

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF THE HEALTH INSURANCE COMMISSIONER  
233 RICHMOND STREET  
PROVIDENCE, RHODE ISLAND 02903**

***In re:* Blue Cross & Blue Shield of  
Rhode Island—Class DIR**

**HIC No. 06-RH-01**

**(Filed November 20, 2006)**

**RECOMMENDATION OF THE HEARING OFFICER**

In response to the November 20, 2006 request of Blue Cross & Blue Shield of Rhode Island (Blue Cross) for approval of subscription rates for Direct Pay members<sup>1</sup> in Class DIR Basic (Pool I) and Preferred (Pool II) programs and after full consideration of the evidence presented at a hearing and the applicable statutes and regulations, I recommend that the rate increase for Pool I be modified to 5.0% and the rate increase for Pool II be modified to 1.9%. The bases for these recommendations are set forth more fully below.

In addition, I also make the following recommendations to the Commissioner:

1. The Direct Pay rating process include a target loss ratio of 70% for Pool II;
2. At approximately six months into the new rate period, Blue Cross should report to the Commissioner its expected Premium Assistance Program take-up and, if the take up is not expected to fully use the projected \$1.5 million in assistance funds, Blue Cross should be prepared to demonstrate that it has taken reasonable steps to (a) publicize the program to its existing members as well as potential members, (b) provide members and potential members with sufficient information about the program and the application process and (c) ensure that a process in place to answer questions about the program and resolve problems arising in its administration. Should Blue Cross fail to meet these standards, the Commissioner should consider appropriate administrative action;
3. Blue Cross should be urged to examine its Medical Underwriting standards for Pool II to ensure that they are not too strict;
4. Blue Cross should take steps to ensure that its Pool I customers understand the circumstances that caused them to be enrolled in Pool I and how and when those

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<sup>1</sup> For ease of reading, throughout this Recommendation I have used the word “member” to refer to both Direct Pay subscribers and members.

customers might become eligible to migrate to Pool II, if such migration is a possibility; and

5. Blue Cross should consider a undertaking comprehensive evaluation or assessment of its customer service/sales staff operations to ensure that consumer issues are fully addressed and that the full range of available options are made known to inquiring consumers.

***Appearances:***

Charles C. DeWeese, consulting actuary, Office of the Health Insurance Commissioner.

Normand G. Benoit for Blue Cross & Blue Shield of Rhode Island.

Genevieve M. Martin and Brenda K. Gaynor for the Department of the Attorney General.

**I. INTRODUCTION**

On November 20, 2006, Blue Cross filed a request for approval of rate increases for its four Direct Pay products. The Blue Cross Direct Pay products provide health insurance coverage for persons and families not eligible for employer-based or state or federal health insurance programs. Enrollment is on a non-group basis either through direct application to Blue Cross or through conversion from prior group (i.e., employer-based) coverage. There are about 14,300 members in the Direct Pay class.<sup>2</sup>

Two rating pools are used for Direct Pay.<sup>3</sup> One rating pool, Pool I, applies community rates, which vary only by family status and by whether or not a member is over age 65. The other pool, Pool II, applies rates based on the age, gender and family status of an applicant. In order to qualify for Pool II, an applicant must pass a medical screen. An annual open enrollment period is conducted for Pool I, while enrollment in Pool II is available continuously throughout the year.

Individuals and families seeking Direct Pay coverage who either (1) do not submit a questionnaire or (2) submit the screening questionnaire but do not meet Blue Cross' medical

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<sup>2</sup> BC Ex. 1 at 9.

<sup>3</sup> Forty-five percent of Direct Pay members are in Pool II and fifty-five percent are in Pool I. Id.

underwriting guidelines are assigned to Pool I. Pool I members generally are expected to require a higher level of medical services, thus Pool I rates are higher than those for Pool II. In order to maintain lower rates for the Pool I population, Pool I's rates are subsidized in part by Pool II premiums.

The four Direct Pay products offered by Blue Cross are HealthMate Coast-to-Coast Direct 400/800 (HM 400), HealthMate Coast-to-Coast Direct 2000/4000 (HM 2000), HealthMate for HSA Direct Plan 3000/6000 (HM for HSA 3000) and HealthMate for HSA Direct Plan 5000/10000 (HM for HSA 5000). The features of these products have been described in detail in the previous Direct Pay Order and Decision and thus will not be described here again.<sup>4</sup>

The Filing proposes premium rates effective April 1, 2007 for the four existing Blue Cross Direct Pay products. The overall average rate increase for someone not aging into a new age bracket is 7.8%. Proposed Pool I rates and Pool II rates for members age 65 and over are proposed to increase by 8.9%. The rate increase proposed for Pool II members under age 65 rate increases vary by age, gender and single or family coverage but range from 5.3% to 5.5%.

The rates proposed by Blue Cross for these products are as follows:

**Basic (Pool I) Monthly Rates**

<b>Age</b>	<b>Category</b>	<b>HM 400</b>	<b>HM 2000</b>	<b>HM for HSA 3000</b>	<b>HM for HSA 5000</b>
Under 65	Individual	\$617.72	\$464.23	\$397.84	\$314.32
	Family	\$1,168.10	\$878.94	\$753.86	\$596.50
65 and over	Individual	\$969.74	\$728.35	\$623.94	\$492.57
	Family	\$1,834.51	\$1,378.93	\$1,181.88	\$933.96

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<sup>4</sup> See, e.g., *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, HIC No. 05-RH-02 (Feb. 20, 2006) [hereinafter 2006 Direct Pay Decision]. Indeed, many aspects of this filing and the details of the Direct Pay line of products are similar to or identical to last year's filing. Thus, revisiting many of those details is unnecessary.

**Preferred (Pool II) Monthly Rates**

<b>Age</b>	<b>Category</b>	<b>HM 400</b>	<b>HM 2000</b>	<b>HM for HSA 3000</b>	<b>HM for HSA 5000</b>
Under 25	Male	\$185.44	\$139.90	\$120.20	\$95.41
	Female	\$258.07	\$194.40	\$166.85	\$132.20
	Family	\$621.21	\$468.62	\$402.62	\$319.57
25-29	Male	\$204.78	\$154.21	\$132.62	\$105.21
	Female	\$292.02	\$219.87	\$188.66	\$149.39
	Family	\$694.63	\$523.71	\$449.78	\$356.75
30-34	Male	\$232.81	\$175.44	\$150.63	\$119.40
	Female	\$346.50	\$260.75	\$223.65	\$176.97
	Family	\$736.08	\$554.81	\$476.40	\$377.74
35-39	Male	\$265.97	\$200.32	\$171.92	\$136.19
	Female	\$343.74	\$258.67	\$221.87	\$175.57
	Family	\$776.35	\$585.02	\$502.26	\$398.13
40-44	Male	\$284.13	\$213.95	\$183.59	\$145.39
	Female	\$375.71	\$282.66	\$242.41	\$191.77
	Family	\$793.32	\$597.76	\$513.16	\$406.72
45-49	Male	\$342.95	\$258.08	\$221.37	\$175.17
	Female	\$415.98	\$312.87	\$268.27	\$212.16
	Family	\$835.56	\$629.45	\$540.29	\$428.11
50-54	Male	\$433.74	\$326.20	\$279.68	\$221.15
	Female	\$485.46	\$365.00	\$312.90	\$247.34
	Family	\$929.52	\$699.95	\$600.64	\$475.69
55-59	Male	\$544.93	\$417.13	\$357.52	\$282.52
	Female	\$553.75	\$416.25	\$356.76	\$281.92
	Family	\$1,039.26	\$782.29	\$671.12	\$531.26
60-64	Male	\$593.23	\$445.86	\$382.12	\$301.91
	Female	\$593.23	\$445.86	\$382.12	\$301.91
	Family	\$1,128.48	\$849.23	\$728.43	\$576.44
65 and over	Male	\$969.74	\$728.35	\$623.94	\$492.57
	Female	\$969.74	\$728.35	\$623.94	\$492.57
	Family	\$1,834.51	\$1,378.93	\$1,181.88	\$933.96

In addition, Blue Cross offers a premium assistance program (PAP) for low-income Direct Pay members. Because fewer than expected Direct Pay members enrolled in the PAP, changes were made to enhance program take-up. Those changes include extending eligibility to Pool II

members (the PAP was previously restricted to Pool I members), increasing the premium subsidy by 20%, and raising the income eligibility cap from 300% of the Federal Poverty Level (FPL) to 350% of the FPL. Blue Cross estimates that it will provide PAP subsidies of about \$1.5 million during this rate year.

