developing the gene therapy factor in the Rate Filing, Blue Cross began with a report from its Pharmacy Benefits Manager (PBM), which identified, by market segment, the number of members found to be potential candidates for each gene therapy drug. *Id*. at 134-35. Blue Cross used actuarial judgment to then reduce the final utilization assumption by 90% relative to that candidate list for the individual market, acknowledging that there are complex clinical and member decisions involved in whether to pursue a gene therapy treatment. *Id.* at 135.

However, as Mr. Mackintosh testified, there is a potential for significantly higher costs and utilization for these gene therapy treatments, including the fact that Blue Cross did not account for the buildup costs associated with undergoing these treatments, which include

hundreds of thousands of additional dollars for each treatment. *Id*. at 137-38. Moreover, at the time of the Rate Filing, there had not been any utilization of gene therapy treatments by Blue Cross membership. *Id*. at 136. By the time of the Public Hearing, however, Blue Cross had seen a member initiate the gene therapy treatment process in the fully-insured market. *Id.* at 137. Given Blue Cross's membership size and premium rates, every $1.5M is nearly 1% in revenue. *Id*. at 136. As Mr. Mackintosh testified, this means that each additional gene therapy claim outside of what was anticipated in developing the Rate Filing renders the Rate Filing 1% deficient due to that single claim.[30] *Id.* Underestimating the likelihood of these types of claims therefore brings more than the typical risk of misjudging future claims.

iii. Inpatient Utilization Trend Could be Underestimated

Further underscoring the need for reserves is the fact that the inpatient utilization trend used in the Rate Filing may not sufficiently account for the increasing costs of inpatient admissions, thereby adding risk that the as-filed rates are not adequate. *Id.* at 133. Mr. Mackintosh explained that when looking at Blue Cross's claim utilization, the number of inpatient claims over $150,000 has ramped up in recent years. *Id.* at 130-31, 132. *See* OHIC Ex. 29. In developing the utilization trend, while the *number* of inpatient admissions is counted, the *dollar value* of those admissions is not included in the trend. *Id.* at 130. Thus, to the extent that inpatient admissions are at a higher cost now than in the prior 13-point regression trend used in the Rate Filing, there is a risk that the filing estimate is understated, rendering the requested rate inadequate. *Id.* at 131. Indeed, with the impact as stated above, just two of these inpatient

[30] As Mr. Mackintosh testified, Blue Cross does not anticipate receiving any rebates or discounts related to these drugs, nor any offset related to other treatments for 2026. Tr. I at 138. Neither Mr. Schultz nor Dr. Whaley challenged Blue Cross's assumptions related to gene therapy.

admissions in the $500k-$1M bucket would wipe away 1% of the contribution to reserves. *Id.* at 132-33.

iv. The Tariff Impact Could be Underestimated

Mr. Mackintosh further testified that another aggressive assumption included in the Rate Filing relates to the impact of tariffs, which was *only* accounted for with respect to pharmacy costs, and even so, only that those costs would increase by 3%. *Id.* at 129. Blue Cross did not account for the impact of tariffs on medical or administrative costs, and did not include medical supplies, such as durable medical equipment, and personal protective equipment, which is often outsourced from countries outside of the United States. *Id.* at 129-30. Anything greater than a 0% impact related to tariffs as to any other aspect of the Rate Filing would add increased risk to the Rate Filing, rendering the as-filed rates inadequate. Moreover, as discussed above, the 3% tariff impact related to pharmacy costs may be underestimated on its own, given studies showing that impact could be up to 10%.

Finally, in assessing the reasonableness of the contribution to reserves, it is important that the alternative methodologies and assumptions to other aspects of the Rate Filing proffered by Mr. Schultz to further decrease the rate be evaluated in the context of the full Rate Filing, where a 3% contribution to reserves likely cannot absorb an additional risk load. *Id*. at 127. To the extent that Blue Cross is instructed to incorporate the more aggressive assumptions proffered by Mr. Schultz into its rates, the corresponding rate impact could be insufficient to cover Blue Cross's claim expenses. *Id.* Currently, Blue Cross is projecting losses in this market for 2025, and was allowed only a 1% contribution to reserves for its 2025 rates. *Id*. at 139. On the heels of significant losses in 2024 and projected losses in 2025, Blue Cross could again be facing inadequate rates in 2026. In this regard, any additional requirement that Blue Cross also reduce

its contribution to reserves could impact Blue Cross's ability to absorb losses and pay the claims of its members.

For all of these reasons, Blue Cross has demonstrated that its requested contribution to reserves of 3% is reasonable and appropriate – in fact, it is particularly critical for 2026 – and must not be reduced.

VII. BLUE CROSS'S DEVELOPMENT OF ITS PROFESSIONAL COST TRENDS TO INCLUDE THE NEW REQUIREMENT RELATED TO PCP SPEND IN THE AFFORDABILITY REGULATION FOR PLAN YEARS 2025 AND 2026 IS REASONABLE AND APPROPRIATE.