## **II. THE HEARING**

### **A. Jurisdiction**

The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

### **B. Hearing Officer**

On January 29, 2007 the Health Insurance Commissioner entered an Order appointing the undersigned Hearing Officer.

### **C. Notice of the Hearing**

The parties agreed to a hearing date and notice of the filing and the hearing thereon was published in *The Providence Journal*, a newspaper of general circulation, on Thursday January 11, 2007.<sup>5</sup> Individual notice of the filing and the hearing was provided to Direct Pay members.<sup>6</sup>

### **D. Prefiled Testimony and Exhibits**

The Following Exhibits were entered into the record:

Joint Ex. 1      Notice of Filing and Hearing

#### Blue Cross Exhibits

BC Ex. 1      Prefiled direct testimony of John Lynch

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<sup>5</sup> Joint Ex. 1.

<sup>6</sup> Tr. I at 42.

- BC Ex. 2 Letter dated November 20, 2006 to Commissioner Koller from John Lynch requesting approval of rates by Blue Cross for its Direct Pay products
- BC Ex. 3 Actuarial schedules and supporting calculations submitted in support of Blue Cross' request for approval of rates by for its Direct Pay products
- BC Ex. 4 Letter dated November 6, 2006 to John Lynch of Blue Cross from James A. Dunlap and George N. Berry of Milliman regarding the development of benefit richness factors
- BC Ex. 5 Prefiled direct testimony of Thomas A. Boyd
- BC Ex. 6 Blue Cross' Cost Accounting Manual
- BC Ex. 7 Blue Cross' Cost Accounting System Overview
- BC Ex. 8 Comparison of calendar year 2007 Direct Pay budget to calendar year 2006 estimated actual Direct Pay budget by natural account
- BC Ex. 9 Comparison of calendar year 2008 Direct Pay budget to calendar year 2007 Direct Pay budget by natural account
- BC Ex. 10 Narrative of calendar year 2006 Class DIR budget
- BC Ex. 11 Interim Affordability Report dated January 24, 2007
- BC Ex. 12 Rebuttal actuarial analysis
- BC Ex. 13 Medical Management Savings for 2005

AG Exhibits

- AG Ex. A Prefiled direct testimony of Barbara Niehus
- AG Ex. B Curriculum Vitae of Barbara Niehus
- AG Ex. C Analysis of Completion Factors Direct Pay Blue Standard
- AG Ex. D Responses to Data Requests
- AG Ex. E Responses to Data Requests
- AG Ex. F Direct Pay Actuarial Schedules Filed By Blue Cross for 2006 Direct Pay Hearing
- AG Ex. G Responses to Data Requests
- AG Ex. H Supplemental Direct Testimony of Barbara Niehus

OHIC Exhibits

- OHIC Ex. 1 Five-Year Historical Data, 2005 Annual Statement of Blue Cross
- OHIC Ex. 2 Five-Year Historical Data, 2005 Annual Statement of Blue Cross
- OHIC Ex. 3 Five-Year Historical Data, 2004 Annual Statement of Coordinated Health Partners
- OHIC Ex. 4 Five-Year Historical Data, 1999 Annual Statement of Coordinated Health Partners
- OHIC Ex. 5 Analysis of Operations By Lines of Business, 1999-2004 Annual Statements of Coordinated Health Partners
- OHIC Ex. 6 Analysis of Operations By Lines of Business, 2000-2005 Annual Statements of Blue Cross

**E. Witnesses at the Hearing**

The following witnesses provided live testimony at the hearing:

Blue Cross

<i>Name</i>	<i>Subject of Testimony</i>
John Lynch	(actuarial support for the rates requested)
Thomas Boyd	(Direct Pay program issues, management of the Direct Pay program and affordability issues)
Kimberly Holway	(Direct Pay customer service)
David Fogerty	(administrative costs)
Augustine Manocchia	(affordability issues)
Virginia Levi	(Direct Pay customer service)

The AG

<i>Name</i>	<i>Subject of Testimony</i>
Barbara Niehus	(actuarial support for the AG's position)

## **F. Public Comment**

Public comment was received in the form of emails, letters and testimony at the hearing. Approximately 89 emails and letters were received by the OHIC and nine persons provided comment during the hearing.

## **G. Positions of the AG and the Public**

### The AG

The AG disputed some aspects of Blue Cross' filing and did not dispute others. In general, the issues raised by the AG were as follows:

1. Blue Cross should define and adhere to a strategy for managing the relationship between the rates for Pool I and Pool II. Pool II provides a subsidy for Pool I, but the exact subsidy amount varies from year to year. The AG recommends that Blue Cross develop rates for the Direct Pay market based on full credibility to Pool II results and applying a target loss ratio of 70% for Pool II.
2. Blue Cross improperly analyzed the value of the benefit plans instituted in the 2006 premium year. This resulted in Pool II members paying rates that were too high in relation to rates paid by Pool I members. Since Blue Cross uses the same methodology for calculating the rates proposed in this filing, the rates for Pool II members are again too high in relation to the rates proposed to be paid by Pool I members.
3. The rate increases requested in this filing are too high. Blue Cross has requested rate increases of 8.9% for Pool I and 5.4% for Pool II. The proposed rate changes should be a rate increase of 6.7% for Pool I and a rate decrease of 1.9% for Pool II.

4. The AG suggests that the medical underwriting standards for Pool II are too high. Lowering the underwriting standards for Pool II would shift some of the healthier members currently in Pool I to Pool II.
5. Blue Cross significantly overstated the cost of paying subsidies under the Premium Assistance Program in the 2005 Class DIR Filing, and has again overstated that cost in this Filing. If Blue Cross is committed to paying \$1,500,000 in subsidies, then the amount of the proposed subsidies should be increased by an additional 15%.
6. Blue Cross has done a poor job of monitoring and measuring its “Affordability Initiatives” as set out in its Affordability Report. Specifically, Blue Cross appears to have no objective standards in place to measure the costs and benefits of each initiative.

#### Public Comment

The public comment was overwhelmingly opposed to the proposed rate increases. In general, the public comment touched on or more of the following:

1. Blue Cross received a rate increase last year and should not get one this year;
2. Blue Cross executives are overpaid (and suggesting that if executive salaries were reduced, then rates might be reduced or not increased);
3. Waste in Blue Cross’ administration of its programs should be eliminated (again suggesting that this might affect rates);
4. Direct Pay members are at a disadvantage because they are not members of a group; and
5. Quinquennial rate changes by age are unfair.

### III. STANDARD OF REVIEW

The rates requested by Blue Cross must be “consistent with the proper conduct of the applicant’s business and with the interest of the public . . . .”<sup>7</sup> In 2004 the Rhode Island General Assembly established the meaning of “proper conduct of the applicant’s business” with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*<sup>8</sup> They decreed that Blue Cross’ mission includes providing “affordable and accessible health insurance to insureds”<sup>9</sup> and “affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals.”<sup>10</sup> The Board of Directors was specifically charged with “ensuring that the corporation effectively carries out the charitable mission for which it was incorporated . . . .” Under the new law, Blue Cross must also “employ pricing strategies that enhance the affordability of health care coverage . . . .”<sup>11</sup> These newly enacted legislative directives make clear that the “proper conduct of the applicant’s business” is no longer left solely to the management’s discretion unless that discretion is exercised to provide “affordable” and “accessible” health insurance.<sup>12</sup>

In addition, the 2004 legislation empowered the OHIC to review Blue Cross’ administrative costs and determine the reasonableness of such costs.<sup>13</sup> Blue Cross, therefore, has the burden of providing detailed information and justification for all administrative expenses in its rate filings if it is to satisfy the requirements of R.I. Gen. Laws § 42-14.5-3.

The General Assembly also mandated that the OHIC discharge its powers and duties to:

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<sup>7</sup> R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

<sup>8</sup> See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff’d*, *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

<sup>9</sup> R.I. Gen. Laws § 27-19.2-3(1).

<sup>10</sup> R.I. Gen. Laws § 27-19.2-3(5).

<sup>11</sup> R.I. Gen. Laws § 27-19.2-10(3).

<sup>12</sup> *Id.*

<sup>13</sup> R.I. Gen. Laws § 42-14.5-3(b) (“[T]he commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs.”).

- (a) Guard the solvency of health insurers;
- (b) Protect the interests of consumers;
- (c) Encourage fair treatment of health care providers;
- (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.<sup>14</sup>

Accordingly, the Commissioner's decision in this matter must take these factors into account.

The Commissioner may approve, disapprove, or modify the rates proposed by Blue Cross.<sup>15</sup>

#### **IV. FINDINGS OF FACT**

After full consideration of the issues raised in the public comment, the exhibits and testimony offered at the public hearing, the documents and papers submitted by Blue Cross and the AG, the analysis provided by the OHIC's consulting actuary, and a review of other relevant administrative materials in the OHIC's files, I make the following findings of fact:

1. The preceding sections I through III of this Recommendation are incorporated into these Findings of Fact.
2. On November 20, 2006, Blue Cross filed a request with the OHIC for a rate increase for its Direct Pay products. The filing contained new rates to become effective April 1, 2007.<sup>16</sup>
3. Blue Cross provided a copy of the filing of the proposed rates to the Insurance Advocacy Unit of the Attorney General's Office.
4. The filing was advertised in *The Providence Journal* on January 11, 2007.<sup>17</sup>

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<sup>14</sup> R.I. Gen. Laws § 42-14.5-2 (the OHIC Statute). See also OHIC Regulation 2.

<sup>15</sup> R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

<sup>16</sup> BC. Ex. 2.

<sup>17</sup> Joint Ex. 1.

5. Blue Cross provided by mail, at least ten days prior to the commencement of hearings, written notice of the proposed rate increase for the Direct Pay class to members.<sup>18</sup>
6. Members of the public provided comments to OHIC prior to the hearing through correspondence and through e-mails.
7. Public hearings were held on February 1, February 2 and February 5, 2007.
8. Public comment was taken at the hearing.
9. Blue Cross and the AG were given a full opportunity to provide testimony in support of their respective positions.

#### **A. The Filing**

10. The average rate increase sought in the filing is 7.8% (8.9% for Pool I members and 5.4% for Pool II members).<sup>19</sup>
11. Current rates have been in place since April 1, 2006, and unless a member ages into a higher age bracket, the new rates are to be in place for all members for the one-year rating period ending March 31, 2008.<sup>20</sup>
12. No significant product changes have been proposed. Blue Cross significantly changed its Direct Pay product line last year and increased its rates substantially. The average rate increase was in the 20-30% range, with somewhat larger increases for Pool I members. In addition, there was a generally higher cost-sharing component for the new products.<sup>21</sup> The products offered this year are essentially the same as were offered last year. Those products are HealthMate Coast-to-Coast Direct 400/800, HealthMate Coast-to-Coast Direct

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<sup>18</sup> Tr. I at 42.

<sup>19</sup> BC Ex. 2.

<sup>20</sup> Id.

<sup>21</sup> See 2006 Direct Pay Decision.

2000/4000, HealthMate for HSA Direct Plan 3000/6000 and HealthMate for HSA Direct Plan 5000/10000.<sup>22</sup>

13. Blue Cross also has a Premium Assistance Program (PAP). Certain changes have been made to the PAP this year. First, Blue Cross has committed to set aside an additional \$4.5 million for the PAP to provide for its continuance in future years. Second, Blue Cross has indicated that effective April 1, 2007, it will make changes to the operation of the program. Those changes involve opening the program to Pool II members, increasing the program's income eligibility limit from 300% of the federal poverty level to 350%, and increasing the monthly dollar amount of premium assistance by 20% for each member receiving assistance.<sup>23</sup>

#### **B. Rate Evaluation**

14. Blue Cross has projected its rate need by analyzing its experience for the Direct Pay plan year April 1, 2005-March 31, 2006 and projecting it forward for two years using price and utilization trend factors that are separate by major care component (Inpatient, Outpatient, Medical/Surgical and Prescription Drug).<sup>24</sup>
15. The proposed rate increase also includes a contribution to surplus<sup>25</sup> plus taxes on that contribution. The surplus contribution and taxes account for roughly one-third of the proposed increase, or 2.5% of the 7.8% sought.<sup>26</sup>

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<sup>22</sup> BC Ex. 2.

<sup>23</sup> BC Ex. 11; BC Ex. 5 at 51-55.

<sup>24</sup> See generally BC Ex. 1 and BC Ex. 3.

<sup>25</sup> In its filing Blue Cross has used the term "reserves." For ease of reading, throughout this Recommendation I have used the word "surplus."

<sup>26</sup> Id.

16. The per member per month administrative costs have declined from the prior filing so that the administrative component of the filing does not play a role in any increase in the rates.<sup>27</sup>
17. The trend factors Blue Cross has used are reasonable. They are relatively consistent with factors filed for use in connection with Blue Cross's large group business, and result in a slightly lower aggregate trend factor (approximately 9.25%, as compared to an average of approximately 9.6% in its most recent large group rate filing). In addition, these trend factors are on the low end of recent trend factors in the small group market that have been observed by the OHIC's consulting actuary in Massachusetts, and are lower than trend factors filed by United Healthcare in its most recent large group rate filing.
18. Ms. Niehus did not dispute Blue Cross' trend factors.
19. When calculating its proposed rates, Blue Cross added the cost of various benefit mandates, new technologies and state assessments that are not included in the Direct Pay experience base. These add approximately 1.2% to the cost of care.<sup>28</sup> The demonstration of these additions is reasonable, and not disputed by Ms. Niehus.
20. Blue Cross based its experience period claims on the old benefit plans (benefit plans in place during the 2005 premium year). Blue Cross then adjusted its projections to the new benefit plans based on analysis of the relative payments under the new plans and benefit richness factors to adjust for the deterrent effect of the higher cost sharing required by the new plans as compared to the old plans.<sup>29</sup>

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<sup>27</sup> Tr. III at 18.