There is no dispute among the parties regarding Blue Cross's development of its professional cost trend, which included a projected increase in fees needed to meet the PCP spending targets set forth in the OHIC Affordability Regulation, 230-RICR-20-30-4.[31] *See* OHIC Ex. 1 at 17-18 (wherein Mr. Schutlz stated that he reviewed Blue Cross's professional cost trends, including the projections related to the PCP spend requirements, and determined that the methodology and resulting assumptions were reasonable).[32]

As Mr. Mackintosh testified, this newly enacted regulation requires carriers to increase their PCP spend targets by 0.5% for 2025, and for the 2026 year, increase that by at least 1% relative to 2025, modeled off of the 2022 benchmark year. Tr. I at 73-74. To determine these amounts, Blue Cross projected estimated spend for both years under current cost and utilization trend assumptions, prior to any adjustment for this regulation. *Id.* at 74. Then, Blue Cross evaluated what the PCP total medical expense percentage would be under the regulation's scenario in each year, in order to comply with the required total medical expense targets. *Id.*

[31] OHIC Ex. 124 is the pdf of the referenced regulation.
[32] In neither his report nor in his testimony did Dr. Whaley challenge Blue Cross's development of this cost trend. *See* OAG Ex. A and Tr. II.

Blue Cross then calculated the additional dollars needed to be allocated to the PCP spend in order to meet the regulation's requirements for each year (2025 and 2026), and added that into the assumed professional cost factors. *Id.* at 75. To capture the required additional spend for 2025 (which was not built into the 2025 rates), Blue Cross added that component of increased spend to its contribution to reserves in the amount of 1.2%, in addition to the contribution to reserves that is needed on its own. Tr. I at 75 -76. Mr. Schultz does not challenge that development, finding "the methodology that was used and the resulting adjustment to be reasonable." OHIC Ex. 1 at 26-27.

The inclusion of the additional PCP spend increases the overall requested rate in the Rate Filing by 4.6% in total. Tr. I at 78. Blue Cross appreciates that there are longer term considerations that potentially could be employed to satisfy the PCP spend obligations without increasing fee schedules for PCPs (and thereby premium), including by directing care to PCPs or by reducing overall medical spend. However, given the truncated time for compliance with this recently enacted regulation, these alternatives would not have had a material impact on PCP spend for 2025 and 2026. Additionally, given the PCP access concerns facing Rhode Island, Blue Cross does expect there to be a greater volume of PCP visits in the short term for 2025 and 2026 that would otherwise allow it to achieve the spend requirements.

As demonstrated in the Rate Filing, and during the Public Hearing, there is no reason to depart from Blue Cross's sound and reasonable methodology in developing these professional costs included in the Rate Filing.

VIII. BLUE CROSS'S DEVELOPMENT OF ITS PHARMACY COST TRENDS RELATED TO GLP-1s IS REASONABLE AND APPROPRIATE.

There is no dispute among the actuaries that Blue Cross's pharmacy cost projection related to GLP-1s is reasonable and appropriate. OHIC Ex. 1 at 18; Tr. I at 246-47. As Mr.

Schultz agrees, Blue Cross has demonstrated the reasonableness of the factors incorporated in its pharmacy cost projection related to GLP-1s. *Id.* There is no reason to reject or modify Blue Cross's pharmacy cost trend in this regard.

Dr. Whaley's report nonetheless identifies GLP-1s as an area where spending might be reduced, stating that increased use of GLP-1s "may lead to longer term reductions in overall spending." OAG Ex. A at 5. This view is irrelevant to Blue Cross's methodologies, assumptions, and rate development. Indeed, Dr. Whaley has presented no evidence that any such alleged reductions in overall spending would occur at all, let alone during 2026 – the applicable rate year. Tr. II at 402, 403. He further concedes that he has not reviewed Blue Cross's Rate Filing with the requisite level of detail to understand how Blue Cross's methodology in developing the factors for GLP-1s already accounts for underlying utilization and costs. *Id.* at 405, 515 (testifying that he did not examine whether adherence to these drugs results in offsets to Blue Cross's medical spending). He further conceded that he did not (and cannot) quantify how the discussion on GLP-1s in his report would or should impact the Rate Filing. *Id.* at 398, 404, 513. Moreover, the articles appended to Dr. Whaley's report relate to the use of GLP-1s for obesity treatment, which is not a covered treatment by Blue Cross, and are therefore completely irrelevant here. They provide no support for the notion (which is speculative at best) that 2026 would see any offset from use of GLP-1s for covered treatment of diabetes in medical and utilization trends that has not been rated for in the Rate Filing.

To the extent that Dr. Whaley's report proffers that Blue Cross's development of its pharmacy cost trends related to GLP-1s is incorrect or deficient, that position should be rejected.

CONCLUSION

For the reasons stated above, Blue Cross has satisfied its burden to show that the

requested rates for 2026 are consistent with the proper conduct of its business and in the interests of the public. Blue Cross therefore respectfully requests that the Commissioner approve its requested rates for 2026: 28.6% (which includes the agreed-to modifications to update the claim base runout period through May 2025 and to remove the previously anticipated 340b legislation impact from its pharmacy cost trend projections, as well as accounting for the impact related to the recently-passed legislation at R.I. Gen. Laws 42-7.4-3(c)).

Respectfully submitted,

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Dated: July 30, 2025

CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of July 2025, a copy of the foregoing Post-Hearing Memorandum was sent via electronic mail to:

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