<sup>28</sup> BC Ex. 3, schedules 23-31.

<sup>29</sup> BC Ex. 1 at 13-16.

21. Blue Cross then estimated the relative split between Pool I and Pool II claims, and adjusted the overall projected rate increase need between Pool I and Pool II.<sup>30</sup>
22. This process resulted in a rate increase request of 8.9% for Pool I and 5.4% for Pool II and an overall increase of 7.8% for the two pools combined.<sup>31</sup>
23. Blue Cross followed methods for determining and projecting price, utilization and mix that are generally consistent with those of its prior rate filings.
24. The filing also uses a budgetary approach on operating expenses consistent with past directives of the OHIC, and its predecessor, the Department of Business Regulation.
25. Ms. Niehus noted that this filing request is based on experience under the old benefit programs, and has suggested that it would be preferable to adjust this filing to reflect the experience under the new benefit programs. In her prefiled testimony, she made calculations using six months worth of incurred claims and including runout for an additional two months, through November 2006.<sup>32</sup>
26. These calculations were the second in a series of actuarial disputes based on claims data with differing end points in time. When Blue Cross made its filing, claims data was only available through October 2006 (the October 2006 data). When Blue Cross produced data to the AG in preparation for the hearing, data was available through November 2006 (the November 2006 data). Finally, during the hearing, Blue Cross provided additional evidence based on data available through December 2006 (the December 2006 data). The AG's actuary was provided an opportunity to review that additional data and provide additional testimony.

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<sup>30</sup> Id. at 15.

<sup>31</sup> BC Ex. 2.

<sup>32</sup> AG Ex. A at 19-24.

27. Ms. Niehus' review and analysis of the partial year data was a very worthwhile exercise because of the significant change in benefit programs and the desirability of reflecting experience on comparable benefit programs. Nevertheless, Blue Cross' filing employed the methodology it has used consistently in this and in other rate filing processes, namely using only data that represents complete years and for which the claim process is complete enough to involve little or no estimation of remaining claims.
28. In calculating an alternative rate (using the November 2006 data), Ms. Niehus made an allowance of approximately 4% to cover trend in claims to a full year basis, including her estimate of any effect of seasonality. The net adjustment recommended by Ms. Niehus is a decrease in the filed rate request of approximately 4%.
29. During the hearing, Blue Cross introduced testimony about BC Ex. 12, which included the December 2006 data. Because paid claims for prior months in December 2006 were relatively high, and higher than anticipated by Ms. Niehus in her prefiled testimony and calculations, the December 2006 data results in a higher projection for the partial year than had been made by Ms. Niehus. In addition, Blue Cross looked to prior year (the 2005 premium year) allowed claims history and developed a seasonality adjustment of approximately 6%. Blue Cross's method is reasonable and is based on analysis of a full year of data (the 2005 premium year), and so is preferable to that of Ms. Niehus. Blue Cross has also applied an adjustment to recognize that, particularly on the high deductible plans, the proportion of services that will be the responsibility of Blue Cross will increase over the year. Blue Cross has applied an additional adjustment to the partial year experience of 1% to reflect this. This adjustment is based on a reasonable analysis.

30. In response to Blue Cross' analysis of the additional data, Ms. Niehus suggests that her method of estimating completed claims for the partial year is preferable, because she believes that the additional paid claims in December are the result of large claims, and so are not representative. Thus, she asserts that the experience reflected in the December 2006 data should be discounted.<sup>33</sup> This is not persuasive. Ms. Niehus has suggested that full credibility should be given to data with two months runout (the November 2006 data), but that data with three months runout (the December 2006 data) is somehow less than credible. We should not pick and choose which months to include or exclude from the available data. If fewer and smaller claims had marked the December data, it would not be appropriate to exclude that data from our analysis.

31. This is not to say that analysis of the partial year data based on the new benefit plans was inappropriate. However, now that this has been done with data that includes the December 2006 claims experience, no actuarial adjustment to the filed rates is called for based on the partial year data. As noted later in this Recommendation, however, actuarial reasonableness does not equate to certainty. Actuarial projections are by definition probabilistic rather than certain. While the actuarial reasonableness of Blue Cross' approach is not seriously cast into doubt, the uncertainties associated with claims data based on older, different products, and the various complex adjustments made to that data cannot be ignored.

### **C. The Pools**

32. Ms. Niehus also disputed Blue Cross's estimation of the distribution of claims between Pool I and Pool II and has proposed a minimum loss ratio for Pool II of 65%. Based on review of

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<sup>33</sup> AG Ex. H.

the testimony and her calculations, and based on Blue Cross's concurrence with her general methodology for estimating the distribution of claims, this is an appropriate adjustment.

33. Blue Cross had set the rate requirements for the two pools based on its desire to hold the Pool I increase to 9%.<sup>34</sup>

34. Blue Cross does not use a consistent methodology for separately rating Pool I and Pool II rates or determining the subsidy provided to Pool I by Pool II. Currently, the rate and subsidy relationships between Pool I and Pool II are developed on a year-by-year basis. Basically, Blue Cross sets its rates for Direct Pay class by developing rates in the aggregate for all Direct Pay members at a level that is anticipated to meet the expected costs for the entire class.

35. Once Blue Cross determined this amount for this filing, it established the subsidy level for Pool I by capping the Pool I rates at 8.9% and then setting the Pool II rates to recover the expected costs of Pool II and the loss expected for Pool I resulting from the capped rates. This resulted in an average rate increase of 5.4% for Pool II.<sup>35</sup>

36. There is no dispute as to whether this method is reasonable. This issue is whether it is optimal for producing a subsidy for Pool I.

37. The Direct Pay pool structure is designed to attract as many healthy members as possible, thereby maximizing the premium subsidy of the less healthy members. This is actually a win-win system for members. If rates are set properly, the premiums paid by Pool II

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<sup>34</sup> BC Ex. 1 at 15.

<sup>35</sup> Id.; BC Ex. 3, schedule 6-10, 12-16, 20; AG Ex. 1 at 5, citing Blue Cross' response to AG1-36.

38. members are (1) sufficiently low to attract a sufficient number of Pool II members and (2) sufficient high to cover Pool II's own costs plus provide a subsidy to Pool I rates. All Direct Pay members benefit because Pool II members pay lower rates than if they were community rated, and the Pool I premium is made more affordable for the less healthy Direct Pay members. The result is that more Rhode Islanders are insured than would be the case if community rating were applied to the entire Direct Pay market.<sup>36</sup>
39. This subsidy system breaks down, however, as the cost of health insurance rises. As premiums go up, healthy people choose—often rationally—to go without health insurance. For less healthy people, however, forgoing health insurance may not be an option. The resulting adverse selection, if left unchecked, will result in a so-called “rate spiral” where increasing premiums increasing drive off health members, leaving only the sick. The resulting cycle of premium increases would eventually make the Direct Pay market unsustainable.<sup>37</sup> This prospect is a continual threat to the Direct Pay market.
40. To keep premiums affordable for all Direct Pay members, Ms Niehus suggests that a target loss ratio of 70% be applied as a benchmark for Pool II. This means that Blue Cross should price Pool II so that about 70 cents of every premium dollar paid by Pool II members should go toward the cost of claims incurred by Pool II members. She does, however, caution that, depending on circumstances, the Pool II target loss ratio could vary in any particular year from 70%. She does argue, though, that the loss ratio never be allowed to fall to less than 65%.<sup>38</sup>
41. Her reason for this loss ratio is simple: Pool II members ought to obtain a reasonable value

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<sup>36</sup> AG Ex. 1 at 7-12.

<sup>37</sup> Id.

<sup>38</sup> Id.

for their premium dollar if Blue Cross expects them to make the decision to purchase, or to continue to purchase, health insurance. Some states regulate loss ratios for selected health insurance products (Medicare Supplement, for example), and a common standard is a minimum 65% loss ratio, although in some cases, a 75% loss ratio is selected. Based on these facts and her own experience in pricing health insurance products, it is her opinion that a target loss ratio of 70% is reasonable.<sup>39</sup>

42. Furthermore, this target loss ratio is consistent with Blue Cross' overall rating goals. Pool I premium has been approximately 69% of total Direct Pay premium over the last few years. In Blue Cross Filing Schedule 20, Blue Cross has proposed a loss ratio of approximately 96% for Pool I. On a weighted basis (69% of premium from Pool I members at 96%, and 31% of premium from Pool II members at 70%), the combined loss ratio would then be approximately 88%. This compares closely to Blue Cross' combined required loss ratio of 88.65%, which is also shown in Blue Cross Filing Schedule 20. This suggests that if Pool II is priced close to a 70% loss ratio and Pool I is priced close to a 96% loss ratio, Blue Cross can achieve its overall pricing objectives and also treat both classes more fairly. While Pool II members would obtain a reasonable value for their premium dollar at a 70% loss ratio, Pool I members would be asked to pay premiums in an amount that approximates the actual costs of their claims.<sup>40</sup>

43. On balance, the approach suggested by Ms. Niehus appears to be a superior approach than that currently used by Blue Cross. In order to protect the pool structure, a more consistent approach ought to be employed when pricing Pool II. This approach is designed to deliver

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<sup>39</sup> Id.

<sup>40</sup> Id.

consistent value to Pool II members, while providing a reasonable subsidy to Pool I members.

44. Blue Cross should implement a target loss ratio for Pool II as a benchmark to ensure that its members receive sufficient value for their premium dollar in order to attract more young, healthy members. That target loss ratio should be in the range of 70%.
45. This year, however, a loss ratio of 65% should be used in order to ease the transition to this method.<sup>41</sup>
46. If Blue Cross were required to institute a 65% minimum loss ratio for Pool II in this rate filing, the rate increase for Pool I would increase to 10.5% (since there would be less available subsidy), and the Pool II rate increase would change to 1.9%. This would be a more reasonable approach than that proposed by Blue Cross in terms of promoting enrollment in Pool II for the purpose of subsidizing Pool I.

#### **D. Contribution to Surplus**

47. As noted above, approximately one-third of the proposed rate increase is comprised of a surplus contribution and the taxes on that contribution. While surplus contributions (and the associated taxes) are generally an acceptable component of rate increases, this component is not appropriate for the proposed rate increase this year.
48. Also noted above, last year's increases averaged 20-30%, in addition to increased member cost sharing. This was a substantial increase for Direct Pay member to bear, and, in general, the already expensive Pool I rate increases were more severe than those for the more moderately priced Pool II. Nevertheless, those rates were approved, with minor pricing

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<sup>41</sup> Tr. II at 69-70.

modifications, on the ground that Blue Cross generally made its case that the rates were justified.<sup>42</sup>

49. As this Office has noted elsewhere, the Direct Pay class is particularly vulnerable to the high costs of health care. This vulnerability stems from the fact that this class directly bears all the costs of its health insurance. There is no employer contribution and no tax subsidy of premium. In addition, this class is also contains a greater component of older, sicker participants (in Pool I) than employer groups, thereby driving up the class' medical claims costs.<sup>43</sup>

50. For these reasons, and as a matter of principle and policy, Direct Pay members should be afforded reasonable aid in their efforts to purchase affordable health insurance. Reasonable aid can be interpreted to include the following: (1) efforts by Blue Cross by virtue of its size and charter to keep health care cost increases low, (2) elimination of unnecessary administrative expenses in relation to its products, (3) investment of plan surpluses in income-based subsidy programs and (4) in actuarial estimates that reflect a higher allocation of the risks to Blue Cross of the uncertainties inherent in the rate projection process.

51. Two other factors are relevant to this discussion. First, Blue Cross will realize record-level net income for 2006. Blue Cross is expected to report \$60 million in net income in its 2006

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<sup>42</sup> See 2006 Direct Pay Decision.

<sup>43</sup> Some public comment alleged that employer groups and other insured groups get a better deal than Direct Pay members. There is simply no evidence of this. Direct Pay members pay the same costs for medical services as Blue Cross' group business members. As has been shown in other filings, Blue Cross generally passes on fewer of its administrative costs to Direct Pay members than to its group members. Direct Pay members do not pay broker fees, unlike group members. The general medical inflation trends used to develop Direct Pay rates are similar to those used to develop rates for employer groups. Furthermore, the Direct Pay rate approval process provides substantially more scrutiny over the rates charged than does the regulatory process for group business. Despite these benefits, however, Direct Pay members pay more direct costs for their insurance because their rates are unsubsidized, fully taxed and because their population contains older and sicker members.

annual report to the OHIC, due March 1, 2007.<sup>44</sup> Second, Blue Cross' surplus level is also at an all-time high. Blue Cross expects that its 2006 earnings will bring it close to its minimum adequate surplus level, as determined by an OHIC-commissioned study of adequate surplus levels for the state's major insurers.<sup>45</sup>

52. Because Blue Cross' surplus level is nearly at the level determined to be adequate, a contribution to this surplus by Direct Pay members at this time is not in the consumer interest and it is not consistent with Blue Cross' mission as a publicly chartered, nonprofit charitable institution. The most vulnerable members of the Blue Cross community of insureds should not be asked to add to Blue Cross' surplus this year, especially on the heels of a 20-30% increase.

53. Although Blue Cross alleges that its surplus for the Direct Pay class is approximately \$7.7 million in the negative,<sup>46</sup> Blue Cross' internal practice of accounting for its surplus by line of business is not determinative in this rate review process. Losses have been experienced in various Blue Cross lines of business in the past. Indeed, Blue Cross (and/or its former subsidiary) incurred losses year-in and year-out in some product lines. For example, Blue Cross' subsidiary lost millions in its Medicaid line of business over a period of years.<sup>47</sup>

There is no reason why Direct Pay must be singled out in this respect. Some of Blue Cross'

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<sup>44</sup> Tr. II at 41-2. Although adjustments may be made to this estimate between the time it was given and the time the report is filed, Blue Cross will nevertheless report that it has had a very successful year.

<sup>45</sup> SAPOR stands for Surplus As a Percentage of Revenues. The report is available at [www.dbr.state.ri.us/documents/divisions/healthinsurance/BCBSRI\\_final\\_reserves\\_Report\\_060811.pdf](http://www.dbr.state.ri.us/documents/divisions/healthinsurance/BCBSRI_final_reserves_Report_060811.pdf). According to this report, Blue Cross has an adequate surplus at 23% of SAPOR. At the end of 2006, Blue Cross is at 22.5% SAPOR. Tr. II at 41-2.

<sup>46</sup> BC Ex. 1 at 53. This figure was as of September 30, 2006. Blue Cross projects that its Direct Pay surplus will be at about negative \$7.5 million as of March 30, 2007. This testimony reflects that, as of the time the testimony was submitted, Blue Cross did not project a loss on its current Direct Pay rates (for the 2006 premium year) and indeed anticipates a \$200,000 contribution to surplus from its Direct Pay members. Id.

<sup>47</sup> See OHIC Exs. 5 and 6. For example, Coordinated Health Partners consistently lost money in the Medicaid line of business from 1999-2004. OHIC Ex. 5. These losses were most certainly covered by net income generated from other lines of business.

lines of business are, at times, covered by revenues generated by Blue Cross' other lines of business. Sometimes this goes on for years (and perhaps not unexpectedly so), as in the case of Blue Cross' Medicaid business.

54. Furthermore, Blue Cross has "reset" its Direct Pay negative surplus to "zero" in the past.<sup>48</sup>

This fact demonstrates that the negative surplus is not a "hard" number, but is instead one that may be malleable for a particular reason. This characteristic of the negative surplus amount also undercuts Blue Cross' use of that number as a meaningful figure for the purposes of this rate hearing.

55. In addition, the legal issue of the individual surplus line has been addressed and disposed of in the 2004 Direct Pay administrative ruling and the subsequent Superior Court decision upholding that ruling.<sup>49</sup> Blue Cross has appealed the Superior Court decision to the Supreme Court, but until the Supreme Court addresses Blue Cross' appeal, the Superior Court decision stands and will be applied by this Office.

56. If Blue Cross were not permitted to include a contribution to surplus (and the associated provision for taxes) in its rates, the overall requested rate increase from approximately 7.8% would be reduced to approximately 5.1%. If Blue Cross were also to institute a 65% minimum loss ratio for Pool II at the same time (as discussed above), the Pool I rate increase would be approximately 6.6% and the Pool II increase would be still be approximately 1.9%.

57. While these pool rate increases (1.9% and 6.6%) are certainly more affordable than those proposed in the filing, I am nevertheless troubled by the Pool I rate increase. First, as

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<sup>48</sup> Tr. I at 65.

<sup>49</sup> See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd*, *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

already discussed, Pool I members experienced significant increases last year. While that increase was slightly mitigated for some Pool I members by the PAP, their hit was large and hard. I am also somewhat concerned about the uncertainty associated with the pricing of the new products based on the claims data from the old products. This is not to say that my previous findings in the Recommendation related to the actuarial soundness of Blue Cross' rating methods are incorrect. Despite Blue Cross' best efforts, there is always uncertainty in such rating methods. While I noted earlier that it would be inappropriate to discount the December claims data when applying the 2006 premium year claims data, it nevertheless highlights the speculative and uncertain nature of the rate projection process. However, under these circumstances, the risk associated with the uncertainties in the process should be borne by Blue Cross. As I noted in last year's Recommendation:

The evidence suggests that Blue Cross and its actuaries have produced "reasonable rates" with respect to its new plans. There is no evidence, however, to suggest that these reasonable rates take into account the uncertainties and risks associated with the new plans. The pricing uncertainty is the accuracy of its financial projections. Unlike typical rate projections which rely more heavily on past claim experience, the rate projections in this case rely on especially complex assumption and factors. These factors and assumptions may not be accurate. Indeed, they could be off (on either the high or low side) by 1%, 3%, 5% or more. If the projections of medical expense are higher than what eventually occurs, Blue Cross will make more money than it anticipates, at the expense of subscribers. If the reverse occurs, subscribers will benefit, but at Blue Cross' expense. Blue Cross has \$280 million in reserves to cushion against its potentially incorrect assumptions and projections. What cushion do Direct Pay subscribers have? As Blue Cross' actuaries have conceded, "it is certain" that actual experience with these plans and rates will not conform to the estimates and assumptions that were used to develop the rates. [citation omitted] Thus, it is not unreasonable to expect that some greater portion of the risks associated with these untested plans should be borne by Blue Cross. Such a reallocation is consistent with Blue Cross' obligations and mission as a state chartered, nonprofit charitable organization. While the allocation of such risk is difficult to quantify, it is not unreasonable to expect that a reallocation of risk should be effected through a pricing modification. Indeed, a pricing modification is the most effective method of ensuring that

less financial risk is borne by consumers and health care providers and more financial risk is borne by Blue Cross.<sup>50</sup>

58. Last year, the pricing modification referenced in the preceding quote was one percent across the board. That totaled about \$550,000 in reduced premium.<sup>51</sup> A reduction of 1.6% from the Pool I rate increase would reduce that pool's rate increase by approximately the same amount. This would reduce the increase for Pool I to 5% and help reduce the risks to Pool I member inherent in Blue Cross' projections.<sup>52</sup>

59. For all of the reasons set out above, I recommend that the Commissioner adjust the pool rates to these amounts.

### E. PAP

60. Last year, Blue Cross instituted a Premium Assistance Program (PAP) for its Direct Pay members. Blue Cross set aside \$1.5 million per year for three years to fund the PAP. Direct Pay members were eligible for the program if they were in Pool I and had a gross annual income at or below 300% of the Federal Poverty Level.<sup>53</sup>

61. Although Blue Cross had estimated that approximately 40% of Pool I members would be eligible in the 2006 premium year, only 15% of Pool I members actually participated in the

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<sup>50</sup> 2006 Direct Pay Decision at 47-8.

<sup>51</sup> Id.

<sup>52</sup> The rates for Pool II should not, however, be equally reduced because along with the lower rates for Pool II is a lower risk to that population that the rates will be too high.

<sup>53</sup> The 2007 Federal Poverty Levels for Rhode Island are:

Persons in family	Poverty guideline
1	\$10,210
2	\$13,690
3	\$17,170
4	\$20,650
5	\$24,130
6	\$27,610
7	\$31,090
8	\$34,570

For families with more than 8 persons, add \$3,480 for each additional person. 72 F.R. 3147-3148 (Jan. 24, 2007).

program, resulting in an expected expenditure of only \$500,000 of PAP monies for the 2006 premium year.<sup>54</sup>

62. The reasons for the low take-up of the PAP are unclear. Perhaps Blue Cross did not adequately advertise the program.<sup>55</sup> Perhaps Blue Cross' administrative mechanisms for qualifying members for the PAP was too burdensome. Perhaps certain eligible members did not apply because they viewed the program as "charity."<sup>56</sup> Whatever the reason, Blue Cross has taken steps to increase PAP take-up. First, Blue Cross has expanded eligibility for the program by opening it up to Pool II members. Second, Blue Cross has increased the upper income eligibility limit to 350% of FPL. This means that an individual Direct Pay member<sup>57</sup> with a gross income not exceeding \$35,735 will be eligible for the PAP. Likewise, a family of three purchasing Direct Pay coverage will be eligible for the PAP if its gross income does not exceed \$60,095. Third, Blue Cross has increased the amount of the PAP subsidies by 20%.<sup>58</sup> Blue Cross has also committed an additional \$4.5 million to the

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<sup>54</sup> BC Ex. 11.

<sup>55</sup> Testimony by Blue Cross personnel did indicate that opportunities to inform members about the PAP may have been missed. Blue Cross personnel have pledged to make better use of the company's telephone service operations to better publicize the PAP and its benefits. Tr. III at 93-96. Indeed, Blue Cross' customer service came up as an issue at a few different points in the hearing. For example, it was also raised with respect to the process for providing information about choices to employer groups of one. Tr. II at 37-40. Again Blue Cross pledged to address the issue. At some point, however, Blue Cross should consider a more comprehensive evaluation or assessment of its customer service/sales staff operations to ensure that consumer issues are fully addressed and that the full range of available options are made known to inquiring consumers.

<sup>56</sup> One member of the public referred to the PAP as "charity." Tr. I at 28-29.

<sup>57</sup> Approximately 78% of Direct Pay contracts are for individual coverage. BC Ex. 5 at 54. In many cases, however, it is less expensive for a family in Pool II to buy coverage for the individuals than buy family coverage. For example, Pool II coverage for a 45 year-old female with a 17 year-old female child would cost \$835.56 per month for HM 400 coverage as a family, whereas Pool II HM 400 coverage purchased separately for each would cost only \$674.05 (\$415.98 + \$258.07). This fact suggests that there may be more families covered by the Direct Pay products than is reflected by the number of contracts for individual coverage. Blue Cross must ensure that Pool II families that buy individual coverage for each member receive the same PAP premium discount as if that family had purchased the more expensive family coverage.

<sup>58</sup> BC Ex. 5 at 54.

program, bringing the available program balance to \$8.5 million.<sup>59</sup>

63. Eligibility limits for the program will be as follows:

Persons in family	Level I Upper Limit (200% FPL)	Level II Upper Limit (350% FPL)
1	\$20,420	\$35,735
2	\$27,380	\$47,915
3	\$34,340	\$60,095
4	\$41,300	\$72,275
5	\$48,260	\$84,455
6	\$55,220	\$96,635
7	\$62,180	\$108,815
8	\$69,140	\$120,995

The PAP discounts will be applied as follows:

Contract	Level I Annual Premium Reduction (≤ 200% FPL)	Level II Annual Premium Reduction (>200% up to 350% FPL)
Individual	\$852	\$564
Family	\$1,608	\$1,068

64. While Blue Cross' efforts with respect to the PAP are laudable, and the Hearing Officer is of the opinion that Blue Cross is taking positive steps to ensure increased take-up of the PAP, given the low take-up last year, benchmarks for take-up this year should be included as a condition of rate approval. As noted in last years' Direct Pay decision, the PAP is an important component of Blue Cross' strategy to meet its affordability requirements. Yet, last year's take-up was far less than projected and at least some of the low take-up is likely attributable to Blue Cross' administration of the program. Since Blue Cross has again estimated PAP expenditures for the 2007 rate year at \$1.5 million,<sup>60</sup> there should be some accountability on Blue Cross' part with respect to this number.

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<sup>59</sup> Last year, Blue Cross committed \$4.5 million and spent only \$500,000 (projected for the 2006 premium year). This year they committed an additional \$4.5 million. BC Ex. 11.

<sup>60</sup> BC Ex. 5 at 54.

65. Accordingly, Blue Cross should be required, six months after the beginning of the 2007 rate year, to demonstrate either (1) that it is on track to apply \$1.5 million in PAP subsidies over the course of the rate year or (2) that it has taken reasonable steps to (a) publicize the program to its existing members as well as potential members, (b) provide members and potential members with sufficient information about the program and the application process and (c) ensure that a process is in place to answer questions about the program and resolve problems arising in its administration.
66. Failure to meet these requirements should be addressed through the administrative process, rather than retroactive rate adjustment. An examination of Blue Cross' PAP process under chapter 13.1 of title 27 of the General Laws may be one method of addressing Blue Cross' inability to either fully disburse the funds or explain why it reasonably cannot do so.
67. These requirements are certainly not a burden on Blue Cross. Blue Cross has made its commitment to the PAP a part of its efforts to ensure the affordability of its Direct Pay products. These requirements are designed to ensure that the PAP is actually a meaningful part of Blue Cross' Direct Pay program.
68. Ms. Niehus has recommended that the Premium Assistance Program ("PAP") funding be increased. She cites two reasons. First, she disputes the projection of enrollment because it does not incorporate expected lapses among current PAP participants. Second, she thinks it understates the expected benefits because she believes Pool II to have more single and fewer family participants.<sup>61</sup>
69. With regard to her first point, Blue Cross has admitted that it made no allowance for lapses,

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<sup>61</sup> AG Ex. A at 25-7.

and projected only increases in PAP enrollment.<sup>62</sup> However, this may be splitting hairs, given that the program is so new and it appears that Blue Cross may not have promoted it adequately. In addition, Ms. Niehus has not made allowance for the possibility that people with PAP may be less inclined to lapse coverage than the population at large.

70. Blue Cross has proposed a significant expansion of PAP. Blue Cross should be encouraged to make sure its administrative processes are designed to encourage more applications from eligible people to the PAP than they have done to date. The combination of improved administration and the expansion to higher income levels and both Pools will likely result in a greater contribution to Direct Pay members through the PAP, and that Blue Cross's overall projection of PAP is reasonable at this time. Thus, I do not believe that Ms. Niehus' proposed 15% increase beyond the amount Blue Cross has committed is called for at this time, subject to review next year.

#### **F. Medical Underwriting**

71. The issue of the appropriateness of Blue Cross' medical underwriting standards for Pool II was raised by Ms. Niehus.<sup>63</sup> Public comment also highlighted the issue. In addition, the issue was raised as to whether Blue Cross fully and adequately informs its Direct Pay members when they may be eligible to switch from Pool I to Pool II. These are indeed complicated issues. Based on the testimony and public comment on these subjects, Blue Cross is urged to review its medical underwriting standards for Pool II. An optimal level of screening should be present so that the benefits of Pool II can be maximized (i.e., lower rates for some members, higher subsidy for Pool I). Anecdotal evidence at the hearing

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<sup>62</sup> Tr. II at 99-100 (counsel thanking Ms. Niehus for pointing this out).

suggested that some relatively healthy people who do not make the cut for admission to Pool II simply drop coverage all together rather than pay Pool I rates. Furthermore, Blue Cross should take steps to ensure that its Pool I customers understand how they got into Pool I as well as how and when they might become eligible to migrate to Pool II, if such a migration is a possibility.

### **G. Issues Raised in Pubic Comment**

72. Most of the issues raised in public comment have been addressed elsewhere in this Recommendation. The issues that have not been fully addressed will be discussed here.
73. The issue of five-year age increases in Pool II has not been addressed. This system was implemented last year to mitigate the severe jump in rates that resulted from the previous ten-year age bands in Pool II. This feature spreads the rate increases out more gradually over time and is therefore a proper practice by Blue Cross.
74. Blue Cross' administrative expenses, including the portion of executive salaries allocated to Direct Pay, were reviewed carefully in connection with this filing. We are satisfied that they are reasonable. The rate increase is related to increases in the cost of care and not to increases or wastefulness in administrative costs.
75. While Direct Pay members do not have employers to help them pay their bills, they do receive important benefits that are similar to those available to group customers. Their premiums are lower than they would otherwise be because Blue Cross negotiates discounts with providers. Direct Pay consumers receive the same discounts that are enjoyed by all other Blue Cross members including both large and small group members. These discounts

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<sup>63</sup> AG Ex. A at 19.

are also available to Direct Pay consumers for the amounts they pay out of pocket as cost sharing under the Direct Pay plans. Also, Direct Pay consumers benefit from the close attention to rate increases provided by the Attorney General and by the Office of the Health Insurance Commissioner. The scrutiny of this review process ensures that inappropriate rate increases are not approved.

#### **H. Affordability**

76. The affordability guidelines have been discussed extensively in other decisions. Therefore, a while discussion of those principles is unnecessary here, application of those principles to this rate filing is nevertheless required.

77. Blue Cross submitted an Interim Affordability Report that addresses affordability efforts that are both system-wide and directly related to the Direct Pay market. Discussion of many of the issues raised in the Interim Affordability Report should (and will) take place outside the scope of this rate approval process.

78. The report and the testimony by Blue Cross related to affordability meet the minimum requirements for the purposes of this hearing, notwithstanding Ms. Niehus' accurate comments about certain aspects of Blue Cross' affordability efforts.

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79. Any Conclusion of Law that is also a Finding of Fact is hereby adopted as a Finding of Fact.

#### **V. CONCLUSIONS OF LAW**

1. The preceding sections I through IV of this Recommendation are incorporated into these Conclusions of Law.

2. The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.5-1 *et seq.*, 27-19-6 and 27-20-6.
3. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*
4. All of the procedural prerequisites for the conduct of the hearing have been followed.
5. The OHIC has jurisdiction in this proceeding to conduct a hearing for purposes of considering whether or not Blue Cross' proposed rates for its Direct Pay products are consistent with the proper conduct of its business and in the interest of the public.
6. The "proper conduct" of Blue Cross' business requires Blue Cross to take steps to enhance to affordability of its products.
7. Blue Cross bears the burden of proving that the proposed rates are consistent with the proper conduct of its business and in the interest of the public.
8. In addition, the OHIC must comply with the requirements of the OHIC Statute when rendering a decision in this matter. The OHIC Statute requires the Commissioner to render a decision so as to, among other things, protect consumer interests, encourage policies that improve the quality and efficiency of health care delivery, and encourage and direct Blue Cross toward policies that advance the welfare of the public.
9. The OHIC is authorized to modify the rates proposed by Blue Cross pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6.
10. A rate increase of 5.0% for Pool I members (as opposed to the rate increase of 8.9% for this pool sought by Blue Cross), is within the proper conduct of Blue Cross's business and in the public interest. Such a rate also protects consumer interests and advances the welfare of the public.

11. A rate increase of 1.9% for Pool II members (as opposed to the rate increase of 5.4% for this pool sought by Blue Cross), is within the proper conduct of Blue Cross's business and in the public interest. Such a rate also protects consumer interests and advances the welfare of the public.
12. Going forward, the rating process should be modified to establish a target loss ratio for Pool II at approximately 70%, with adjustments to that benchmark as deemed necessary or appropriate by Blue Cross. Such a modification is within the proper conduct of Blue Cross's business and in the public interest. It also protects consumer interests and advances the welfare of the public.
13. At approximately six months into the new rate period, Blue Cross should report to the Commissioner its expected Premium Assistance Program take-up and, if the take-up is not expected to fully use the projected \$1.5 million in assistance funds, Blue Cross should be prepared to demonstrate that it has taken reasonable steps to (a) publicize the program to its existing members as well as potential members, (b) provide members and potential members with sufficient information about the program and the application process and (c) ensure that a process in place to answer questions about the program and resolve problems arising in its administration. Should Blue Cross fail to meet these standards, the Commissioner should consider appropriate administrative action.
14. Blue Cross should be urged to examine its Medical Underwriting standards for Pool II to ensure that they are not too strict.
15. Blue Cross should take steps to ensure that its Pool I customers understand the circumstances that caused them to be enrolled in Pool I and how and when those customers might become eligible to migrate to Pool I I, if such migration is a possibility.

16. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.



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John Aloysius Cogan Jr.  
Hearing Officer

February 21, 2007

## **ORDER AND DECISION**

I, Christopher F. Koller, Health Insurance Commissioner of the State of Rhode Island, accept the recommendations of the Hearing Officer.

This is the second Direct Pay hearing conducted by this Office and the fourth Blue Cross rate review process completed this Office (two Direct Pay and two Medigap). These hearings and rate reviews highlight several important factors in the Direct Pay Market.

First, Direct Pay Subscribers face three fundamental inequities compared to the rest of the commercial market. They buy their health insurance without the benefit of employer contributions – which typically amount to 75-80% of the cost of health insurance. They purchase health insurance with after-tax dollars – a penalty worth up to 30% compared to employees. Finally, as a whole, the Direct Pay pool is generally older and sicker than other commercial pools – resulting in overall higher claims costs for the pool that must be recovered through higher premiums.

Second, given these inequities, both the Direct Pay market oversight and the rates approved in this decision represent an appropriate resolution of a difficult situation. Direct Pay subscribers have a higher degree of regulatory oversight than any other parts of the commercial health insurance market. As a result of this oversight, the rates for Direct Pay products are comparable to the prices in the large and small group markets, and less expensive than Direct Pay products in other states in the region. While Blue Cross continues its efforts to make this market sustainable and improve the overall affordability of health care system in Rhode Island, the reductions in this ruling from their proposed rates continue to indicate this oversight is necessary. Blue Cross is to be commended for continuing to invest in and expand the eligibility criteria for its Premium Assistance Program, which targets a ten to fifteen percent rate reduction to the populations that most need it. Blue Cross must

demonstrate, however, the ability to administer successfully the program, so it can become an integral part of the Direct Pay product offering.

Finally, with employer insurance eroding, the number of uninsured increasing and the overall medical expense trend continuing to run higher than the general rate of inflation, policy efforts beyond the confines of this rate hearing process must continue to ensure the relative affordability of individual health insurance, including the following:

- 1) Pursuit of the ability of Direct Pay subscribers to purchase their health insurance with pre-tax dollars, as in the group market;
- 2) The inclusion of as many younger and healthier individuals in the insurance pool as possible – through the development lower cost benefit packages and consideration of mandating the purchase of health insurance – as is the case with car insurance; and
- 3) The creation of larger, more stable insurance pools operating under common rules by merging the Direct Pay and the small employer group markets<sup>64</sup>.
- 4) The continued focus of insurers in Rhode Island on efforts to address the underlying costs in the health care system through innovative methods of benefit design, provider payment and system investments – consistent with the affordability principles outlined in previous decisions by this Office.

All of these efforts should be pursued deliberately. Failure to do so will inevitably lead to harsh consequences for the Direct Pay market. Simply standing still will leave the Direct Pay pool,

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<sup>64</sup> There is common opinion expressed in members' letters and testimony that "more competition among insurers" would result in significantly lower overall rates. This has not been borne out by the experience of other markets – 80-90% of health insurance expenses are medical in nature. Absent common underwriting rules, insurer competition is a boon to younger healthier groups and a bane to older and sicker ones. However, a larger insurance pool as recommended here, with insurers competing based on common rules, could result in more innovation, better service and reduced rate volatility.

with its disproportionately sicker population, extremely vulnerable to the rate spiral referred to by the Hearing Officer.

While these policy efforts are pursued, regulatory efforts will continue – to protect the Direct Pay consumers and work with Rhode Island’s licensed health insurers on their statutory responsibilities to improve the accessibility, quality and efficiency of the health system in the state. Blue Cross’ affordability efforts are an important part of this work.

The rates and recommendations contained in this ruling represent an appropriate determination given the evidence presented at this hearing.

**ENTERED AS AN ADMINISTRATIVE ORDER OF OFFICE OF THE HEALTH INSURANCE COMMISSIONER THIS 21st DAY OF FEBRUARY, 2007.**



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Christopher F. Koller  
Commissioner  
Office of the Health Insurance Commissioner

**THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS DECISION MAY BE APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.**

